Report of the Psychological Wellbeing Practitioner Review

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1. Executive Summary

This report summarises the Department of Health commissioned review of the Psychological Well-being Practitioner curriculum and associated materials undertaken by University College London between November 2012 and March 2013. The report contains context and background, key themes that emerged from the review and a set of recommendations for taking this work forward.

- The recommendations cover the following broad areas over the two phases:
- Minor changes to current learning materials and curriculum
- Revised Best Practice Guide
- Substantial rewrite of the curriculum with a theoretical basis of behaviour change
- Revision and clarification of the assessment of PWP skills and knowledge
- Improved university and service links
- Funding and oversight of IAPT training

DH have agreed with UCL that this work is to be undertaken in three phases subject to copyright issues being resolved with the author of 'Reach Out' and the proposed phasing of this work is outlined in the recommendations. The first phase consists of setting out a programme of change. The second phase will consist of a more substantial rewrite of the curriculum, a revision of the PWP best practice guide, revision and production of training materials and the development of the self help best practice guide. UCL have agreed to undertake this work at no cost with the Expert Reference Group and other colleagues that have been established during the first phase of the the review. The third phase is concerned with implementation of these changes. UCL have a strong group in place and broad support for implementing these wider changes in the medium to long term.

2. Introduction

In November 2012 the Department of Health (DH) commissioned a review of the PWP curriculum and associated materials in order to update and revise them as appropriate. There were a number of reasons for commissioning the review, including developments in the evidence base, the need to refine the assessment process, the changing demands on IAPT services, new roles emerging with IAPT services and the need for a better integration of PWP course accreditation and the national curriculum, in particular the assessment of trainee competence.

The review was undertaken by a group from University College London (UCL) (see Appendix 1) supported by an Expert Reference Group (ERG) to enable expert experience and opinion to support the review (see Appendix 2).

The review ran from November 2012 - March 2013 and was required to deliver the following products:

- An updated PWP Best Practice Guide
- A revised PWP curriculum
- A revised Reach Out materials to reflect curriculum
- A revision of Good Practice Guidance on the use of Self Help materials
- A specification for training and supervision of staff in consistent competence assessments, with proposed accreditation status

- A final report summarising all of the above

In order to further the review group's understanding of the issues involved in revising the curriculum and to allow as many people as possible the chance to contribute to the review, the team undertook an extensive consultation exercise (see below).

This report describes how the review was undertaken, describes the products developed and importantly highlights recommendations for further work beyond the scope of the review. During the course of the review the issue of copyright of the Reach Out materials arose that has prevented the review group from amending/ editing the Reach Out materials. This limited the work the group was able to do in revising the materials and in particular, making recommendations for the development of the assessment methods. However, discussions which took place during the consultation on the initial draft report have now clarified this issue and it is anticipated that collaborative development of a new set of new set of materials will be possible.

It is important to note that the work of the review group, in particular, the response of the DH to the revisions of existing materials and the recommendations for future developments need to be considered alongside revisions to the PWP course accreditation process and other guidance on the commissioning of both clinical and educational services.

3. Background

The Improving Access to Psychological Therapies (IAPT) programme was a national initiative by the DH that began in 2008 with the aim of improving access to evidence based, NICE recommended, psychological therapies for common mental health problems, primarily depression and the anxiety disorders. IAPT services are based on a stepped care model as recommended by NICE, and in order to operate this model, two types of staff roles and associated trainings for them were developed; High Intensity Therapists (HITs), to work at step 3 with more severe common mental health problems and Psychological Wellbeing Practitioners (PWPs) to work at step 2 with more mild to moderate mental health problems.

High intensity training programmes already existed when IAPT was established, and therefore the IAPT HI training programme was largely an expansion and refinement of an existing and well-tested model. The development of a step 2, low intensity work force was, in contrast, a new and innovative development. Whilst a HI therapist can be easily recognised as a traditional therapist, for example, when delivering Cognitive Behavioural Therapy (CBT), PWPs have been likened to facilitators or coaches. In this role PWPs primarily facilitate and motivate patients to use a variety of self-help materials (for example self-help booklets and computerised CBT) via a range of different modalities (for example, face to face individually or in groups, and by telephone).

In order to train this new workforce, novel training and associated materials were required. A national curriculum, specimen job descriptions, commissioning guidance, a guide to the used of self help materials and a PWP best practice guide were developed. Perhaps the most important development, particularly in relation to the training of PWPs, were the set of 'Reach Out' materials which were initially developed by Professor David Richards and Mr Mark Whyte with subsequent revisions by Professor Richards and colleagues (e.g. the Reach Out guide for supervisors). The Reach Out materials set out the learning objectives for the programme and provided a more detailed curriculum (the current national curriculum could be seen as an abbreviated form of Reach Out) which covered key areas of assessing and treating patients at step 2, working within an inclusive values base and an awareness of the wider healthcare, social care and employment context. Reach Out also provided specimen support materials, copies of specimen job descriptions and also set in some detail what PWP competences should be assessed (both in the HEI and in the clinical site) and how this should be done. In so doing the Reach Out materials played a vital role in ensuring that there was a consistent approach to the training of PWPs. A brief summary of Reach Out is provided below:

Reach Out

In line with the curriculum, Reach Out consists of four modules (Recognition, Recovery, Respect and Reflection) with associated learning outcomes. The course runs for approximately one year and consists of 45 days in total, 25 of which are taught by a training provider with the remaining 20 intended as learning days provided within the IAPT services:

Recognition, 15 days – this is the first module on the course and covers assessment and engagement of patients with common mental health problems and is taught largely in an intensive block at the beginning of the course. Recognition is assessed via clinical simulations, a reflective commentary and an exam.

Recovery, 10 days – this module covers evidence based low intensity interventions for common mental health disorders and runs over 10 days in parallel with module 1. The recovery module is assessed via clinical simulations, a reflective commentary and an exam.

Respect, 10 days – this module covers values, policy, culture and diversity and runs over 10 days in parallel with module 4. Competency is assessed via a presentation and accompanying reflective commentary, and exam.

Reflection, 10 days – this is the final module on the PWP course and covers working within an employment, social and health care context and runs over 10 days in parallel with module 4. Competency is assessed via a simulation of case management supervision, reflective commentary, and exam.

The curriculum includes practice outcome documentation. This consists of 11 practice outcomes across the 4 modules relating to practice in service. These outcomes are signed off by the trainee's supervisor and submitted to the course. In addition to the edition for educators there are also versions specifically for trainees and supervisors; the content is very similar, sharing a number of common elements including core assessment methods and interventions, and learning outcomes.

Over the course of the past five years there have been some challenges in establishing a robust national PWP training programme, perhaps unsurprising given the pace at which the new programmes were established. This is clearly highlighted by the provisional accreditation awarded to some courses and the loss of accreditation of other courses. In addition to concerns about the content of the teaching (which was outside of the national curriculum and step 2 evidence base), a major concern centred on the assessment of competence. It was this issue that was one of the major reasons why DH asked for this review to be undertaken. Some detail on the assessment process as set out in Reach Out is provided below.

Assessment for each of the modules is outlined in Reach Out as noted above but it has become clear that there was a lack of clarity about detailed interpretation and scoring using the assessment scales for clinical skills. This has in part arisen from an associated lack of guidance (specifically a manual) but which was addressed by the provision of specific training programmes in the use of the scales. The difficulties have been focused on ensuring a consistent standard of assessment that assesses both adherence (performing the required behaviour) and competence (performing the behaviour in a skilful manner).

In Reach Out the focus of assessment of clinical competence has been around assessing trainees as competent in the low intensity clinical method. Clinical simulations (with actors) are the preferred method of assessment for use with trainees assessed via the Reach Out scales.

In addition to the problems described above with the methods of assessment, other concerns and possible misunderstandings have arisen concerning the assessment processes, they include:

1. A lack of clarity about the respective roles of the courses and services in assessing competence in the low intensity method (a matter for the courses) and clinical competence (a matter for the services)

2. This lack of clarity (see point 1) in part stems from the relative weakness of some of the practice-based outcomes and the varying importance placed on them by services. This also raises an additional concern about the competence of some supervisors to properly assess practice-based outcomes and the implications of this for trainees, services and courses, if trainees were failed on these outcomes.

3. The issues identified in points (1) and (2) have also led to considerably variability in when patients are seen first seen by trainees with some services deeming trainees to be competent to see patients under supervision (based on an assessment of trainees prior experience) prior to being assessed as competent in method by the course and other services considering early patient contact to be important both for trainee skills development and the meeting of service targets.

4. The time taken for trainees to be assessed as competent in the methods of assessment and interventions typically took between 10 to 12 weeks and this led to problems for services, even with well planned practice learning assignments, with the proper occupation of trainees in the first three months of the course.

5. Concern was also expressed that during this initial period trainees were unable to consolidate the skills that they were learning in modules 1 and 2 by gaining direct experience of working with or observing others with patients

6. The opportunity for trainees to directly observe the practice of experienced practitioners and to have their own work directly observed and supervised also varied considerably and both limited the opportunities for learning and for supervisors to assess trainees competence.

7. There was also a concern that trainees can successfully complete the course without a university-based assessment of their competence in working with patients.

8. Finally, there was a recognition in the consultation that the varying demands on services and consequently trainees (for example, the increasing use of 'triage' assessments and the introduction of new interventions) required some developments both the teaching of core skills and their assessment (for example, less precise specification of the time taken to undertake an assessment).

Accreditation

The issues highlighted above, particularly around the assessment of competence, have had implications for the accreditation of courses that has resulted in a number of courses having a provisional accreditation or losing their accreditation (the accreditation process is currently co-ordinated by the British Psychological Society (BPS)). PWPs are not registered with the HPC. As PWPs often do not have individual accreditation (notwithstanding the limited number accredited with the BABCP) this meant that individual trainees who attended and passed a course that was not accredited were deemed to be not qualified to practice as a PWP. This was resolved in a number cases by external experts running 'recovery programmes' for particular courses.

Course accreditation was initially undertaken jointly by the BPS and BABCP but is currently managed by the BPS alone with the BABCP still involved individual practitioner accreditation. While a review of the accreditation process is outside the scope of this project, the close relationship to accreditation of the revision to the overall assessment system requires that is considered. One factor that should be considered is the implications of this review for the respective roles of external examiners, the internal quality assurance role of the HEIs and the role of the accreditation panel.

The PWP Best Practice Guide

Given developments in the national IAPT programme and within local services an update of the Best Practice Guide was felt to provide a useful opportunity to address a number of issues, for example; retention of PWPs, developments in the PWP role (e.g. the senior PWP role) and issues around recruitment and appropriateness of training sites for trainees.

The Guide to the Use of Self Help Materials

This guide was developed following a conference in Leeds in 2010. The original guide had the ambitious aim of informing IAPT staff on the appropriate development and use of self-help materials. Results from the consultation suggest that very few of those who participated in the review were aware of the guide and even fewer had made use of it. This suggest that a careful review of the purpose of the guide is needed and that it will require a substantial revision if it is to be of any use.

Six Additional factors of relevance to the review

As was acknowledged above the primary reasons behind the review centred on the updating of the curriculum and associated materials and processes. There are a number of contextual factors that both support the need for a review and which need to be considered in the undertaking of the review.

Additional demands on the IAPT programme: the national IAPT team have supported the development of work for people with a range of needs that are outside the initial focus of IAPT. In some cases this represents further detailed work with the existing remit (and curriculum) for example the work recently completed on the curriculum for IAPT staff working with older people (REF). In other cases there has been an extension of the work of IAPT to 'new' populations that may require changes in the curriculum and associated materials, for example, working with people Long Term Conditions (LTC) and Medically Unexplained Symptoms (MUS). Other developments such as the work on psychosis and personality disorder are clearly outside the scope of this review, as it is not intended for there to be a role for PWPs in the assessment of or treatment of these disorders.

Retention: There are significant concerns around the retention of PWPs in IAPT services. The review group were unable to obtain any reliable data on this from the DH or other sources. Reports from services and

regional leads (which was supported by the information that emerged from the consultation process) suggest that turnover for PWPs varies considerably. A number of reasons have been suggested for this, namely, movement of PWPs on to other training programmes (such as IAPT high intensity and clinical psychology training), a lack of career opportunities, the stress and nature of the role (in significant part related to the volume of patients seen), and importantly, as suggested by the consultation undertaken as part of this project, the limited value for the role and lack of support in the role that a significant number of PWPs experience).

Developments in the IAPT model: IAPT services have undergone a series of developments and changes since the inception of the programme, a number of which have relevance to this review. They include: (a) the development of briefer 'triage' style assessments than was originally envisaged (b) the use of or integration of IAPT services with a 'single point of access', in some case not only for IAPT services but for the wider mental health services (c) the requirement from local commissioners to meet the needs of other populations such as those with hazardous or harmful drug or alcohol misuse (d) the development of 'Any Qualified Provider' (AQP) as a commissioning route for IAPT services which has meant, in some cases, that a large number of providers (in one case over 15 different providers) can be delivering both low and high intensity IAPT treatment in any given area and finally (e) a specific development with relevance for step 2 work, that is the senior PWP role.

Education commissioning and training placement: The model for the commissioning of IAPT training varies greatly across England with some areas receiving full salary support and funded training places and others receiving only funded training places. This has caused difficulties with filling commissioned training places for PWPs as services may be reluctant to take trainees (with a reduced training caseload) over fully trained PWPs (with a full caseload) in their efforts to meet performance levels of the IAPT programme. This lack of salary support and funding can also give rise to issues with ensuring an appropriate training environment for PWPs as in many areas there is no mechanism to monitor or support this. In addition, the move of education commissioning responsibility from Strategic Health Authorities (SHAs) to Health Education England (HEE) supported by Local Education and Training Boards (LETBs) means that there is a lack of clarity around future arrangements for the commissioning and funding of IAPT training beyond March 2013.

4. The PWP Review Project

The review was undertaken in three stages; (1) the establishment of the team, the ERG and the project plan; (2) consultation with a variety of stakeholders via online submissions and workshops across England and; (3) the development of products.

The products required by DH were as follows:

Updated PWP Best Practice Guide - To provide updated guidance, which continues to support varied configurations of local IAPT services and provides clarity for the role of the senior PWP role including the production of a model job description and person specification.

Revised PWP curriculum - An update to the curriculum to support developments in the training delivered to PWP's, particularly as the IAPT programme extends to providing interventions to more diverse clinical groups, older people, people with long term conditions, medically unexplained symptoms and potentially those with a severe mental illness.

Revised Reach Out materials to reflect the changes in the curriculum - These materials are informed by the PWP curriculum and require updating at the same time as the curriculum. The issue of copyright is still outstanding therefore preventing these changes being made.

Revision of Good Practice Guidance on the use of Self Help materials - The Good Practice Guidance on self-help materials will require synchronisation with the training materials and to incorporate information on the most effective self-help strategies for each extended group and groups with specific needs.

Final report summarising all of the above - Report due at the end of the review summarising the products provided, the outcomes of the consultation exercise and the recommended next steps.

5. Method

The method underpinning this review had four key elements

(a) the establishment of a review team supported by an Expert Reference Group (ERG) - the UCL review team consisted of individuals with relevant expertise including academics, clinicians, service users and

commissioners (see Appendix 1). The ERG (see Appendix 2) had a similar composition but ensured both broader representation in the review and the provision of additional expertise. Its role was essentially an advisory one. The team and the ERG met monthly over the course of the project (see Appendix 3 for a timetable of meetings).

(b) a review of all existing materials

(c) an IAPT wide consultation programme (see below) to inform the decisions of the review team

(d) a set of recommendations for changes to the PWP element of the IAPT programme as set out in the scope. These recommendations are organised in two phases, Phase 1 - that is those issues which it is possible to make fairly immediate changes and Phase 2 - that is those which require consideration beyond the immediate scope of the review but which the team considered important to an effective review of the curriculum and associated materials.

In undertaking the review the team were mindful of the considerable changes in the role of the national IAPT team and the implications for the implementation of the recommendations in this report.

The Consultation

In order to be able to better reflect the changing and evolving nature of IAPT services and more specifically the PWP role, the UCL team built in a consultation process to the review in order to gain views, information and views from a broad range of people. The consultation ran from late January to mid February 2013 and included a series of online questionnaires (see www.ucl.ac.uk/pwp-review to access questionnaires) and 3 consultation events held in London, Bristol and Leeds. These three meetings specifically focused on the review and membership included PWPs, clinical leads, HI therapists and educators.

In support of the consultation process, members of the team have also presented at and discussed the review at the following :

- Southern Course Leads Consortium Meetings
- DH regional leads network
- DH workforce leads network
- “Evolving Your IAPT Service” - an IAPT event in Birmingham
- A PWP master class in Bolton for all PWPs in the North West

These meetings were used to raise awareness of the review, gain views on the development of the products and augment the consultation process. The team estimates through the meetings above and the online consultation over 500 people have been involved in the process. In addition the team have received additional comments through the project website and through conversations with colleagues.

It should be stressed that the consultation questionnaire and associated events should not be seen as and were not intended to be a representative survey - rather it was an opportunity for a wide range of people to contribute and share their views and experiences relating to the PWP role and training.

6. The Consultation

The Online Consultation

A summary of the online consultation is provided below. It opened via the PWP review website (www.ucl.ac.uk/pwp-review) on the 21st January 2013 and closed on the 11th February 2013. Respondents were asked to complete either an online survey or email a completed consultation document to the team. The online consultation had three different sets of questions:

- General questions - relating to the content of the curriculum and assessment of competence specifically and including some questions about the PWP role and training.
- Senior PWP Questions - relating to the senior PWP role
- PWP Course Questions - aimed specifically at PWP training providers.

These questions can be found at http://www.ucl.ac.uk/pwp-review/onlineconsultation

In addition there was a parallel consultation process with service users that was disseminated via service user organisations and groups. This report does not include this element of the consultation http://www.ucl.ac.uk/pwp-review/onlineconsultation.

Respondents

A total of 343 people responded to the online questions with an additional 10 responses via email. This was broken down across the three sets of questions as follows:

- General PWP Consultation Questions - 294
- Senior PWP Questions - 39
- PWP Course Questions - 10

It should be noted that a number of people have contributed to this review outside of the formal consultation through individual discussions with and emails to the team. These are integrated with the summary of the consultation below.

The team categorised the respondents to the consultation broadly by staff group (see table 1) and then specifically for the online element (see table 2)

Table 1.

Total Consultation Respondents		
Respondent by staff group	Number	Percentage
PWPs	186	78.2
Clinical leads and service managers	22	9.2
Other clinical staff	14	5.9
Trainers	16	6.7
Not stated	26	10.9

Emerging Themes

A number of themes emerged in the analysis of the questionnaires.

General PWP Consultation Questions

1. A significant number of respondents suggested that practice based learning outcomes lacked clarity across the whole curriculum and that services, in particular, were not always clear how to best use this time.

Potential responses include:

- Further specification around shadowing, supervision, directly observed and modelled practice
- Site supervisors to have greater and possibly more formal involvement in the training

2. Reach Out generally viewed positively but some concern expressed that assessment scales in Reach Out can be unclear in terms of how adherence and competence is assessed.

Potential responses include:

- Development of specific written guidance on marking the Reach Out scales

3. The majority of respondents suggested that the balance of taught time across the 4 modules in the curriculum was not right.

Potential responses include:

- Further time to be spent on the Recognition and Recovery modules with less time allocated to Respect and Reflection
- Possible merging Respect and Reflection in to a single module
- Most elements of the Respect module to be integrated across the course

4. A large number of respondents, particularly PWPs themselves, felt that there was not enough training for triage assessment. PWP regularly reported acting as triage workers for IAPT (and in some cases for wider mental health services).

Potential responses include:

- Training to focus on the principles of PWP assessment that can be applied in a range of different contexts
- Further training on triage assessment
- Further training on risk assessment

5. A majority of respondents highlighted a number of issues with training around the content of assessment (of patients) although these problems were varied in content with no single theme emerging (but the use of telephone assessment, treatment planning, diagnosis and problem specification, and risk assessment all featured)

Potential responses include:

- Further training on telephone skills and risk assessment
- Further training on provisional diagnosis/problem specification and treatment planning

6. A large number of respondents highlighted problems with the competence assessments for PWPs and there was also a general view that the course was over assessed. A particular issue arose over guidance around not seeing patients until Modules 1 & 2 were successfully completed and what happened in actual practice. Responses were evenly split on whether or not this should be amended.

Potential responses include:

- A reduction in the course assessment load, with fewer exams in particular
- Greater involvement from site supervisors in assessment of competence
- The use of formative (or summative assessment of competence in low intensity method) earlier in the course which may enable trainees to see patients earlier under close supervision with a summative patient based assessment to sign off trainees as clinically competent towards the course
- Greater use of shadowing and direct observation of practice by trainees
- Greater specification of activities in period when trainees are unable to see patients
- Consensus that the supervision simulation assignment could be improved

7. Respondents held quite divergent views on any additional disorders/interventions that may be included in the revised curriculum with a number reporting that they were not adequately prepared for the treatments that services are offering and patients they are seeing.

Potential responses include:

- A general consensus that the curriculum should include interventions for GAD
- Non-inclusion of training in behavioural experiments, at least in Phase 1, given that views were evenly divided with strong opinions expressed
- Widespread support for the inclusion of group interventions in the curriculum
- Revision of the section on sleep problems

8. A large number of respondents highlighted significant issues with the retention of PWPs.

Responses to this included

- A number of respondents reported that PWPs left to take the opportunities provided by further training as HI therapists or and clinical psychologists but a number of responses stressed that this is linked to PWPs feeling undervalued in the role.
- A significant number felt that the primary reason for being unable to retain PWPs is due to lack of support, primarily from services but also from some courses.

- Some reported that PWPs were difficult to retain due to the lack of career progression and insufficient remuneration
- The difficulty of managing large caseloads and the stress of the role were cited by many as significant reason for poor retention of PWPs
- Very few respondents felt that the senior PWP role, while a very welcome development, was a substantial and effective response to these problems

Senior PWP Questions

Responses to the senior PWP questions, were primarily answered by senior PWPs and included:

- Most services employ senior PWPs at AFC band 6 (with one band 5 and one band 7 identified)
- The senior PWP role encompasses a range of different activities including; management and supervision; developing and monitoring pathways and some specialist clinical roles (e.g. group interventions)
- Many senior PWPs had received training in supervision and management but a number reported receiving no formal training
- Most senior PWPs had attended an accredited PWP course but a significant minority had not.

PWP Course Questions

There were 10 responses to these questions.

- Where stated course fees were mostly between £4500 - £4999 with one responding that fees were between £4000 - £4500
- The majority of respondents have an undergraduate course and a non-graduate (academic equivalence route) route in to training
- All courses reported having a system to work with employing organisations to shortlist and interview trainees.
- Plans for diversifying the content of the curriculum were mixed. Some already provide this through one-day CPD conferences for PWPs and an MSc level PWP supervisor's module. Others had plans to provide CPD training on topics like LTC, MUS and older people. There was concern about the funding of these additional elements
- Half of respondents had developed links with future Local Education Commissioning Boards (LETBs)
- A number of threats to the sustainability of the courses were identified; uncertainty around future commissioning and funding plans; increased fragmentation of services; unwillingness of some services to take trainees; difficulties with employing organisations recruitment processes and timescales

Consultation Workshops

There were three consultation events; London, Bristol and Leeds; held throughout January 2013. The events were intended to be as inclusive as possible. The London and Leeds events were well attended but due to poor weather and short timescales the Bristol event was poorly attended.

Emerging Themes

This section summarises some of the themes that emerged from the three consultation events held through January 2013. These themes reflect broadly reflect the content of the responses to the web-based consultation.

1. The curriculum was generally seen as too prescriptive but also with some major omissions. A large number of services reported that that significant additional training is required for trainee PWPs within the service. In addition, both courses and services reported a lack of clarity about the respective roles of services and training courses. There was, however, a recognition that it was not possible to specify too much in any curriculum. The need to develop an over-arching theoretical framework (perhaps based in behaviour change theory) with more focus on the principles underlining the work of PWPs was supported.

2. Many suggested that there are difficulties with provisional diagnoses/problem specification, including training for PWPs and some services' reluctance to work with the 'medical model' implicit in such an approach, despite this being at the centre of the NICE approach to treatment.

3. The high levels of stress that PWPs are often under was noted and linked to high caseloads and lack of support for the role in some services.

4. There was support for further time to be spent on module 2 (Recovery), including consideration of a GAD interventions, drugs and alcohol misuse assessment and intervention, group interventions, and behavioural

experiments. A number of reports of expressed concern about PWPs 'drifting' in to HI work. There are divergent views on whether or not BE should be included in the curriculum.

5. It was noted that a number of services are seeing patients outside of the original commissioning intentions for IAPT (for example, drug and alcohol misuse, eating disorders) .

6. It was suggested that a significant proportion of module 3 could be covered as practice based learning and this will require more collaboration and integration between services and courses.

7. A significant number reported problems with the accreditation process, specifically around rigidity of requirements (e.g. specification of the duration of assessments outlined in the recent accreditation handbook). It was agreed by a large number of attendees that the respective roles of accreditation, courses, services and external examiners have become confused and that this was unhelpful.

8. It was suggested that the current approach to the assessment of PWP trainee competency to see patients (not prior to passing modules 1 and 2) may be unhelpful, particularly for services and could have a detrimental affect on training itself - e.g. trainees unable to practice skills learnt for a significant period of time. A number of PWPs and clinical leads reported that time spent before this period was not able to be used effectively and there was a general acknowledgement that a large number of services do not adhere to the requirement set out in the curriculum not to see patients before successful of the assessments for modules 1 and 2.

9. Many felt that the senior PWP role alone cannot have a significant effect on retention of PWPs. More developments are is required including; further support, further training, opportunities to specialise and a general recognition that many do not value the PWP role. It was also noted that poor retention can have a significant negative impact on service access and outcomes.

10. The majority of people were simply unaware of the self-help best practice guide but thought that this could potentially be useful if revised.

Recommendations

As noted above it is suggested that the recommendations that follow should be delivered in three phases; phase 1 sets out the programme of change (as described in this report), phase 2 is making those changes identified and phase 3 is concerned with implementation of those changes.

The review team and the ERG took the view that the extent of the changes suggested by the consultation and, in large part, supported by the team and the ERG cannot be delivered within the scope and timescale of this project. In addition, difficulties with copyright make it challenging to deliver on all elements of the DH requirement. It has therefore been suggested that the outcomes of this review should be delivered in two distinct phases.

The review identified a compelling case for a substantial change in the IAPT PWP curriculum. A large number of these changes are outside the scope of the original review but in the view of the UCL team and the majority of the ERG are necessary to prepare PWPs to work in a responsive and effective IAPT service which remains committed to the principle of the implementation of evidence based psychological interventions. (It should be noted that both the UCL team and the majority of the ERG have indicated their willingness to contribute to Phase 2 of the review).

This means that the following recommendations should be adopted and implemented in Phase 2. Further work will be required to specify the detail required to support and implement the recommendations.

Recommendation 1: Changes to current learning materials - subject to agreement on copyright, the following proposed changes to Reach Out (note these are provided in a separate document (Appendix 4) and not an edited version of Reach Out) should be considered and are specifically concerned with:

- The inclusion of a GAD intervention section (with implications for the balance teaching days for module 2 (increased) and module 3 (reduced)
- Changes to the structure and content of practice based outcomes
- Changes to the method for the assessment of supervision in Module 4
- A set of minor revisions to the structure, purpose and scheduling of the assessment (clinical simulations) for Modules 1 and 2 of trainee competence

- An outline manual and associated training programme to clarify marking criteria for the simulations in Modules 1 and 2

Content of a national curriculum

Recommendation 2: Behaviour Change Theory - there should be a substantially re-structured curriculum that provides a theoretically integrated approach to the provision of low intensity interventions based on behaviour change theory.

Recommendation 3: Assessment of patients - there should be a revised section on assessment which emphasises the principles underlying assessment for low intensity interventions and which equips PWPs to undertake assessment (including risk assessment) with different objectives, content and structure depending on the purpose of the assessment and the setting in which the assessment is undertaken.

Recommendation 4: Interventions - there should be a greater emphasis in the curriculum in training PWPs to plan and deliver an integrated programme of care built on a core set of interventions. This should be based on behaviour change theory that will provide a framework to bring together a range of evidence based, low intensity interventions under a core curriculum. By focusing on core methods for the delivery of care, training should allow for the introduction of a range new interventions and problems into the work of PWPs. Key areas for consideration in an expanded curriculum should include drug and alcohol misuse, exercise, behavioural experiments and group interventions.

Recommendation 5: Structure of the curriculum – the current curriculum has 4 modules (recognition, recovery, respect and reflection), the substantial changes set out above could be based on three modules:- assessment, intervention and context.

Recommendation 6: Post qualification training – this might include training for senior PWPs specific to the role and training in particular interventions and disorders not covered in as much detail in the core training, for example LTC and MUS.

Assessment of PWP knowledge and skills

Recommendation 7: Assessment of Competence - the substantial revision of the curriculum as set out above will require a corresponding substantial revision of the assessment of PWP competence. The emphasis should remain on objective structured clinical examination through the use of clinical simulation and direct assessment of clinical practice.

Recommendation 8: Reduction in the number of exams – the emphasis in PWP training is on developing individuals' clinical skills which are built on a sound theoretical understanding of the basis for the interventions and the evidence which supports their application. Written exams are used to assess this knowledge but there was widespread agreement that the current four exams could be reduced in number. While it is for individual HEIs to determine the precise content and structure of the assessment of PWP competence any changes to the curriculum should lead to a reduction in the burden of assessment and not an increase.

Improved University and IAPT Service Links

Recommendation 9: Strengthening links between universities and service providers - there is considerable variation in how effectively practice based learning is currently implemented. There should be a greater emphasis on the role of supervisors in direct observation and joint assessment of trainees work. Consideration should be given to ensuring all supervisors are trained to use the revised assessment methods set out in Recommendation 3.

Recommendation 10: Designated training sites - many courses (and services) have in place well developed protocols for the joint appointment of trainees and for liaison with sites. However, there are few courses where any formal assessment of the sites suitability to take trainees is in place. It is recommend that a quality assurance process is established so that training providers and funders can be assured that a service can provide an appropriate training environment. This should be linked to the developments covered in Recommendation 9.

Funding and Oversight of PWP Training

Recommendation 11: Funding of training – to date funding of IAPT training has been managed through the local SHA/MPET arrangements. However in 2013/2014 this will transfer to local LETBs. Support for training (beyond the payment of HEI fees) has varied considerably with some SHAs providing 80% or more of training

year salary costs (so trainees are effectively supernumerary) to more limited bursaries or no additional funding. While the IAPT programme was expanding and new funding was available for service development this variability in funding did not present a threat to training numbers. However, as new service developments have come to an end, the lack of support for training beyond the covering of fees present a real threat to training (and hence the maintenance of the PWP workforce) as services see trainee posts as a potential threat to a service's ability to meet key performance indicators. It is therefore recommended that all LETBs adopt a system of additional support in the form of bursaries or salary support.

Recommendation 12: Safeguarding future PWP training – the IAPT programme has benefitted from the presence of a national team and strong regional support. From the perspective of PWP training this will end from March 2013. In the short-term a number of issues including the clarification of the role of the accreditation panels, external examiners and HEIs in the accreditation of courses and the implementation of the Phase 2 recommendations in this report need national coordination and support. The UCL team and the ERG are prepared to continue this work, although the revised curriculum will need a base. In the longer term the purpose and function of a national curriculum will need review and consideration should be given to whether a professional body or possibly HEE could take on responsibility for the continued oversight of the programme.

Conclusion

The review of PWP training and training materials has identified some significant and wide reaching changes which will require substantial work to develop and implement. These changes will help ensure that PWPs and IAPT services are able to best respond to the emerging evidence and changes in the PWP role in the future.

Appendix 1 - PWP review team

The team put together by UCL to undertake the review was as follows:

- Professor Stephen Pilling (UCL) - Project Director
- Rob Hardy (UCL) - Project Manager
- Rachel Newman (UCL) - LI Course Director
- John Cape (Camden and Islington NHS Foundation Trust) - IAPT Clinical Lead
- Katie Greenfield (UCL) - Research Assistant
- Professor Tony Roth (UCL) - Education Specialist
- Gareth Stephens - Service User and Trainee PWP
- Nick Hanlon - Service User and Expert Advisor
- Dr Peter Ilves (Wandsworth CCG) - GP Commissioning Lead
- Laura Stancevic (East London NHS Foundation Trust) - Senior PWP

Appendix 2 - PWP review Expert Reference Group (ERG)

The ERG that advised on the review was as follows:

- Steve Kellet (Sheffield University) - Course Lead
- Mark Papworth (Newcastle University) - Course Lead
- Sheena Liness (Kings College London) - HI Course Lead
- Nick White (East of England) - Workforce Lead and Clinical Lead
- Liam Gilfellon (Yorkshire and Humber) - Regional and Workforce Lead
- Andrew Keltins (Anxiety UK) - Coordinator of Services
- Lucy Kerry (British Psychological Society) - Education Lead
- Professor Dave Richards (Exeter University)
- Brendan McLoughlin (Mental Health Matters) - Director of Primary Care
- Lee Walker (NHS London) - Education Commissioner
- Paul Farrand (Exeter University) - Senior Teaching Fellow
- Marie Chellingsworth (University of Nottingham) - Course Lead
- Susan Ramsdale (University of Central Lancashire) - Course Lead