Guidance on Preceptorship and Continued Professional Development for Psychological Wellbeing Practitioners

1. Introduction

This guidance sets out recommendations for a structured preceptorship year for psychological wellbeing practitioners (PWPs) who have completed their British Psychological Society accredited PWP training programme. It also offers suggestions for suitable PWP continuing professional development opportunities, during and beyond the preceptorship year.

A preceptorship is defined as "a period to guide and support all newly qualified practitioners to make the transition from student to develop their practice further" (NHS Employers, 2017)[1] A preceptorship is a structured period of transition for the newly qualified practitioner, during which they are supported by an experienced practitioner to develop their confidence and refine their skills.

When Psychological Wellbeing Practitioners complete their training they transition into a new role as a qualified practitioner that can mean:

- A change in support and supervision arrangements
- Saying goodbye to the student peer group
- A perception that they should have fully formed competences in all areas of practice
- A perception that they can immediately take on a full caseload
- Learning opportunities are less obvious and co-ordinated, and less directly targeting PWP competences.

The preceptorship provides a co-ordinated approach to supporting, sustaining and developing PWPs during their first year after qualifying, within the PWP role, and can help to support staff wellbeing, performance and retention. The preceptorship is, however, never an alternative to undertaking a BPS-accredited PWP training programme.

2. Principles and Processes of the PWP Preceptorship Year

The preceptorship should be adopted as a framework for the first year of qualified practice. There are three processes that structure the preceptorship:

a) Induction and preceptorship plan
Within the first month, the PWP and their manager should work together to produce a preceptorship plan. This should identify learning needs, and an individualised continuing professional development (CPD) plan for consolidating and extending competence in the PWP model. The preceptorship plan should define a realistic transition to full caseload, allowing continued space for regular continuing professional development within the PWP's job plan, as recommended in the IAPT Manual (2018)[2] and the PWP Training Review (2015)[3].

[1] http://www.nhsemployers.org/your-workforce/plan/education-and-training/preceptorships-for-newly-qualified-staff
[2] https://www.england.nhs.uk/wp-content/uploads/2018/06/the-iapt-manual.pdf
[3] https://www.ucl.ac.uk/pals/sites/pals/files/9_cpd_and_post-qualification_training.pdf

b) Regular supervision with an experienced practitioner
There should be a standing item on supervision agendas to review progress with the individual CPD plan and discuss transition issues into the qualified role, including any areas of uncertainty or difficulty. Any obstacles to implementing the CPD plan should be reviewed and resolved.

c) The first appraisal
The first appraisal, which will normally take place between 6 and 12 months into the qualified role, should include a formal collaborative review of the preceptorship plan. The outcomes of the preceptorship should be reviewed and the next professional development plan agreed.

3. Potential Continuing Professional Development Activities for PWPs

The PWP Training Review (2015) guidance specifies that PWPs should have the same level of access to CPD activity as other practitioners. For example, accredited cognitive behavioural therapists are required to undertake five different types of CPD activity each year, including at least 6 hours of skills training. Continuing professional development does not just consist of attending training. It can cover a whole range of activities including:

- Reading
- A focused approach to clinical skills development using supervision
- Teaching or presenting to others
- Coaching or mentoring conversations
- Formal training days

Some suggestions for PWP CPD activities during and beyond the preceptorship year are listed below:

3.1 Clinical skills consolidation

a) Working with more complex presentations of step 2 common mental health problems (e.g. LTCs) supported by regular discussion in supervision (e.g. identifying and maintaining a clear focus for the intervention in spite of challenges that may arise).
b) Working with a range of client groups (e.g. older adults, black and minority ethnic groups, veterans, working through interpreters, young people)
c) Improving knowledge and understanding of how the range of different mental health disorders present to support assessment skills
d) Improving knowledge and skills related to the effective delivery of step 2 groups and digital interventions e.g. computerised CBT.
e) Seeking out and working with a presentation that the PWP hasn't worked with for a while (e.g., panic or phobias)
f) Strengthening a particular element of an intervention that the PWP may struggle with (e.g., developing a Problem Statement Summary; explaining fight and flight in a personalised way; developing graded exposure homework keeping to the four principles of graded exposure) using supervision of a few cases and methods such as listening to recordings and role playing to help develop this aspect of their practice.
g) Keeping a reflective log to help reflect upon aspects of clinical work that have gone well and also any clients they have found more challenging, to understand and learn from this e.g. "what was it about the intervention, you or the client that made the work feel more difficult?"
h) Taking time to discuss and reflect in supervision on what went well with clients who have done well. What was most helpful? Were individual techniques carried out in a particular way? What metaphors, explanations, rationales were used? What were the

intervention, client and clinician factors that may have contributed to a successful outcome?

i) Buddying up with an experienced PWP and observing or watching a recording of each other's sessions and reflecting on these together, offering feedback and suggestions for development.
j) Observation and feedback on their practice by an experienced practitioner, with a focus on maintaining fidelity to the method and preventing drift away from recognised ways of working.

3.2 Addressing interpersonal issues

k) Developing interpersonal clinical skills: working with clients when there are interpersonal difficulties in the client's presentation (e.g. reassurance seeking in the room – name this and include in a graded exposure hierarchy for example). Learning to manage a problem within the intervention is likely to be a helpful learning experience that can be taken through the rest of your career (i.e. how to name a problem with the client and how to discuss that, put it in five areas, and include in the treatment).
l) Reflecting on one's own responses to clients or interventions and discussing these in supervision e.g. particular clients that trigger difficult emotions in; awareness of treating a client differently from others; some of the PWP's own responses that may get in the way of progress – being too quick to suggest solutions, telling a client what a homework assignment was for rather than finding out what they have learned; one's own beliefs about interventions or clients.
m) Practicing how and when to say no to a client. How to have that difficult conversation in a therapeutic way.

3.3 Gaining new clinical knowledge and understanding

n) Observing a high intensity therapy session to further understand the difference between low intensity and high intensity assessment and treatment sessions (ensuring that this doesn't encourage drift from the low intensity model).
o) Attending a journal club to present or discuss relevant pieces of research
p) Learning about research methods and getting involved in local research studies
q) Attending PWP-specific CPD training (e.g. national PWP conference)
r) Teaching other healthcare professionals or local community groups on mental health and low intensity interventions.
s) Training in skills for working with specific populations as a specialism (e.g. people with long term health conditions, by undertaking the PWP LTC top up training).

3.4 Developing leadership skills

(these development opportunities would normally be considered only after the preceptorship year)

a) Completing IAPT PWP supervisor training providing by an accredited PWP training provider and providing PWP clinical skills and/or case management supervision to other PWPs and trainee PWPs.
b) Shadowing IAPT managers and leads including attending relevant meetings
c) Completing in-house leadership and management trainings (e.g. recruitment, managing absences). Trusts and organisations may have a range of training options available (e.g. Quality Improvement; having difficult conversations; chairing meetings).
d) Attending relevant leadership and management training sessions available locally via CCGs and via NHS Elect, regional NHS Leadership Academy hubs etc.
e) Completing the NHS Leadership Academy Edward Jenner foundations in leadership online programme.
f) Accessing coaching or mentoring via the regional NHS Leadership Academy hubs.
g) Linking up with other PWPs in senior positions via regional PWP networks.

3.5 CPD Exclusions

CPD for PWPs should not include working with types of client problems or delivering interventions that do not fall under the step two PWP remit. This is because it is important that clinicians work within the model and remit in which they have core training, in order to offer high quality care to clients.

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