

The Roles and Readiness of Recently Qualified Clinical Psychologists

Kate Dimmock

Commissioned by Dave Green and Tom Isherwod, Leeds DClin. Psych.

TABLE OF CONTENTS

1.0 Introduction.....	1
2.0 Background and Rationale	1
2.1 <i>IAPT and NWWAP.....</i>	<i>1</i>
2.2 <i>Agenda for Change and Preceptorships</i>	<i>2</i>
2.3 <i>Potential Implications for CP Practice.....</i>	<i>3</i>
3.0 Service Context	5
4.0 Aims.....	5
5.0 Method	6
5.1 <i>Design.....</i>	<i>6</i>
5.2 <i>Data Collection.....</i>	<i>6</i>
5.2.1 <i>Quantitative Survey</i>	<i>6</i>
5.2.2. <i>Qualitative Interviews.....</i>	<i>7</i>
5.3 <i>Sample.....</i>	<i>7</i>
6.0 Results	8
6.1 <i>Survey Results: Quantitative Analysis</i>	<i>8</i>
6.1.1 <i>Asked to do Role.....</i>	<i>8</i>
6.1.2. <i>Asked to do and relationship with job description.....</i>	<i>9</i>
6.1.3 <i>Readiness for NWW Roles</i>	<i>10</i>
6.1.4. <i>Support.....</i>	<i>12</i>
6.1 <i>Qualitative Analysis.....</i>	<i>13</i>
6.2.1 <i>Readiness data.....</i>	<i>14</i>
6.2.2 <i>Experiences in Post.....</i>	<i>16</i>
6.2.3 <i>Out of Depth Feelings.....</i>	<i>17</i>
7.0 Discussion	19
7.1 <i>Summary of results.....</i>	<i>19</i>
7.2 <i>Implications for Service</i>	<i>19</i>
7.2.1 <i>Increase in Leadership/Management and MDT teaching</i>	<i>19</i>
7.2.2 <i>Supporting CPD and Peer Supervision.....</i>	<i>21</i>
7.2.3 <i>‘Asked to do’ V Readiness</i>	<i>22</i>
7.2.4 <i>Clinical Needs.....</i>	<i>22</i>
7.3 <i>Limitations of Study</i>	<i>23</i>
7.3.1 <i>Lack of previous research: Is it NWW or have RQCPs never felt prepared?.....</i>	<i>23</i>
7.3.2 <i>Sample: Bias and Size.....</i>	<i>23</i>
7.3.3 <i>Methodology: Thematic Analysis and Researcher Bias</i>	<i>24</i>
7.4 <i>Strengths</i>	<i>25</i>
8.0 Conclusion	25
References.....	27
Appendix A. Year Participants Qualified, Banding and Services they were working in.....	29
Appendix B. Results for Support in NWW Roles.....	30
Appendix C. Early Thematic Maps	32

List of Tables and Figures

Table 1. Summary of key principles for NWW projects and implications for the practice of clinical psychology.....	4
Box 1. The NWW Roles Expected of Band 7 & 8a CPs.....	6
Box 2. Roles Felt Ready for Data.....	15
Box 3. Needs From the Course Data.....	16
Box 4. ‘Not Being Ready Ok’ Data.....	17
Box 5. Experiences in Post Data.....	18
Box 6. Out of Depth Feelings Data.....	18
Figure 1. Number of Participants Asked to do Each NWW Expectation.....	9
Figure 2. Asked to do and Relationship with Job Description.....	10
Figure 3. Readiness for Research, Further Specialist Training & Developing Specialised Care Packages.....	11
Figure 4. Readiness for Leadership, Consultancy & Managing Staff.....	11
Figure 5. Readiness for Supervision of Interprofessionals, Trainees Psychs, Assistant Psychs & Staff Training.....	12
Figure 6. Support for Leadership Vs Research Expectation.....	13
Figure 7. Final Thematic Map showing three main themes of Readiness (& sub-themes), Experiences in Post and Out of Depth Feelings.....	14

1.0 Introduction

Several policies have appeared recently which are affecting and are likely to continue to affect the practice of clinical psychology over the next decade. A recent government proposal to 'improve access to psychological therapies' has thrown clinical psychology into the limelight and consequently there has been a snowball effect of proposed changes, one major one being recommendations for 'new ways of working' not only for clinical psychologists but for all healthcare professionals. Generally, more is being expected of clinical psychologists than just delivering one-to-one therapy. Traditionally clinical psychology training courses have focused strongly on research and clinical teaching but this may no longer fit with the 'more' that is being expected of clinical psychologists upon qualification.

2.0 Background and Rationale

As mentioned there have been recent changes affecting the practice of clinical psychologists (from now on CPs) and it feels important to highlight some of these in order to understand the context in which the present project was carried out.

2.1 IAPT and NWWAP

A report on Britain's growing mental health problem by Lord Layard (2005) highlighted the economic effect of people claiming incapacity benefits due to 'common mental health problems' such as depression and anxiety. Layard highlighted the heavy costs on the economy of mental illness and suggested the solution was an increase in the availability of evidence-based psychological therapies. Subsequently, there was a 2005 Government programme - 'Improving Access to Psychological Therapies' (IAPT;

DoH, 2005) offering £306 million investment in psychology to train and employ an extra 3600 psychological therapists with potential roles for existing CPs in leading these IAPT initiatives (Clark & Turpin, 2008).

Alongside this, New Ways of Working for Applied Psychologists (NWWAP; BPS, 2007a) was prompted and funded by the Department of Health (DoH) along with National Institute for Mental Health in England (NIMHE) and the British Psychological Society (BPS) following a similar mindset to ‘NWW for Everyone’, which emphasised a ‘Skill-mix approach’ suggesting that there should be an increase in multi-disciplinary team-working with the expectation that there would be an increase in psychological input to these teams and a reduction in the responsibilities held by psychiatrists as other members of the MDT take on these roles, including CPs.

2.2 Agenda for Change and Preceptorships

Additional changes within the NHS which are affecting clinical psychology roles and responsibilities are the increase in and transparency of salaries through agenda for change (AfC) bandings. Clinical Psychologists will generally be the highest paid *integrated* members of a team and expectations will be high in order to justify this banding. Also within the AfC bandings is the *Preceptorship* level for newly qualified CPs. This was developed in order to address the transition from a Band 6 Trainee Clinical Psychologist to full specialist practitioner status at Band 8a via a transitional Band 7 post – the Preceptorship (BPS, 2006). Interestingly for this project, this stage of development is about gaining further knowledge and experience to develop as a specialist practitioner in terms of assessment and treatment of clients with “the most complex clinical problems” so a developmental rather than final stage. Interestingly, this does not include mention of appropriate leadership or management roles for this level of development, although the Career Pathways and Roles NWWAP sub-group (BPS, 2007d; see Table 1) does include a development of leadership role for a band 7

CP. Thus on the one hand CPs are being expected to 'do more' within their roles, but on the other an attempt is being made to protect the transition period.

2.3 Potential Implications for CP Practice

Based on the above recent changes, there are several potential implications for the work recently qualified CPs might be doing in post, as highlighted in Table 1 below, along with summaries of the NWWAP policies. Themes that stand out from the NWWAP policies are an increase in responsibility and leadership and management roles for CPs, with some development of leadership skills being expected as early as Band 7. As these are not the traditional roles emphasised on training courses it is possible that newly qualified CPs are under-prepared for these new roles. However, based on the AfC preceptorship level newly qualifieds, in theory, are being allowed to develop these skills gradually

Table 1. Summary of key principles for NWW projects and implications for the practice of clinical psychology

NWW Project sub-group	Summary of project aims	Implications for future CP practice
Role of Applied Psychologist in Improving Access to Psychological Therapies (IAPT; Turpin, 2007)	<ul style="list-style-type: none"> • Liaison with DoH's IAPT • Major role in developing and implementing IAPT services • Training and supervision of new CBT therapists –bands 5 and 6 • Focus on CBT • Defining competencies needed for CBT (Roth and Pilling, 2007) • Focus on workforce issues and career framework for psychological therapists working within IAPT service • Richards & Suckling (2008) e.g. of IAPT model being rolled out 	<ul style="list-style-type: none"> • Leadership and management role-CPs not prepared for this • CBT only therapy acknowledged-implications for 'other' psychotherapies • Less of a clinical role (within IAPT service) • Neglects central CP competency of research- low intensity and high intensity CBT seen as only therapy with evidence base.
Organisation of services and leadership (BPS, 2007b)	<ul style="list-style-type: none"> • Stronger role for CPs (e.g. NWW for psychiatrists) • Outlines skills required for leadership e.g. "business-minded" • Service-user involvement in service development • MDT working • Development of Leadership Strategy (DCP) and Introduction to Clinical Leadership and Management Course (Golding, 2008) 	<ul style="list-style-type: none"> • Managerial roles - need for managerial skills • 'Business mind' – training to qualified gap in such skills
Working psychologically in teams (Onyett, 2007)	<ul style="list-style-type: none"> • Integration of CP into team- leading and disseminating psychological knowledge • Actively involved in design and operation of teams • Consultancy role • Leadership role • Supervisory role • CP skills used for understanding team dynamics not just client-work 	<ul style="list-style-type: none"> • Difficulty integrating but retaining professional identity • One of the team Vs "Boss" • Informal consultancy and supervision Vs formal • Inter-disciplinary supervision • Transparency of salary differences and feelings this creates. • Isolation –different levels of understanding within MDT
Models of training in applied psychology (BPS, 2007c)	<ul style="list-style-type: none"> • Competency-based training e.g. supervisory/consultancy/team-working skills • Develop alternative models of training (Kinderman, Wang, NWW A and B models) similar to medical model of training • More clearly specified models and pathways through training 	<ul style="list-style-type: none"> • Focus on competencies not 'specialisms' - More generalised CPs on qualification? • Increase in consultancy, etc competency training
New Roles (Taylor & Lavender, 2007)	<ul style="list-style-type: none"> • Overlaps 'training models' and 'career pathways' • Focus on pre-qualification roles • Make use of huge psychology undergraduate capacity and skill to increase number of psychological therapists at lower pay band levels • Assistants and Associates – 'proper' roles with accreditation and regulation - not just a means to an end • Aim to meet demand-supply gap for psychological therapists 	<ul style="list-style-type: none"> • Positive use of potential workforce but potential bottleneck if CP posts remain few in comparison to number of psych grads • No mention of increase funds for DCLin psych – only IAPT therapists • Clearly defined roles but most psych graduates will still want to complete CP training – high turnover of therapists
Career pathways and roles (BPS, 2007d)	<ul style="list-style-type: none"> • Within context of Knowledge and Skills Framework and Agenda for Change • Defined 'bands' for CPs and what should be doing at each level: Band 7 – <i>preceptorship</i>, autonomous clinician with responsibility for own caseload, resource for team, continuing development of specialist role and leadership skills; Band 8a – 8b – <i>highly specialised</i>, more complex caseload and continuing professional development, resource for team in working with most complex service users, clinical leadership, research, evaluation and audit skills, delivery of training and development, clinical supervision and advice, delivery of innovation and service improvement projects; Bands 8c, d-9 – <i>Consultant CP</i>, all of above but increase in responsibility e.g. managing finance, research and development, implementing policies. 	<ul style="list-style-type: none"> • Within NWW – expectations of team of a band 7 may be higher than within CP? • Hierarchical nature within CP • Focus on what should be doing based on band rather than what job requires • 'Christmas tree effect'- not many high 8s/9s so CPs remain within a bands 7-8a while increasing responsibility, etc. • Hazy distinction between bands • IAPT requires CPs to act as highly competent consultants earlier in career – previously 'consultant' and 'leader' reserved for more senior staff (Turpin, 2008).

3.0 Service Context

The Clinical Psychology Training Program attempts to prepare trainees for the varied roles ahead of them upon qualification. There has been a recent shift in the emphasis of the course to transferable clinical and professional competencies rather than clinical specialisms. However, the course retains an emphasis on research and clinical competencies which may not 'fit' with new roles as suggested by NWW. For instance the Leeds training course structures trainee development around the BPS competencies expected of a qualified CP. However, these only hint at consultancy and supervision in the "communication and teaching" competency and the "supervision" competency refers to trainees receiving supervision rather than being trained in methods of supervision- a core competency expected of newly qualified CPs and only offered in the form of a workshop a couple of years into a first post. There is even less evidence of a "leadership and management competency". Thus it is likely that newly qualified CPs may feel there is a gap between skills base upon qualification and skills required for their first post. Hence, the present project was commissioned by the Leeds DClin Psych. in order to evaluate how well the course prepares trainees for the roles they are expected to do upon qualification.

4.0 Aims

The present project aims to explore the roles and readiness of recently qualified clinical psychologists (RQCPs) in light of the above issues. In particular:

1. What roles RQCPs are being expected to take on.
2. Whether RQCPs feel prepared for these roles upon qualification.
3. Whether RQCPs feel supported in taking on these roles.

5.0 Method

5.1 Design

A mixed methodology was used in the study involving an initial quantitative survey, followed by qualitative telephone interviews.

5.2 Data Collection

5.2.1 Quantitative Survey

A short questionnaire was developed using the Bristol Online Survey Programme (BOS; <https://www.survey.bris.ac.uk/>). This programme allows the user to develop questionnaires unique to their requirements that can be accessed online by participants once completed. The original survey was piloted by 2 RQCPs (not in final numbers) and a few visual changes were suggested to make the survey more user-friendly.

The survey asked the following questions about 11 roles shown in Box 1:

1. Have you been asked to do.....
2. Was this in your job description?
3. How ready did you feel for.....upon qualification? (on a scale of 1-5 where 1 is 'not at all ready' and 5 is 'completely ready')
4. How supported did you feel in this role (on a scale of 1-5 where 1 is 'no support' and 5 is 'lots of support')

Box 1. The NWW Roles Expected of Band 7 and 8a CPs

1. Supervision of inter-professional staff
2. Supervision of psychologists in clinical training (8a)
3. Supervision of assistant psychologists
4. Providing inter-professional training
5. Responsible for service development (8a)
6. Managing and coordinating staff (8a)
7. Regularly undertaking research
8. Undertaking additional specialist training
9. Developing specialised care packages
10. Leadership (7 only at developmental level)
11. Consultancy

The aim of asking whether roles were in job descriptions was to get a sense of their formality as it is possible that RQCPs have been doing most of these roles for a while, but they are now becoming part of a formal job specification to fit with NWW expectations.

5.2.2. Qualitative Interviews

Eight of the 25 participants took part in a short telephone interview, each lasting between 30 and 45 minutes, to expand on their survey responses using the following semi-structured topic guide:

1. Generally People seem prepared and expect to do training/supervision but not so much leadership and management – was this your experience
2. If not ready what would have helped you to be ready? (Course/prior experience)
OR if ready what helped you feel this way?
3. If not supported what kind of support and when would have helped? *OR* if supported what made you feel this way and when received?

Any responses reported from this stage of the study were kept anonymous. The responses were recorded by hand in note form and thematic analysis methodology (Braun & Clarke, 2006) was used to identify themes and patterns of experience to emerge from the interviews. This kind of analysis involves identifying themes by "bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone" (Leininger, 1985, p. 60). These themes were brought together collectively across participants to create a comprehensive picture of their experiences.

5.3 Sample

All recently qualified clinical psychologists from the Leeds, Hull, and Sheffield Clinical Psychology Training courses (qualifying 2006 & 2007) were contacted via

email and asked to complete an online survey exploring the roles and responsibilities of recently qualified clinical psychologists. Twenty-five people completed the survey. All answers remained anonymous unless participants were happy to be contacted for a follow up interview. Thirteen survey participants consented to be contacted for follow up telephone interviews. Eight of these were available at the time the interviews were carried out.

6.0 Results

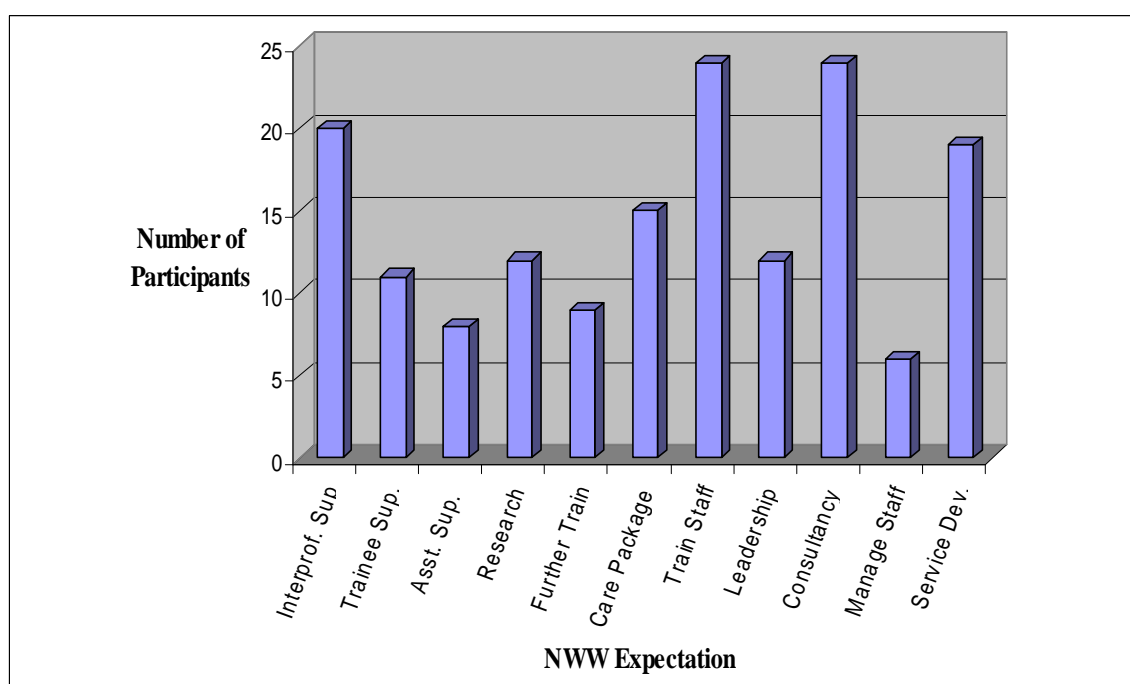
6.1 Survey Results: Quantitative Analysis

Based on the sample size and the information required from the data, descriptive statistics were an appropriate method of analysis of the survey responses.

6.1.1 Asked to do Role

An important first step in the analysis was exploring what roles RQCPs are being asked to do in post. Figure 1 shows the number of participants asked to do each NWW expectation.

Figure 1. Number of Participants Asked to do Each NWW Expectation



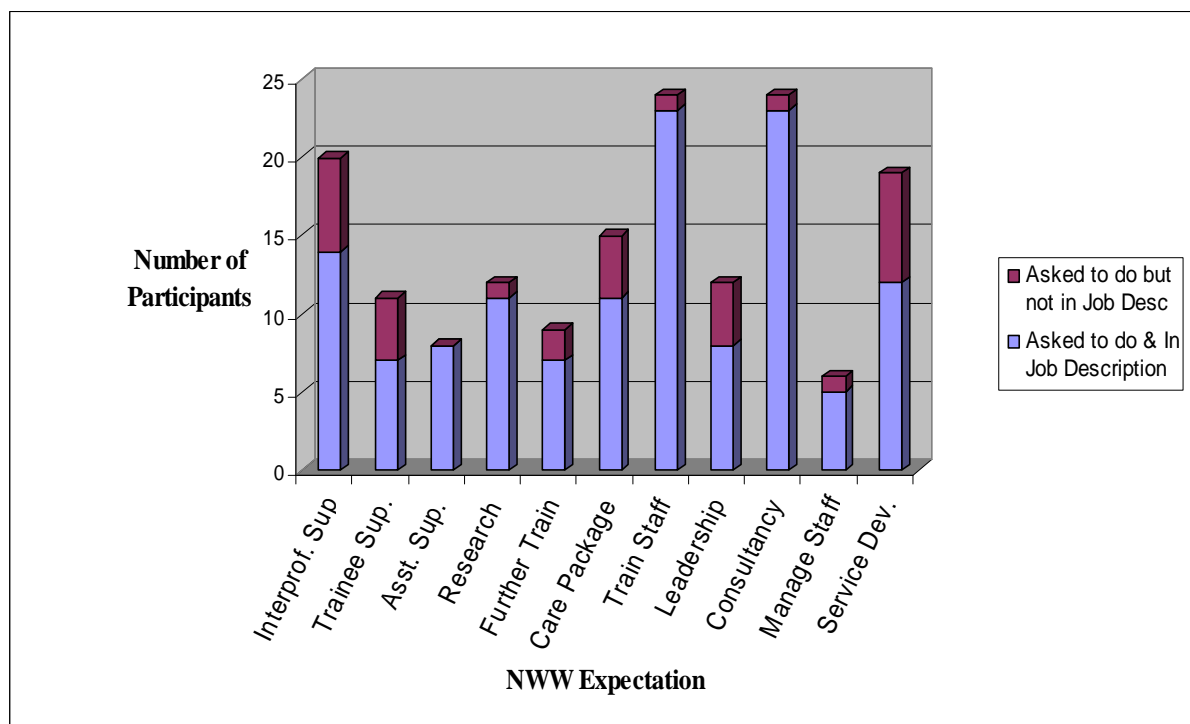
Twenty-four out of 25 participants were asked to do consultancy, and staff training, followed by service development and inter-professional supervision. Interestingly, it seems a number of participants were asked to do some form of leadership and management of staff.

It should be noted that only 3 participants reported being at an 8a banding (16 were at band 7 and 6 did not provide this information; see Appendix A for breakdown). All 3 at 8a had been asked to lead, one had been asked to manage and coordinate staff and all had been responsible for service development. Therefore, potentially, 9 band 7's were asked to lead, 4 to manage staff and 15 to contribute to service development.

6.1.2. Asked to do and relationship with job description

Figure 2 shows how many of those participants asked to do a certain role had this included in their job description.

Figure 2. Asked to do and Relationship with Job Description.



This figure shows how many individuals were doing roles not included in their job description. From this it seems that generally participants were doing roles they expected to be doing based on their job specification. However, there may also be a level of working beyond these expectations for a few people with certain roles. For example, for supervision of psychologists in clinical training, leadership, and responsibility for service development 57%, 50% and 58% of participants, respectively, were asked to do these roles outside of their job specification.

6.1.3 Readiness for NWW Roles

The next stage of analysis focused on the important question of whether RQCPs felt prepared for the roles they were being asked to do upon qualification from clinical psychology training. Figures 3, 4, and 5 show level of ‘readiness’ for the NWW expectations on a scale of 1-5 (where 1 = “not at all ready” and 5 = “completely ready”).

Figure 3. Readiness for Research, Further Specialist Training & Developing Specialised Care Packages

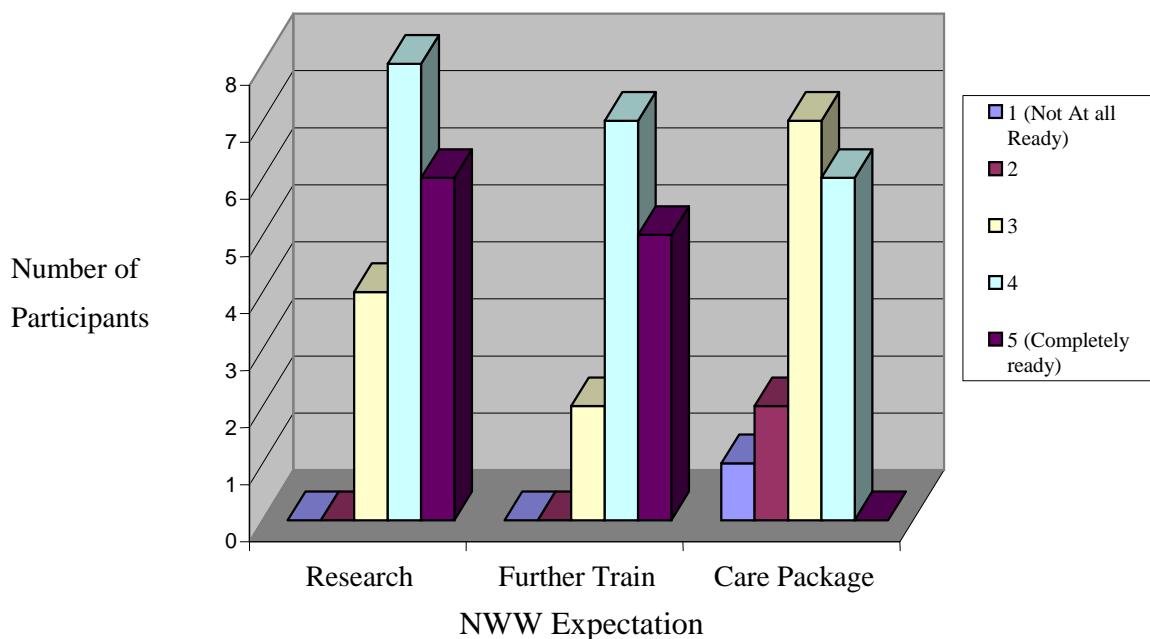


Figure 4. Readiness for Leadership, Consultancy & Managing Staff

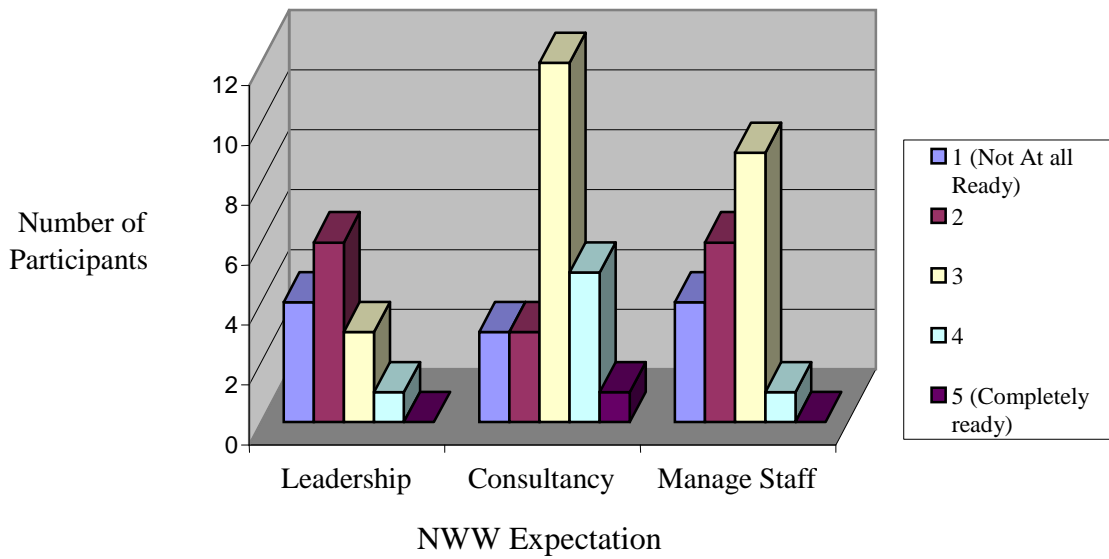
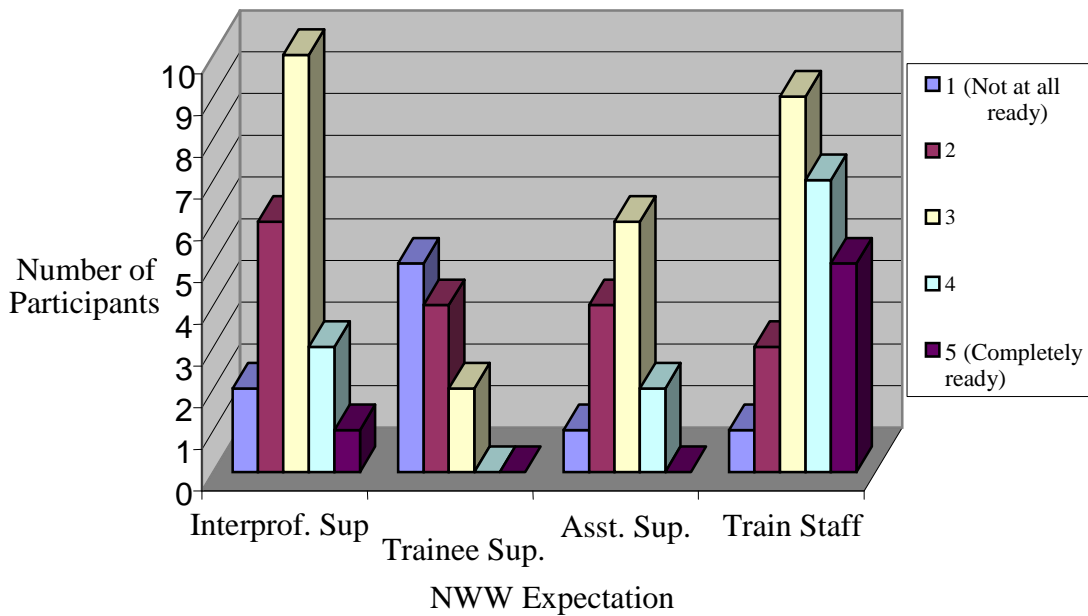


Figure 5. Readiness for Supervision of Interprofessionals, Trainees Psychs, Assistant Psychs & Staff Training



The roles that stood out as being more heavily weighted on the side of feeling ready were regularly undertaking research and undertaking additional specialist training and

possibly developing specialised care packages and providing inter-professional training. Although this was affected by the number of participants scoring readiness at the midway point of '3' which is difficult to interpret it can at least be assumed that these participants did not strongly feel under-prepared.

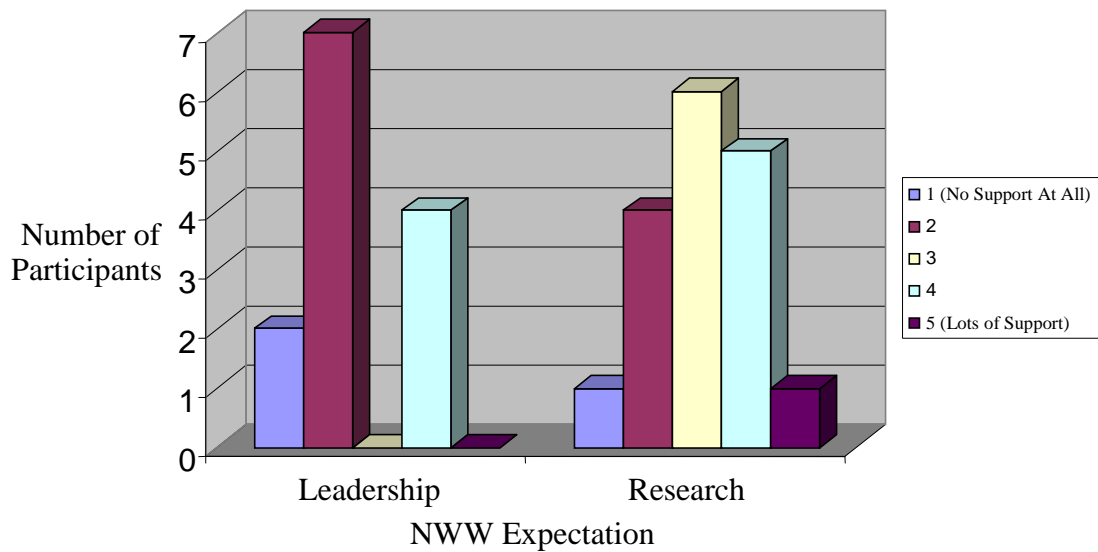
The roles that stood out for being weighted in the opposite direction were leadership, managing and coordinating staff and supervision of psychologists in clinical training (this is interesting in relation to the above results for 'asked to do and relationship with job description'). The consultation expectation was more evenly spread across the levels of readiness but it seems more participants were at the 'not at all ready' extreme end, than the 'completely ready' extreme end. Supervision of inter-professional staff showed a similar pattern.

Based on this, the only roles all participants (who were asked to do the role) felt ready for were regularly undertaking research and undertaking additional specialist training which is interesting in light of the proportion asked to do these roles and will be revisited in the Discussion section.

6.1.4. Support

There were no clear patterns within the support data (see Figure 6 and Appendix B for support data for each role). However, there were some interesting comparisons. For example, of those asked to take on a leadership role, 67% of participants felt that they were not supported (scores of 1 or 2 on a scale of 1-5 where 1 is 'no support at all' and 5 is 'lots of support'). This was compared to support for taking on research which was more evenly distributed. This is interesting in light of the 'readiness' data as less people felt ready for leadership than research and presumably would require more support for the former.

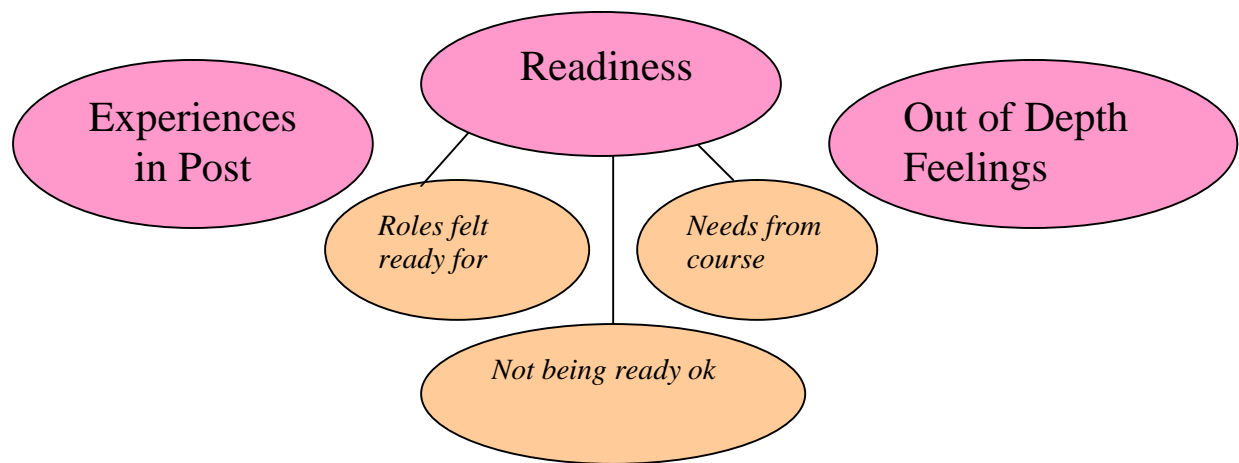
Figure 6. Support for Leadership Vs Research Expectation



6.1 Qualitative Analysis

Qualitative analysis of the telephone interview data was based on a thematic analysis methodology described in Braun & Clarke (2006). The data was coded and analysed for pertinent themes which were eventually refined to three main theme of: *Readiness*, *Experiences in Post* and, *Out of Depth Feelings*. These seemed to encapsulate all relevant aspects of the data (Process of refinement via early thematic maps detailed in Appendix C). These are explained in more detail below along with some interesting examples from the data. It should be noted that the theme of readiness was a pre-existing theme, theory-driven, and inherent in the responses given, whilst the other themes (including readiness sub-theme 'not being ready ok') emerged through a more inductive process.

Figure 7. Final Thematic Map showing three main themes of Readiness (and sub-themes), Experiences in Post and Out of Depth Feelings.



6.2.1 Readiness data

This included three sub-themes which are described below.

'Roles felt ready for' data (Box 2), included data with a positive feel to it about the actual roles participants felt the course had prepared them well for such as staff training, clinical/therapeutic work and research. This data also included experiences within and outside the course that had helped participants feel prepared.

Box 2. 'Roles Felt Ready For' data

"Placements helped – LD lots of staff training around tricky clients – challenging as trainee but helped to feel comfortable in this role...lots of liaison/systemic work helped"

"Definitely fully prepared for staff training"

"Did specialist placement in consultation as I knew I would be doing this when qualify so very ready and jumped ahead of what was expected as had dealt with these complexities before"

"Lots of focus on the course on research and clinical issues"

'Needs from the course', data (Box 3) included discussion about the roles participants did not feel ready for such as leadership, management and, some aspects of supervision and complex clinical work or, suggestions about what the course could have done better in order to prepare them for the roles they are expected to do.

Box 3. Needs From the Course Data

“Not just how to dip in and out of MDT but how to work from within an MDT..... getting the balance right between expert and generic worker..... how to develop a mental referral process and how to not take on cases others don't like and negotiate all this as a new member of team. i.e. how to cascade work and support other to do psych work”

“...managing waiting lists.....more teaching around supervision, chairing meetings in an MDT”

“...need more theoretical training on the course about leadership and management and more on the job training on placements.....make this a focus of some placements.....not pushed as trainees but expected to do it as soon as qualify”

'Not being ready ok' data (Box 4) included comments that the course was teaching at an appropriate developmental level and that roles such as leadership were expected further into the career and were not easily taught but developed through experience, so not being ready for these roles was felt to be appropriate. Also within this sub-theme were comments about what kind of support helps newly qualified CPs to take on new roles once in post – so either the participants were unprepared but supported so it was manageable or the roles they were unprepared for were not yet expected of them and they were supported in working towards the higher level roles in their own time. This data was perhaps less expected and fell outside the pre-existing themes.

Box 4. 'Not Being Ready Ok' Data

"...did have some emphasis on consultation and MDT working but it's difficult as there's so much to do on the course anyway so much pressure to do research and be a good clinician don't think the course had the scope to do leadership too. Anxiety as a trainee makes it difficult to lead on anything so it's more about getting to it in practice".

"I wan't prepared for management of other staff or supervising trainees but this comes after the preceptorship so it's appropriate"

"...very much supported lots of experienced clinical psychologists to support me to take on new roles"

"I really valued peer supervision in the past as you lose 19 others upon qualification"

"...helps if newly qualified is seen as a developmental stage in your career rather than you're qualified so get on with it"

There did seem to be a relationship between these data and the type of service individuals were working in. For example, when participants were working within a psychology department or in a service with several other CPs, they more often felt they were working at an appropriate developmental level compared to MDT working as the sole CP in a service.

6.2.2 Experiences in Post

This theme included discussion of what participants were doing in their roles including what they felt were new ways of working but was not necessarily linked to feeling unprepared but felt more like a neutral description of what is expected of them (see Box 5).

Box 5. Experiences in Post Data

“Health and Medicine are more about consultation and indirect work like helping people think about people psychologically”

“teaching etc is really emphasised in my post for example a junior OT wanted to learn about CBT so we both ran a group together then him alone”

“my first post was within an older adult CMHT so you have to be prepared to do lots of training to people older and more experienced than you”

Again, there was a clear relationship between the type of service individuals were working in and the experiences they had in post. The comments about NWW-type roles (MDT working/consultation/staff supervision) were more frequent from participants who were working within an MDT, often as the sole, or one of few psychologists.

6.2.3 Out of Depth Feelings

This theme included feelings about what was being asked of participants and whether they felt they were working above their expectations.

Box 6. Out of Depth Feelings Data

“I was thrown into a leadership role you don’t have chance to develop gradually as you have to do it from day one it’s sink or swim”

“One year into post I was asked to supervise trainees this feels like quite a steep learning curve as I expected this two years after qualifying”

“Only two or three months into post I was providing consultation to some very experienced people”

“I didn’t really expect to be lone psychologist so early in my career out on own as a newly qualified which automatically makes you bit of a leader”

“you’re thrown in the deep end when you qualify....at the moment I’m doing an 8a for 7 pay but out of my own will to further my career”

Once again, an important influence on these feelings seemed to be the type of service individuals were working in. For example, when they were working within a MDT of some kind (CMHT/medical team) and were the only CP within that team there were often feelings of working above and beyond their expectations and they were taking on roles that would have probably been taken on by more senior psychologists if within a psychology department.

An interesting outcome from the 'out of depth' data, were comments relating to *clinical* preparedness (rather than leadership/managerial preparedness). This did not seem to be an issue related to service-type as there were comments around not feeling prepared for the complexity of clients' difficulties both from those working within uni-disciplinary and MDT services.

“[working above and beyond expectations?] in terms of complex clients yes compared to trainee cases this was challenging and I wasn't prepared as I expected cases to be similar to those as a trainee but those cases I was given as a trainee are usually passed back to the PCT”

This also included data about not feeling supported within post. For example, the feeling that there was little understanding of an appropriate role for a newly qualified CP within some MDT services. This was more frequently felt within an MDT service and increased access to other CPs was often seen as something that would have helped these individuals feel more supported.

“I had support from medical team but expected it from other psychologists I wanted a secure base to face the medical team from”

“ my management tried to support me as much as they could but they can't always when it's a psychological expertise issue”

It should be noted that although a common theme was feeling ‘out of depth’ there were also a few comments that although initially uncomfortable, this eventually led to an increase in confidence and competence in these NWW roles.

“...all find our feet and do it but feel unprepared”

7.0 Discussion

7.1 Summary of results

The quantitative results suggested that Band 7 CPs *are* being asked to do leadership and managerial roles albeit less frequently than other roles such as consultation and staff training and supervision. Generally, participants did not feel ready for the higher level roles of leadership and management. The qualitative results showed an important distinction between experiences of participants working within a psychology department and those working within an MDT as the sole CP (or one of few) with more experiences of leadership roles alongside supervision and consultation to the MDT seemingly resulting in feelings of being “thrown in at the deep end” when working within these kinds of services. However, several participants reported these feelings being okay with adequate support.

7.2 Implications for Service

7.2.1 Increase in Leadership/Management and MDT teaching.

There are several implications for the clinical psychology training programmes from the present study. There was a clear indication from the participants interviewed that more training around leadership and management would have been useful, which qualified the similar quantitative finding. Within this was quite specifically a need for some kind of teaching about managing waiting lists, and the referral process which ‘lone’ psychologists may suddenly be expected to manage alone rather than as a

department. As mentioned earlier the training programmes are focused around a set of transferable competencies and interestingly, two of the roles that participants felt ready for (research & staff training) were two of the core competencies on the Leeds training course (staff training coming under the competency of “teaching” at Leeds). However, these competencies do not include a “leadership and management competency”. Thus, trainees currently are dependent on highly varied placement experiences for development of these apparently crucial skills. It was interesting that it was from placements that participants reported developing these skills and this may be an avenue for the course to emphasise and encourage these kinds of roles within placements. It does, however, seem that the Leeds course has increased teaching around these roles over the last couple of years. For example the current third years have lectures entitled: ‘Consultancy’, Working in teams’, ‘Working in challenging systems’ and, ‘Becoming a supervisor’. Additionally there are three joint teaching sessions with Hull and Sheffield on: ‘How to survive under employment conditions’, ‘Bringing about change in healthcare organisations’, and ‘Team working and leadership’. Thus it may be the case that the courses are already reacting to the new demands being placed on RQCPs and that the current cohort would feel better prepared than those involved in this study.

As mentioned, and unsurprisingly, the type of service participants were working in had a significant impact on the roles being asked of RQCPs and consequently impacted on the experiences within post. For example, the out of depth feelings were more evident for those working in MDT services as it seems that these are where NWW, in terms of the IAPT element, is happening now. Again this should not be seen negatively, but the data highlights the association with this kind of working with the roles NQCPs may not be as prepared for and a common element of this way of working seemed to be an expectation from the team of a more leadership/service development role than those within psychology services where there is a certain hierarchy of CPs with the more

experienced taking on these roles. Based on this I would anticipate a difficult task ahead for CPs within teams who attempt to get the balance right between leading and managing a team, while remaining an ‘integrated’ and equal member of the team at the same time as maintaining a Preceptorship role. Another issue raised by participants was the complexity of working within an MDT and the need for the course to focus on these issues within teaching to try and work with barriers to successful MDT working. Again, based the changes already seen in the Leeds teaching, this may be an area that courses are beginning to introduce as integral part of DClin Psych training.

Additionally, with potentially fewer CPs per team (most likely one linked to a team) there is the potential for feelings of isolation amongst these lone workers as understood from some of the participants and as experienced personally in an older adult CMHT placement. Thus an important recommendation for the course should be encouraging ongoing support such as formal peer supervision. Some of these more difficult experiences of RQCPs possibly highlight a difference in the way that NWW initiatives and the idea of Preceptorships are being received in different services. If the only change in a service is the addition of a CP it is not hard to see why this would be a difficult role to carve out. Increasing education about the role of a newly qualified CP to services that have traditionally been without CP may help to ensure that there is not such a discrepancy between the work expected of individuals with the same AfC banding across services. It may also help to ensure that this Preceptorship period is more than just a nice idea in theory, and that the band 7 role is protected during the transitional period.

7.2.2 Supporting CPD and Peer Supervision

In terms of service-specific in-post factors that help or hinder participants’ readiness for roles, it may be that the course cannot control this. However, as mentioned some aspects such as encouraging or facilitating peer supervision, and increasing continued

professional development courses were raised in the data as a means of continuing to support ex-trainees as they find their feet early on in post. On a positive note, Kiemle and Golding (2008) describe the Introduction to Clinical Leadership and Management (ICLM) training already in place for CPs. However, this is aimed at those CPs at consultant (or aspiring consultant) levels rather than newly qualified CPs. It may be that there is need for a similar 'lower-level' support/training around leadership and management for more recently qualified CPs based the suggestion that 'having effective leadership in place at all levels.....is crucial' (BPS, 2007)

7.2.3 'Asked to do' V Readiness

Another interesting (and positive) outcome of the study was that generally the roles that participants were more frequently asked to do were the roles they felt most ready for which shows that generally, the service in question prepares trainees appropriately. However, there were also signs that the *research* expectation, was one that participants felt completely ready for but only a few were actually asked to do (in fact as many people were asked to lead). This suggests that certain skills that are highly developed during the course may not be required upon qualification. It is difficult to know what the implications of this particular result are as it would be a shame to lose this important skill of CPs and it may be more about encouraging services to make use of these skills. It could also be the case that the participants were not long in their posts and research would come with time.

7.2.4 Clinical Needs

An interesting and perhaps unexpected outcome involved *clinical* preparedness. This was not focused on in the roles and thus was possibly neglected in the quantitative results. However, it clearly emerged from the qualitative data that participants felt somewhat under-prepared for the complexity of their caseload. This is interesting in light of the recent shift to transferable competencies in training rather than clinical specialisms.

7.3 Limitations of Study

7.3.1 Lack of previous research: Is it NWW or have RQCPs never felt prepared?

One limitation to the current project is the lack of similar earlier research to provide an example of what was happening for earlier cohorts of CPs. Thus, it is difficult to say whether what we have seen is necessarily about *new* roles and responsibilities. It may be that these roles have always been expected of RQCPs and that there has always been a skills gap between qualification and first post. However, a clue may be the reactions of RQCPs involved in this study (although a relatively small sample) there did seem to be feelings that there has been a shift in what they are expected to do in post. It may be that current trainees would feel more aware and prepared for NWW and the roles expected, as personally I feel very aware of NWW and I am expecting to do these roles. On the other hand, this knowledge does not make me feel 'ready'. There may also be an element of a shift in formality of NWW roles where they are now becoming part of a formal job description rather than being carried out informally in post. This lack of previous research could also be quite a positive element of the study as no previous research suggests this project partially fills a gap in the literature and the efficacy of the clinical psychology training doctorate as a service, is an essential subject area for clinical psychology as a whole profession to be aware of empirically not just theoretically.

7.3.2 Sample: Bias and Size

It should be noted that there was a bias in the sample towards those working within an MDT-type service (only 2 participants reported working within a psychology service; (see Appendix for breakdown of services included) which potentially led to a bias in reporting of feeling unprepared. However, it may also be an interesting example of NWW coming into play as we see more of these kinds of 'lone' roles for CPs as they are filtered out into services to 'improve access to psychology'. For example, one of the participants described her post and 2 others within the same trust being redesigned so as

to fit with NWW ideas about IAPT. In this way services that had previously only had liaison with CP departments now had these CPs physically amongst them.

“ ...service completely changed as there used to be a psychologist in a separate psychology department and the service was redesigned so that the psychologist sits within the CMHT and is expected to spread psychological thinking and they specifically took on newly qualifieds to do that role”

The sample size was also relatively small, especially in terms of quantitative research which inherently raises questions about the generalisability of the results and did not easily allow for formal statistical testing. However, this was intended as a small scale project to offer insight into the issues facing RQCPs and it would prove very interesting to follow up this work with larger scale research year by year to track any changes as NWW becomes more and more established.

7.3.3 Methodology: Thematic Analysis and Researcher Bias

The investigator's role and biases are a crucial element in qualitative research. Stiles (1993), suggests that personal involvement in a topic can result in biased results but can also motivate deeper understanding of the area. As a psychologist in clinical training who has experienced NWW on several placements, and will be a newly qualified CP in the very near future, my involvement and expectations were not neutral. Additionally, The method of telephone interviewing and note-taking rather than electronic recording, is open to selective reporting by myself which may be done in a self-fulfilling prophecy-type way. However, Stiles also suggests that this is generally a weak effect as we tend to disconfirm our expectations all the time, and I felt that this was the case with the present analysis. Although generally the themes were pre-existing in nature, and data were analysed according to these themes, this was not done at the expense of negative instances that worked to change some of the investigator's initial views. For example, my pre-existing assumption that all un-preparedness would be negative was challenged by the sub-theme 'not being ready ok'. Thus it felt important to highlight these data within a sub-theme.

7.4 Strengths

Although there were some limitations to the present study, several methodological strengths should be highlighted. Yardley (2001) suggests that there are three broad principles under which the quality of qualitative research can be judged. Firstly *sensitivity to context* whereby there is an awareness of the literature related to the subject matter such as the discussion of the wider policies the present project is affected; Secondly, *commitment*, (demonstrated in the present study in terms of a knowledge and understanding of the substantive field inherent in my role as a psychologist in clinical training), *rigour* (this includes the appropriateness of the sample to the research questions, which speaks for itself), *transparency and coherence* (demonstrated in clearly stating the stages of the research process and how participants were selected and the steps used in analysis) and thirdly; *impact and importance* (demonstrated in the project making an important contribution to the service in question and being, empirically, a new piece of research with implications for the service).

8.0 Conclusion

The present project attempted to empirically explore the roles and responsibilities of recently qualified clinical psychologists with a focus on their readiness to take on new roles after training in light of NWW changes. There was a feeling that the course emphasises academic, clinical and research training and there is a need for more emphasis on leadership training alongside practicalities around dealing with managed health care and hospital politics and MDT working. However, being unprepared was manageable with adequate support, peer supervision and ongoing training. Thus, there is room for DClin. Psych. courses to increase the emphasis on the NWW roles expected of trainees upon qualification, with the knowledge that ongoing support and

involvement in ex-trainees' personal and professional development is equally important.

References

- Bristol Online Survey Program, (BOS). To be found at <https://www.survey.bris.ac.uk/>
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.
- Clark, D. & Turpin, G. (2008). Improving opportunities. *The Psychologist*, 21, 700-701.
- Golding, L. (2008). Clinical Leadership Training: Correspondence. *Clinical Psychology Forum*, 186, 4.
- Kiemle, G. & Golding, L. (2008). Editorial: Clinical leadership and management training for clinical psychologists. *Clinical Psychology Forum*, 183, 7-8.
- Layard, (2005). *Mental Health: Britain's biggest social problem?* Paper presented at the No.10 Strategy Unit Seminar on Mental Health on 20th January 2005. Retrieved 29th April 2008, from <http://cep.lse.ac.uk/textonly/research/mentalhealth/RL414d.pdf>.
- Leininger, M. M. (1985). Ethnography and ethnonursing: Models and modes of qualitative data analysis. In M. M. Leininger (Ed.), *Qualitative Research Methods in Nursing*, pp. 33-72. Orlando, FL: Grune & Stratton.
- Onyett, S. (2007). *New Ways of Working for Applied Psychologists in Health and Social Care – Working Psychologically in Teams*. Leicester. British Psychological Society.
- Richards, D.A. & Suckling, R. (2008). Improving access to psychological therapy: The Doncaster demonstration site organisational model. *Clinical Psychology Forum*, 181, 9-15.
- Roth, A.D. & Pilling, S. (2007). *The competencies required to deliver effective cognitive and behavioural therapy for people with depression and anxiety disorders*. London: Department of Health.
- Smith, J. A. (2003). Validity and qualitative psychology. In J.A. Smith (ed) *Qualitative Psychology: A Practical Guide to Research Methods*, p.232-235. SAGE publications ltd London
- Stiles, W. (1993). Quality control in qualitative research. *Clinical Psychology Review*, 13. 593-618.
- Taylor, J.L. & Lavender, T. (2007). *New Ways of Working for Applied Psychologists in Health and Social Care – Final Report of the New Roles Project Group*. Leicester. British Psychological Society.
- The British Psychology Society (2006). *Managing the Transition from Trainee Clinical Psychologist Through Preceptorship to Full Specialist Practitioner Status*. Leicester. British Psychological Society.

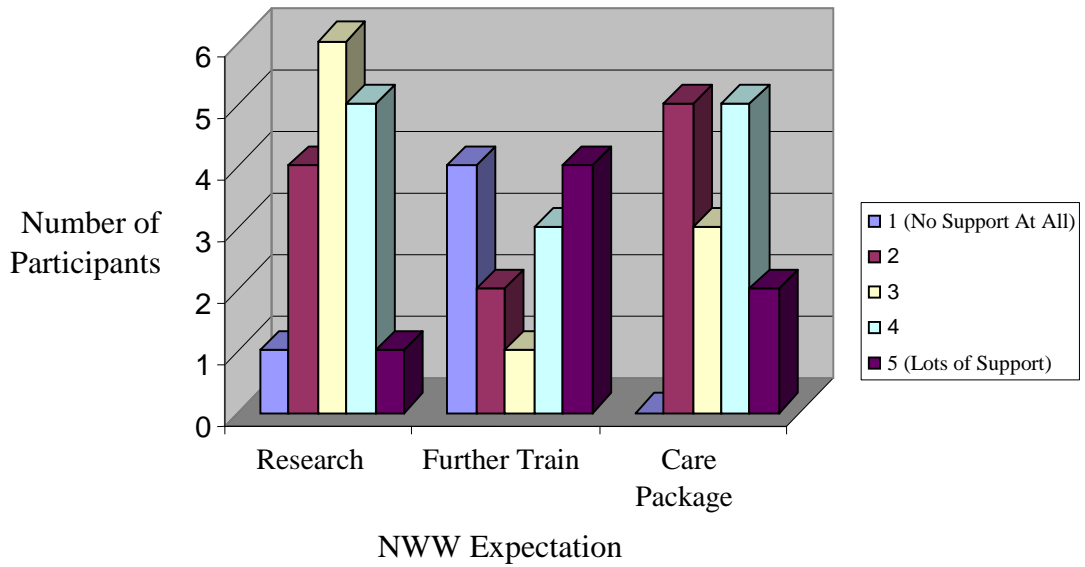
- The British Psychology Society (2007) *Leading Psychological Services*. Leicester. British Psychological Society.
- The British Psychological Society (2007a). *New Ways of Working for Applied Psychologists in Health and Social Care: The end of the beginning*. Leicester. British Psychological Society.
- The British Psychological Society (2007b). *New Ways of Working for Applied Psychologists in Health and Social Care – Organising, Managing, and Leading Psychological Services* Leicester. British Psychological Society.
- The British Psychological Society (2007c). *New Ways of Working for Applied Psychologists in Health and Social Care – Models of Training*. Leicester. British Psychological Society.
- The British Psychological Society (2007d). *New Ways of Working for Applied Psychologists in Health and Social Care – Career Pathways and Roles* Leicester. British Psychological Society.
- Turpin, G. (2007). Improving access to psychological therapies: A briefing paper. *Clinical Psychology Forum*, 181, 57-62. Leicester. British Psychological Society.
- Turpin, G. (2008). From the Editor's chair. *Clinical Psychology Forum*, 186, 9-10. Leicester. British Psychological Society.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, 15, 215-228.

Appendix A. Year Participants Qualified, Banding and Services they were working in.

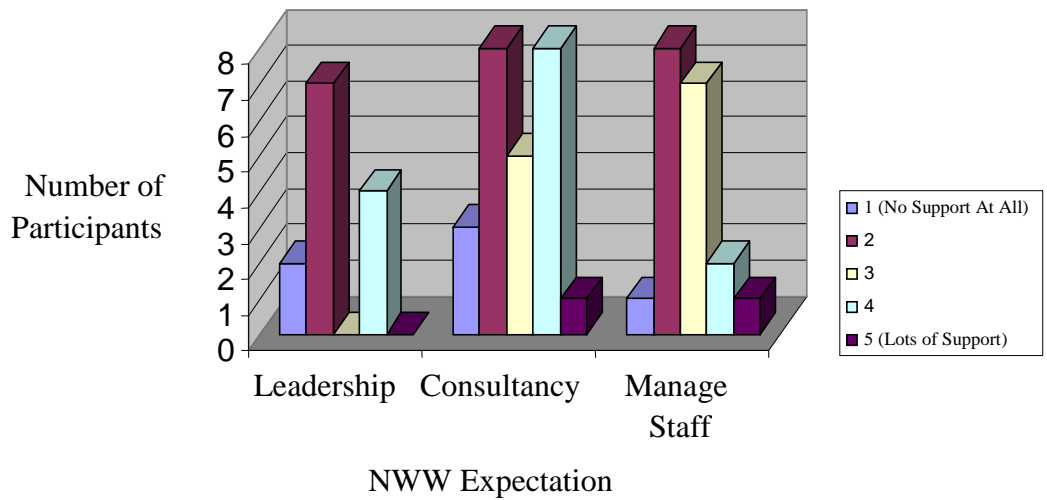
Participant Number	Year Qualified	Banding	Service
1	2007	7-8a	Forensic Learning disability inpatient unit
2	2006	7-8a	Adult mental health
3	2007	7	Primary care
4	2007	7	Psychological services
5	2007	7	Adult mental health CMHT
6	2007	7	Hepatitis C service (health/medical team)
7	2006	7	Acute clinical neuropsychology
8	2006	8a since qualified	Older adults memory and palliative care
9	2006	7-8a	CAMHS
10	?	7	?
11	2006	7	Older adults psychology service
12	2006	8a	Older adult service
13	2007	?	?
14	2007	7	Looked after children
15	2007	7 (equivalent)	Children's learning disability private company
16	?	?	?
17	2006	8a (recently received after 18 months at 7)	Early intervention in psychosis AOT
18	2007	7	Older adults service
19	2006	7	Joint post - Acute adult mental health inpatient and CMHT
20	2006	8a	Specialist weight management service
1	2006	7	Adult mental health half inpatient half community
22	2007	?	Specialising in learning disabilities
23	?	?	Specialist child clinical psychologist
24	2006	7-8a	Adult psychological therapies service
25	2007	7	Within 2 older adult CMHTs

Appendix B. Results for Support in NWW Roles.

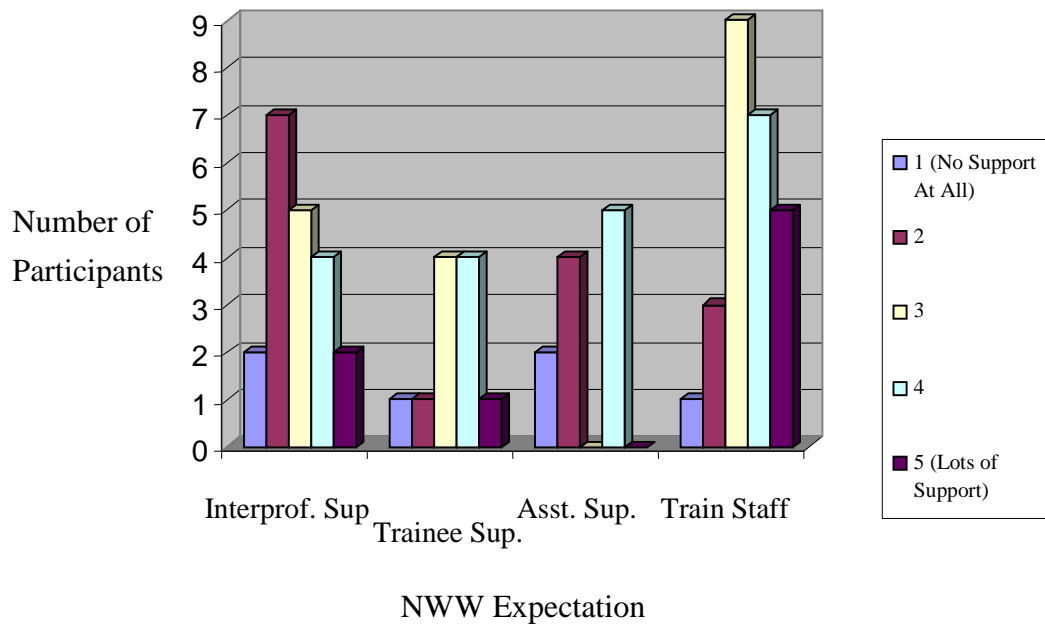
Support for Research, Further Specialist Training & Developing Specialist Care Packages



Support for Leadership Consultation and Managing Staff/Service Development

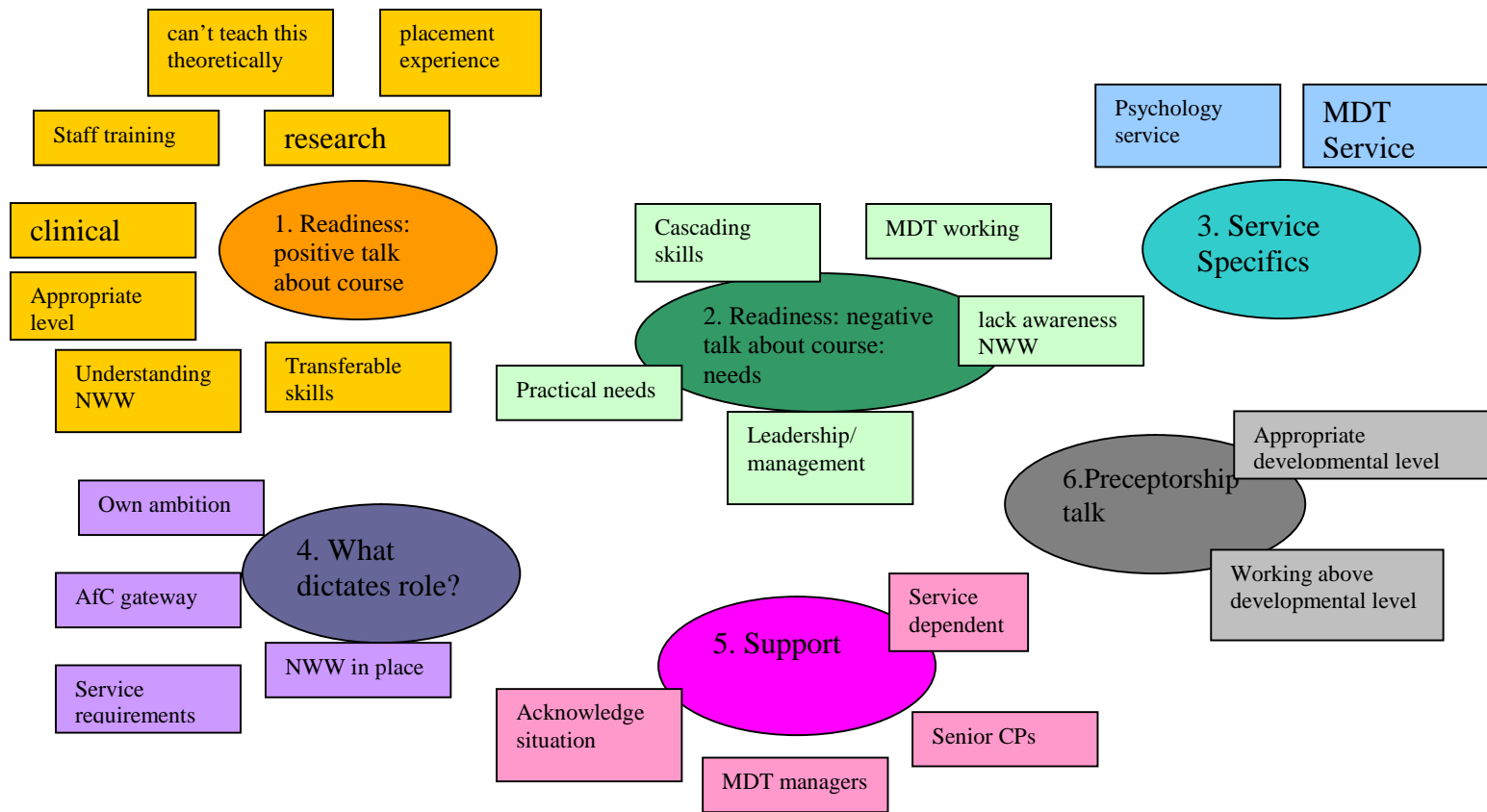


Support for Supervision of Interprofessional, Staff, Trainee & Assistant Psychologists, & Interprofessional Training

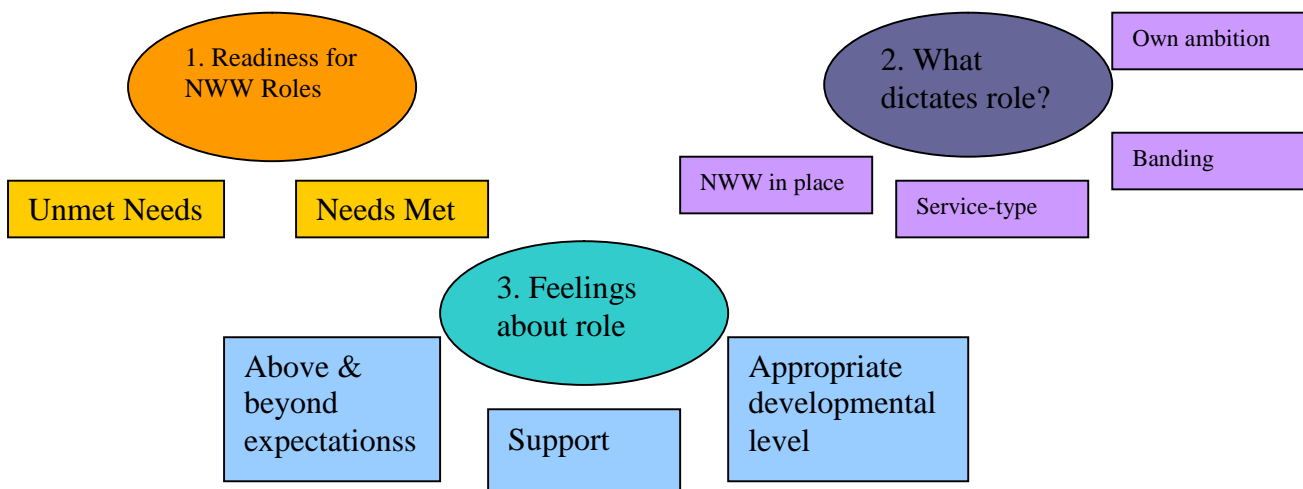


Appendix C. Early Thematic Maps

Appendix Ci. Initial Thematic Map with 6 main themes and corresponding codes



Appendix Cii. Second thematic map – refined to 3 main themes and sub-themes



N.B. Although refined down to 3 major themes this map did not feel to work with the data I had and 'What Dictates Role' was more of an overarching influence on the data than a theme within the data.