The British Psychological Society
Promoting excellence in psychology

Division of Clinical Psychology

DCP Policy on Supervision

May 2014

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Acknowledgements

The Division of Clinical Psychology Professional Standards Unit wishes to thank the following trusts:

- Camden and Islington NHS Foundation Trust, Camden Primary Care Trust and Islington Primary Care Trust for allowing us to use their 'Responsibilities of Psychology and Psychological Therapy Managers in Multi-professionally Managed Services' in Appendix E.
- South West London & St George's Mental Health Trust for allowing us to use their examples of 'Supervision Contracts' in Appendix A.

We would also like to thank the following people who contributed to the development and production of this document.

Tina Ball	Clinical Director, (Learning Disabilities), Sheffield Health & Social Care Trust
Dr Helen Beinart	Consultant Clinical Psychologist, Oxford Institute of Clinical Psychology Training, University of Oxford
Dr Laura Golding	Academic Director, DClinPsychol Programme, University of Liverpool
Jane Street	Consultant Clinical Psychologist, Associate Director for Psychology & Psychotherapies, Wandsworth and Clinical Lead, Wandsworth Psychological Therapies and Wellbeing Service (IAPT)

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DCP Equality and Diversity Statement

The British Psychological Society's *Code of Ethics and Conduct* (2009) is based on the four ethical principles of respect, competence, responsibility and integrity. This code is the basis for the Division of Clinical Psychology's work and is the foundation for the Division's diversity statement.

The Health and Care Professions Council (HCPC) as the regulatory body for the profession set out their statements in relation to equality and diversity in the *HCPC Equality and Diversity Scheme* (2007).

The Division of Clinical Psychology expects members to deliver services fairly in response to individual needs, and to behave with respect and decency to all. Members of the DCP do not discriminate based on a person's age; ability or disability; family circumstance; gender; political opinion; race, nationality, ethnic or national origin; religion or belief; sexual orientation; socio-economic background; or other distinctions. Such forms of discrimination represent a waste of human resources and a denial of opportunity.

The DCP recognises that discrimination, harassment and bullying does occur and expects members to challenge inappropriate behaviour and discriminatory practice either directly, or through working within cultures and systems to establish changes to practice.

Supervision is a critical element of clinical practice since it links scientific research to the realities of clinical work, and is the means by which theory becomes linked to practice (e.g. Fleming & Steen, 2012; Scaife 2001; Bernard & Goodyear, 1998).

Introduction

Supervision is one strand of clinical governance for professions within health services, alongside continuing professional development (CPD) and life-long learning to ensure safe and accountable practice and high quality clinical and professional services.

Supervision is identified within a range of documents in relation to the governance of professional practice, for instance the Care Quality Commission's *Essential Standards of Quality and Safety* (2010) and the Health and Care Professions Council's Standards of Practice 2c.2 (HCPC, 2011).

The Department of Health (1993) defines supervision as, 'A formal process for professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety in complex situations. It is central to the process of learning and scope of the expansion of practice and should be seen as a means of encouraging self-assessment, analytical and reflective skill.'

Supervision within clinical psychology can be defined as 'the formal provision, by approved supervisors, of a relationship-based education and training that is case-focused and which manages, supports, develops and evaluates the work of junior colleagues'. (Milne, 2007)

This document updates and replaces previous guidance from the DCP on this area, namely *Policy Guidelines on Supervision in the Practice of Clinical Psychology* (2003) and *Continued Supervision* (2006). Reference should also be made to the BPS *Code of Ethics and Conduct* (2009), the BPS *Generic Professional Practice Guidelines* (2008), *DCP Continuing Professional Development Guidelines* (2010) and *DCP Guidelines on Activity for Clinical Psychologists* (2012). The BPS's *Register for Supervisors* (RAPPS) contains standards for knowledge, skills, experience and understanding for the provision of effective supervision and these would be recommended as good practise for those offering supervision. (See Appendix D for RAPPS learning outcomes.)

This document confines itself primarily to the supervision needs of qualified clinical psychologists; supervision of trainee clinical psychologists is determined by additional guidance for clinical psychology training programmes: *Guidelines on Clinical Supervision* (BPS 2010). Supervising of assistant psychologists is addressed within the *Guidance on the Employment of Assistant Psychologists* (DCP, in preparation).

1. Aim of this document

The aim of this policy is to:

- Describe managerial, professional and clinical supervision.
- Set out standards for best practise in supervision for and by clinical psychologists.
- Outline responsibilities for the line/operational manager, supervisor and supervisee within this process. In particular, to demonstrate that the supervisee has a proactive role to bring concerns and issues to supervision and engage openly and honestly with the process.
- Reference how supervision, CPD and appraisal work together to provide a system for clinical governance and staff development.
- Provide guidance on the delivery, development and audit of supervision – such as contracts, recording, monitoring and audit.

1.1 Purpose and function of supervision

The primary purpose of supervision is to ensure the safety and quality of care and treatment for service users.

Supervision also supports professional development, developing and embedding new skills and ensuring adherence to good practice both in clinical and professional areas.

Where clinical psychologists work with more complex/transdiagnostic clients there is a particular role for supervision to support them to develop and refine (and re-refine) formulation and intervention plans.

Effective supervision also has a role in providing support for the individual and maintaining morale. This can be of particular value when psychologists are working in highly complex and sensitive areas – such as trauma or child sexual abuse – where the need to establish sufficient time to take issues to a safe and confidential place away from the normal work setting may need to be factored into the job plan.

At a time of ongoing change within services, the supervisory function has a particular role to allow the individual practitioner to reflect on the personal impact of their work and manage concerns in order to assist them in maintaining their level and standard of functioning.

Several models of supervision (see Beinart, 2012 for a review), identify supervision tasks and functions such as: education; support; quality assurance/monitoring; conceptualisation/formulation and consultation. These may occur in the broader service/team context and models such as Hawkins and Shohet (2012) and Holloway (1995) stress the importance of the broader context. Current theory and research also emphasises the centrality of the supervisory relationship to effective supervision, e.g. Beinart (2012) and Watkins (2013).

2. Standards and recommendations for good practise

These standards apply to all members of the DCP and provide a good practice benchmark for all clinical psychologists, although it is recognised that there may be different approaches within different organisations. Individuals in independent practice, either as sole practitioners or within an organised service, will require robust supervision arrangements that meet these standards and the underlying principles that underpin them.

1. All clinical psychologists, at all stages of their career and in all work contexts, will engage in regular planned supervision of their work.
2. All aspects of a clinical psychologist's work including clinical, consultancy, supervisory, research, educational, or managerial, will be subject to supervision.
3. The amount and frequency is dependent on context, experience and work demands:
   - 3.1 An absolute minimum will be one hour per month, one to one supervision with a psychologist, for all staff, however part time.
   - 3.2 It is recommended that a full time newly qualified clinical psychologist will have weekly clinical supervision for a minimum of one hour.
   - 3.3 It is recommended that a full time mid career clinical psychologist will have clinical supervision for a minimum of one hour per fortnight.
   - 3.4 It is recommended that a senior psychologist would have clinical supervision for a minimum of one hour per month.
4. It is recommended that a supervision contract (see Appendix A for examples), agreed and signed by supervisor and supervisee be established, and reviewed regularly, at least annually. The annual review will identify the amount of supervision required and incorporate supervision time in relation to the demands of the work and may be reflected in a work plan (DCP, 2012).
5. All clinical supervisors will be appropriately trained for the role.
6. All supervision will be documented and records kept (see Appendix B).
7. The individual has a responsibility to identify the need for and to seek access to supervision within their work situation.
8. Supervisors apply supervision models and best evidence to their supervisory practice and attend carefully to their supervisory relationships.
9. Supervisors demonstrate ethical practice and are respectful of diversity in all its forms.

3. Types of supervision

It is important conceptually to separate out:

- Line management supervision
- Professional supervision
- Clinical supervision.

In practise, in some services these three areas will each be dealt with within different supervisory arrangements, with an individual meeting with their team manager (a non-psychologist) on perhaps a monthly basis, meeting with their professional supervisor monthly and with the clinical supervisor on a weekly basis.

However, at times two or even all three may be combined within one supervisory relationship. In these situations it may be particularly important to ensure that all aspects are appropriately addressed. There are examples of matrices illustrating how and where the different elements may be met (Appendix C).

It should be noted that at times a particular issue will be and should be addressed in all three areas; one example would be a clinical issue concerning safeguarding of a vulnerable adult which may need to be discussed with the line manager (to support formal reporting), within professional supervision in terms of how the individual managed the situation and within clinical supervision to refine the clinical intervention.

3.1 Operational/line management supervision

Line management structures are determined by the employing organisation and line managers are responsible for developing systems for the managerial supervision of staff within their service. Line management supervision has a focus on appraisal and monitoring of performance, and is specifically concerned with operational issues and quality of service. This complies with clinical governance requirements, and addresses the need for accountability. Line management supervision ensures that staff perform the tasks they are paid to perform as part of the services that the organisation is commissioned to deliver. A key aim is to ensure that there is consistency between the individual's work and the objectives of the service.

3.2 Professional supervision

Professional supervision is a distinct function but may be combined with other roles. It has the overall focus on the individual as a professional within a professional role and its key function is to ensure that professional practice standards, ethics and codes of conduct are met.

Such supervision will address issues such as

- team working and relationships;
- progress against personal development plan (PDP) goals and organisational objectives from the appraisal;
- CPD needs and priorities;
- use of broader competencies, in particular leadership skills (DCP, 2010);

- professional and ethical issues and concerns; and
- longer term career development.

This offers a confidential (in so far as there are no concerns regarding fitness to practice and/or competence) reflective space for clinical psychologists to think and talk about their work, and their responses to the work.

Supervisors will need to possess solid understanding and expertise in key areas of professional competence for clinical psychologists, and have had appropriate preparation for their role of supervisor of qualified professional staff members. In most situations this would be provided by a psychologist in a more senior position; however, for senior psychologists peer supervision could be acceptable although this should be monitored within the appraisal system and access to a more senior psychologist should be available, even if external and in some circumstances necessitating providing funding to receive this from an external supervisor.

The frequency and duration of professional supervision will be of a standard that allows all aspects of work to be discussed, and enables the development of a beneficial supervisory relationship. This will be negotiated with, and agreed by all involved parties: supervisee, supervisor and line manager. A minimum standard is one professional supervisory session per month.

The focus, content, and process of supervision will be negotiated between supervisee and supervisor. The focus and content of supervisory discussions will shift and vary from individual to individual, over different work contexts, and over time.

Professional supervision may incorporate clinical supervision wholly or partly depending on the individual's need and/or the organisational context. Ideally the two would be kept separate or have clearly defined times as in practise one can easily be neglected in favour of the other.

3.3 Clinical supervision

Clinical supervision has the specific purpose to maintain, update and develop clinical skills in assessment, formulation and interventions. This may address clinical work from various orientations – complex cases, based on diagnoses/conditions, interventions or model specific.

Regular clinical supervision within the model of care that the clinician uses is a prerequisite for clinical practice. Such supervision also requires integration of clinical material with theoretical perspectives. There is a particular focus on the need to ensure that the work is evidence based and relates to most recent research and theoretical literature, as well as guidance from National Institute for Health and Care Excellence (NICE), the Scottish Intercollegiate Guidelines Network (SIGN) and other formal guidance.

The function is to ensure safe and effective practice within a respectful and trusting relationship. As there may be a high level of personal disclosure, strong emotions and also at times a high amount of challenge from the supervisor it is crucial that a good relationship is engendered and supported.

Clinical supervision will allow reflective space to review on-going clinical work where the individual practitioner can step back and critique this with a view to addressing biases or errors within work and learning new skills, having access to fresh ideas and new perspectives. It is invaluable in helping to deal with 'stuckness'. In particular it would allow the exploration of challenging attitudes and mind sets or particular mental frameworks.

This would also offer a 'safe space' to allow recognition of the personal impact of the work both generally and particularly at times with individual cases.

Traditionally the emphasis has been on the provision of reflective space but increasingly the formative and normative component is becoming stronger as demonstrated by clear guidance from NICE, SIGN and local protocols; in addition to the focus on payment by results (PBR) and the requirements for more immediate information on clinical activity. There is also the statutory aspect to the work, e.g. where a psychologist is working with a case where there is child sexual abuse or financial abuse of a vulnerable adult and safeguarding issues. The supervisor may need to give a clear message or other direction and this will be recorded formally.

In some areas of work, clinical supervision will be highly structured and model specific, such as within IAPT services. At times there may be supervision focusing on specific areas, such as development disorders/neuropsychology, trauma.

Where the clinician is working to develop clinical skills (and/or qualification) within a particular modality, such as cognitive, interpersonal, psycho-dynamic or systemic therapy, there may be externally determined standards required for accreditation for both the supervisor and supervisee. In this case there will be an expectation to prioritise time for such supervision (including possible travel), CPD opportunities or even to pay for external supervision.

Supervision is usually hierarchical with a more experienced supervisor providing supervision to a less experienced supervisee. However, clinical supervision is more competency based so it is possible that a more 'junior' staff member could provide clinical supervision to a more 'senior' member of staff. This may provide particular challenges to the supervisory relationship which need to be carefully negotiated and managed. With an increasingly wider range of clinical areas of work, and the need to be more self directed, individual practitioners are more likely to seek this collaborative, co-creative model. Regular supervision may be supplemented with ad hoc sessions (for instance where there is a recognised expert, e.g. in trauma, who colleagues utilise for specific cases). Increasingly, no one supervisor can meet all clinical supervision needs. Consultation is considered to be the term for ad hoc or one off use of supervision.

The status of any advice from the supervisor will vary given the level of qualification and autonomy of the practitioner – for newly qualified clinical psychologists or supervisees undertaking initial training in a new clinical areas, the supervisee might be advised to follow the advice of their supervisor. Once qualified, generally the psychologist is autonomous and decides whether to take advice; they would then be accountable as an individual for that judgement.

3.4. Alternative approaches to the provision of supervision

Supervision, especially clinical supervision, is normally considered to be provided one-to-one and face-to-face. However, there are many examples of alternative types of provision. Clinical supervision could be group based, with an identified lead, or peer based, with all members sharing expertise. It can be conducted by telephone (such as is common within Mindfulness-based CBT); Skype or other instant messaging solutions as well as email. Some models (e.g. systemic) use reflective teams or live supervision, where the supervisor is in the room with the clinician and client. Good practice would indicate the use of recorded or observed material within supervision at times.

These approaches all have benefits, even if primarily pragmatic, but there would also be disadvantages and a situation where a psychologist did not receive face-to-face and one-to-one supervision with reasonable frequency would not be considered acceptable practise.

3.5. Informed consent from clients in relation to supervision

Clinical psychologists will inform clients and supervisees of their own supervisory arrangements. Clients undertaking a course of formal psychological therapy will be informed of the fact that all therapists use clinical supervision as part of their work. Clinical psychologists will attempt to gain a general and informed consent from clients and supervisees for those occasions where potentially identifiable case or supervisory material needs to be part of supervisory discussions.

4. Complex issues that might arise in supervision

4.1 Aspects of the supervisory relationship

There can be a number of issues that arise in supervision that require careful management. The prime concern for all practitioners should be patient safety and well-being; this will also include concern about the wider governance of the service and the provision of safe and effective care, as well as professional ethics.

Some examples are:

- concerns about confidentiality, breaches of information governance;
- reporting of safeguarding issues;
- whistle blowing;
- personal issues – for instance, managing carer responsibilities;
- concerns about own fitness to practise;
- concerns about others fitness to practise;
- addressing capability issues within one's position, for instance being asked to take on work that is outside current skill range;
- ethical dilemmas within the local team/service; and
- managing boundary violations or dual relationships.

These issues could arise within different areas of supervision and may require different

courses of action. Most organisations have policies and procedures in relation to these areas, and the human resources department may be able to assist; in some areas the Health and Care Professions Council (HCPC) might need to be involved.

It needs to be stressed that supervision should not be viewed as 'personal therapy' for the supervisee; it could be easy for boundaries to be affected. In such situations it may be valuable for the supervisor to take this to their own professional supervision to ensure that they provide the right balance, for instance where a staff member brings an issue such as their own substance misuse to supervision.

Supervisory space needs to be a safe space for the individual but there can be times when organisational changes threaten this. Increasingly, as work roles change, there may be boundary issues that affect the supervisory relationship, such as for instance in a reorganisation where two psychologists were originally peers but now one is in a more senior position than the other. A supportive and contained relationship between supervisor and supervisee are cited as factors promoting satisfaction with supervision. In order to achieve these goals a supervisor and supervisee should have an explicit agreement about the circumstances under which issues discussed in supervision will be discussed with a third party. This should be reflected in the supervision contract, e.g. under 'boundaries' and should include reference to third party discussion where:

- concerns about the supervisee's work with service users are not being resolved through supervision;
- concerns about the supervisee's well-being are not being resolved through supervision;
- there appears to be a breach of the HCPC's *Standards of Proficiency*, BPS *Code of Conduct, Ethical Principles and Guidelines*, the DCP's *Professional Practice Guidelines* or the DCP's *Core Purpose and Philosophy of the Profession* on the part of the supervisee or supervisor; and
- behaviour on the part of the supervisor or supervisee where disciplinary proceedings might apply.

4.2 Sociocultural aspects to consider in supervision

The relationship between the supervisor and supervisee must be built on mutual trust and respect to ensure safe and effective practice. As there may be a high level of personal disclosure, strong emotions and also at times a high amount of challenge from the supervisor it is crucial that a good relationship is engendered and supported.

It is therefore important to recognise that people who have grown up in sexist, homophobic, racist or other discriminatory cultures may have problems building a trustful relationship between themselves and a supervisor or supervisee who comes from a very different cultural background. In such instances, if this cannot be resolved by discussion and internal mediation, the reallocation of the supervisor or supervisee without prejudice may be the only possible solution to ensure a good outcome.

4.3 Diversity impact assessment in relation to supervision

Category	Impact	Solution
1. Age	Differences in experience, values, knowledge and understanding.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.
2. Disability (including long-term physical health problems)	Access, travel, time commitment, impact of sensory impairment.	Deal with practical issues, including reducing travel and ensuring accessible facilities. Possible reallocation of supervisor or supervisee without prejudice. Ensure aids and adaptations are provided.
3. Religion/ 4. Culture	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.
5. Pregnancy and maternity	Possible gaps in continuity, maternity leave, childcare.	Need to ensure standards are met, especially around continuity of supervision.
6. Marriage and civil partnerships	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.
7. Sexual orientation and 8 Gender re-assignment	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor supervisee without prejudice.
9. Gender	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.

5. Quality, aspects of effective supervision

5.1 Expertise in the provision of effective supervision

The Society's Register for Supervisors (RAPPS) contains standards for knowledge, skills, experience and understanding for the provision of effective supervision at an introductory level and is recommended as good practise for those offering supervision. These are attached in Appendix F.

5.2 Training and CPD for supervisors

The supervisor will ensure that they have attended core supervision skills training and undertake further regular training relating to supervision over the course of their career. There are introductory and advanced training available from most of the training courses for placement supervisors. The BPS and many training courses provide training that is BPS approved and confers eligibility for the Register for Applied Psychology Practitioner Supervisors.

5.3 Problems in accessing supervision

There may be some settings where it is difficult to access suitable supervision to meet these standards, where, for instance, a psychologist is the only psychologist working in an organisation, for example, the sole clinical psychologist within an district general hospital or in an independent or third sector provider. In these situations, the individual and their manager will need to ensure they meet the standards of the HCPC and BPS and use this document to ensure the supervision needs are met. It would be advised to liaise with local DCP branch chairs for professional advice.

5.4 Monitoring and audit

All services employing clinical psychologists will ensure that effective supervision is provided and received. This can be monitored in a variety of ways, including formal audit and via annual appraisals.

The outcomes of supervision will be systematically reviewed and evaluated on a regular basis (at least annually). A minimum audit would be to ensure that psychologists all have this at the minimum frequency and more detailed analysis of qualitative aspects, such as the content and purpose. An ideal would be annual monitoring of the quality of supervision via a survey of supervisees associated with annual appraisal.

6. Conclusion

This document updates the guidance from the DCP for members and builds on that provided by earlier documents.

It sets clear standards in terms of supervision in relation to grades, quality aspects of supervision and for the supervisors in providing supervision.

It has become clear during the process of writing this document that supervision within clinical psychology is very much an area in development in terms of:

- the emergent literature on theoretical aspects of supervision;
- the work on a competency framework for supervisors; and
- the currents plans to take forward the RAPPS system to accredit supervisors.

It is hoped that the guidance within this document will be relevant over a reasonable timescale; it had been written, where appropriate, quite broadly to ensure that the increasingly diverse work contexts within the delivery of psychological services are addressed within it.

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Appendix A. Two examples of supervision contracts

SAMPLE CONTRACT FOR INDIVIDUAL AND GROUP CLINICAL SUPERVISION OF PSYCHOLOGICAL THERAPY

For use by all qualified practitioners within …….

Name of Supervisee (s): .....

Name of Supervisor: .....

Work Base: .....

Place of Supervision: .....

The supervision contract is a commitment by the supervisor and the supervisee to enable the supervisee, as a qualified practitioner of psychological therapy, to discuss in confidence issues relating to their clinical work with clients/patients, to ensure safe practice and to enable the development and maintenance of clinical therapeutic skills.

1) Supervision will take place on a …… weekly basis for ……. hours.

2) Supervision will usually be provided individually unless otherwise agreed and reviewed at least annually.

3) The supervisor has the responsibility of ensuring that a private venue (as free from interruption as possible) is available and booked for each session.

4) Sessions cancelled unavoidably due to annual leave, sick leave, etc, should be re-booked as soon as convenient to both parties.

5) Notes will be taken by the supervisor and a copy given to the supervisee.

6) Subjects discussed will be treated as confidential as set out by the Trust's guidelines on supervision.

7) The supervisee has the responsibility to highlight in supervision concerns, pressures and information they feel the supervisor should be aware of.

8) The supervisor has responsibility to use supervision to provide structure, support and exploration to maintain, enhance and/or develop the supervisee's clinical skills.

9) ……. is the qualified clinician who will act as third party, in a consultative role, if difficulties and conflicts arise between supervisor and supervisee.

10) When requested the supervisor will provide feedback for the supervisee's appraisal.

Date agreed: ..... Review date: .....

Signed:

Supervisor: ..... Supervisee: .....

PROFESSIONAL SUPERVISION CONTRACT

Supervisor: ..... Supervisee: .....

Date contract agreed: ..... Contract to be reviewed: .....
(Minimum annually)

Frequency of supervision: Monthly Duration of each session: 1–1.5 hours

Focus:

The professional supervisor ensures that the individual clinician is working within appropriate professional boundaries, and is adhering to appropriate professional standards, in line with the objectives of the service and the Trust. They also contribute to appraisals, identification of training needs and reviewing of objectives in the personal development plan.

The primary focus of professional supervision will therefore be on the development and maintenance of professional and clinical skills appropriate to the role of the supervisee.

Clinical caseload/workload will be reviewed routinely to monitor the types of clinical work undertaken, the caseload mix, waiting times and the development of clinical expertise.

Appraisal objectives will be routinely reviewed.

CPD activities will be reviewed and objectives discussed/recorded.

The supervisee will take responsibility for highlighting areas of need for further support in relation to specific aspects of clinical work, professional roles or managerial tasks.

Issues discussed and agreed outcomes will be recorded and agreed by both parties for each supervision session. The notes will be emailed to the supervisee who will then be able to comment or amend if necessary

Boundaries:

Regular supervision will be scheduled by agreement at the frequency specified with a commitment to good time keeping and avoidance of interruption.

Where issues of personal well-being are of concern to either party and appear to fall outside of the supervisory relationship, a third party (within the department) may be consulted with the permission of the supervisee/supervisor. We have identified XX.

The content of supervision and associated written records are confidential unless there are concerns raised about competence or risk.

Material from supervision/related records, specific to either party, is only to be discussed outside of supervision with the agreement of the supervisee and/or supervisor except where it is necessary to consult with a third party in the event of concerns regarding clinical or professional misconduct on the part of either the supervisor or supervisee.

Signed:

Supervisor: ..... Supervisee: .....

Date: .....

Appendix B: Recording of supervision sessions

Good practise would indicate that the recording of supervision sessions should include:

a. Copies of all supervisory contracts and updates to the contract.
b. The date and duration of each session.
c. A supervision logbook should be kept, and include at least minimal notes on the content of supervision, decisions reached, agreed actions.
d. A written record should be made of all regular reviews, including outcomes, of supervision. This would normally be the responsibility of the supervisor to ensure that a record is kept.
e. In some situations (e.g. risk issues) it would be good practice to also record a discussion and/or agreement within the relevant case file or as part of the clinical record; this is the responsibility of the supervisee. It would be good practise to record within the clinical case record, in particular any clinical decisions. The supervisee will record in the clinical record any risk issues and how they are addressed.

Appendix C: Psychology and Psychological Therapies: Responsibilities of psychology and psychological therapy managers in multiprofessional managed services

1. This document sets out the responsibilities of psychology professional management in multi-professionally managed services and teams. The majority of NHS services are multi-professional and managed through general service managers and/or clinical directors. Professional management supplements service management, with responsibility for managing and advising on profession specific areas where general managers may not have expertise. This paper clarifies the respective responsibilities of service and professional managers where these may be unclear.

2. Service management involves all aspects of managing the service/team. It includes:
   - Strategic direction for the service
   - Operational policies
   - Clinical governance of the service
   - Workload allocation
   - Supervision of staff in relation to their work in the service.

3. Professional management involves ensuring the professional standards and continuously improving the professional quality of work of professional staff. It includes:
   - Appointment of professionally competent and skilled staff
   - Profession specific elements of clinical governance – professional standards assurance and quality improvement
   - Profession specific clinical supervision
   - Continuing professional development.

4. Responsibility for hiring, appraisal and disciplinary matters can rest with either service or professional management. Line management is the term often used for this 'hiring and firing' responsibility. Sometimes there is a degree of vagueness as to which of service or professional manager has the line responsibility or it may be stated that this responsibility is shared.

5. As there can be different understandings as to what is the responsibility of service management and what of professional management, it can be useful to set out and agree the specific responsibilities of each. The Appendix is a suggested matrix of the respective responsibilities of service/team managers and psychology/psychological therapy professional managers in relation to psychologists and psychological therapists working in a multi-professional team. In this example, the psychology professional manager takes the line management responsibilities.

6. Job descriptions should include that the post holder is responsible to both service manager and professional manager. The precise form of wording will vary depending on the balance of responsibilities. In the example in the Appendix where the psychology/psychological therapy manager undertakes line management responsibilities for a psychologist who is working in two different teams, the job description should set out the relationship with regard to line management arrangements for both teams.

	Service/team manager	Psychology/psychological therapy manager
Recruitment	Contributes to writing and agreeing job description, recruitment procedures and selection of candidates.	Leads on recruitment, ensuring team/service manager(s) agree job description and procedures for selection of candidates.
Induction	Lead for induction is by agreement between service/team manager(s) and psychology manager, with the other contributing. Where psychologist is to work full-time in a team, the service/team manager will usually be responsible for induction; where the psychologist will work in more than one team, the psychology manager will usually be responsible.	
Work allocation	Responsible for allocation of work within the team/service.	Advises service/team manager(s) on parameters of appropriate kind of work/roles for psychologist in the team.
Standards, quality monitoring and clinical governance	Responsible for monitoring and ensuring work of the psychologist is within the policies and standards of the team/service.	Responsible for standards, quality monitoring and clinical governance of specialist psychology work in the team, within overall clinical governance arrangements of the team.
Appraisal/ IPR	Where a psychologist is full-time in a team/service, the service/team manager and psychology manager jointly carry out the annual IPR/ appraisal. Where the psychologist works in more than one team/service, the psychology manager leads on the annual appraisal/IPR and ensures the relevant team/service managers contribute and agree IPR objectives.	
Training and CPD	Contributes to setting CPD goals as part of the IPR process and scheduling and facilitation of CPD.	Responsible for agreeing annual CPD plan and facilitating psychologist in undertaking agreed CPD, with involvement of team/service manager(s) in setting CPD goals and scheduling of CPD.
Annual leave/ absence monitoring	Lead responsibility for agreeing annual leave and ensuring absence reporting and monitoring is by agreement between service/team manager and psychology manager, with the other contributing. Where psychologist works full-time in a team, the service/team manager will usually be responsible for leave arrangements; where the psychologist works in more than one team, the psychology manager will usually be responsible.	
Disciplinary	Ensures matters that might require formal disciplinary procedures are brought to the attention of the psychology manager. Liaises with psychology manager in taking forward disciplinary procedures where these relate to the performance of the psychologist in the team/service.	Responsible for any needed disciplinary procedures, with involvement of service/team manager(s) as needed.

While in principle, these respective responsibilities can be detailed in the job description of the post, in most cases a summary of line management and reporting arrangements for both teams should be sufficient.

Appendix D: RAPPS learning outcomes

Understanding and application

1. Have knowledge of the context (including professional, ethical and legal) within which supervision is provided and an understanding of the inherent responsibility.
2. Have an understanding of the importance of modelling the professional role, e.g. managing boundaries, including protecting time), confidentiality, accountability.
3. Have knowledge of developmental models of learning which may have an impact on supervision.
4. Have knowledge of a number of supervision frameworks that could be used for understanding and managing the supervisory process.
5. Have an understanding of the importance of a safe environment in facilitating learning and of the factors that affect the development of a supervisory relationship.
6. Have skills and experience in developing and maintaining a supervisory alliance.
7. Have knowledge of the structure of supervised professional experience including assessment procedures at different levels of qualification up to Chartered status level, and the changing expectations regarding the supervisor's role.
8. Have skills and experience in contracting and negotiating with supervisees.
9. Have an understanding of the transferability of professional skills into supervision and the similarities and differences.
10. Have an understanding of the process of assessment and failure, and skills and experience in evaluating supervisees.
11. Have skills and experience in the art of constructive criticism, on-going positive feedback and critical feedback where necessary.
12. Have knowledge of the various methods to gain information and give feedback (e.g. self report, audio and video tapes, colleague and client reports).
13. Have skills and experience of using a range of supervisory approaches and methods.
14. Have knowledge of ethical issues in supervision and an understanding of how this may affect the supervisory process, including power differentials.
15. Have an understanding of the issues around difference and diversity in supervision.
16. Have an awareness of the on-going development of supervisory skills and the need for further reflection/supervision training.
17. Have knowledge of techniques and processes to evaluate supervision, including eliciting feedback.

Printed and published by the British Psychological Society.

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Incorporated by Royal Charter Registered Charity No 229642

INF224/05.2014