South London and Maudsley NHS Foundation Trust

SUPERVISION POLICY

for All Staff

Version:	7
Ratified By:	Clinical Policy Working Group (CPWG) Joint Staff Committee (JSC)
Date Ratified:	3rd March 2026 (CPWG) 2th March 2026 (JSC)
Date Policy Comes into Effect:	21st April 2026
Author:	Helen Winter, Lead Psychologist for Staff Support Counselling and Wellbeing Jo Cook, Deputy Director of Psychology and Psychotherapy
Responsible Director:	Derek Tracy
Responsible Committee:	Clinical Delivery Board
Responsible Committee Approval Date:	11th February 2026
Target Audience:	All Trust Staff
Review Date:	March 2028

Equalities Equality Impact Assessment	Assessor: H Winter	Date: December 25
HRA Impact Assessment	Assessor: H Winter	Date:05/01/26

Document History

Version Control

Version No.	Date	Summary of Changes	Major (must go to an exec meeting) or minor changes	Author
1.0	20.01.2008	Re-written Policy	20.01.2008	S.Dennis
2.0	13.04.2011	Updated from Professional lead consultation	Minor	S.Murray
2.1	September 2011		Minor	P. Hasler
2.2	29.09.11	Updated on the audit process	Minor	Peter Hasler, Deputy Director of Nursing
2.3	April 2012	Associated documents added. Appendices amended.	Minor	P. Hasler, Deputy Director of Nursing
3.0	May 2014	Integrating Supervision Policies and updating to meet NHSR requirements	Major	A. Beck, Trust Director of Psychology and Psychotherapy
4.0	Sept 2014		Minor	A. Beck, Trust Director of Psychology and Psychotherapy
5.0	March 2018	Recommend all staff (excepting medics) receive monthly supervision in some form. All supervisors must be trained. Clinical supervision must be recorded electronically on LEAP. Supervision	Major	A. Beck, Trust Director of Psychology and Psychotherapy

		audit will be annual. This policy has been aligned to new policy procedures.		
5.1	August 2020	Include locum staff and ensure supervision takes an inclusive approach	Minor	A. Beck, Trust Director of Psychology and Psychotherapy
6.	March 2023	Integration of Safeguarding Supervision Guidance	Major	C Pollard, Trust Director of Psychology and Psychotherapy
	March 2023	Record of supervision recommended to be held on LEAP but other electronic recording is acceptable as long as accessible to both supervisor and supervisee and available to be produced as requested. Audit trail through appraisal.	Major	C Pollard, Trust Director of Psychology and Psychotherapy
	March 2023	Addition of guidance for staff engaged in research activities (3.4). Addition of safeguarding supervision guidance for staff working on clinical trials and research activity within the trust (6.4)	Major	C Pollard, Trust Director of Psychology and Psychotherapy
	March 2023	Addition of other staff groups not previously included.	Major	C Pollard, Trust Director of Psychology and Psychotherapy
6.1	August 2024	External supervisor arrangements	Moderate	H. Winter

6.2	16/07/2025	interim review conducted, policy content remains valid and full policy review being completed – expected completion date (16 January 2026)	Minor – Front page & document history	Jo Cook/Policy Co-ordinator
7	December 2025	Updated legislation and profession specific guidance where needed. Creation of External Supervisor Contract and Guidance referenced Requirement to record when supervision has occurred via LEAP (LEAP updated to improve accessibility)		H.Winter

Consultation

Stakeholder/Committee/ Group Consulted (only where comments were provided)	**Date**	**Changes made as a result of consultation**
Clinical Delivery Board	11.02.26	None
Clinical Policy Working Group	03.03.26	Clarified access permissions when staff change line manager.
Joint Staff Committee	12.03.26	None
Safeguarding	Nov 2025	Section 6.4 Supervision Standards **1. Updated Legal References**

		• Previous version referenced *London Child Protection Procedures (2021)*.
		• Updated version now cites *London Child Safeguarding Children Procedures (2025)* and *Working Together to Safeguard Children (2025)*, aligning with current statutory guidance.
		
		2. Expanded Scope of Supervision
		
		• Original policy required safeguarding review in “every clinical case”.
		• Updated policy specifies review in “every applicable case”, explicitly including both children and adults.
		
		3. Enhanced Documentation Requirements
		
		• New expectations include:
		  ○ A follow-up action plan.
		  ○ Updated risk assessments.
		  ○ Use of ePJS safeguarding tabs for recording safeguarding information.
		
		4. Clarified Supervisor Responsibilities
		
		• Supervisors are now expected to reflect on their own safeguarding knowledge limitations and seek advice from safeguarding leads when necessary.
		
		5. Additional Guidance for Supervisees
		
		• Supervisees are encouraged to access specialist safeguarding supervision within their service or directorate if deemed appropriate by the supervisor.
		
		6. Improved Language and Emphasis on Accountability
		
		• The updated version uses clearer, more directive language (e.g., “should be clearly documented”) and reinforces

		that “a decision not to act is regarded as a decision”.
Professional heads, Clinical directors, key stakeholders	Dec 2025	Updated legislation and profession specific guidance where needed.
Chief Nurse, Medical Director and Director of Therapies offices	Dec 2025	Profession specific updates made.
Equality manager		EIA Approval given
Involvement Manager	Sept 2025	Policy deemed to not directly impact service users. Policy is not new but an update. SU involvement not required for this review.
Procurement	December 2025	Collaboration on the development of external supervisors contract and guidance
LEAP + working group	Jan 2026	Update to LEAP functionality for recording supervision

Plan for Dissemination of Policy

Audience(s)	Dissemination Method	Paper or Electronic	Person Responsible
All Staff	Updated on policy list. Staff alerted through SLaM e-bulletin. Add to Team Brief.	Electronic	Clinical Policy Co-ordinator Communications team.
All Staff	Ensure all receive training	Face to face, paper and electronic	Learning development team.
All clinical-facing staff	Ensure Supervision Records are kept	Electronic	Audit through appraisal
All clinical-facing staff	Annual audit of supervision completion.	Electronic	Policy authors and LEAP.

Key changes to policy:

Version 7

Addition of anti-racism and cultural competence to introduction (Section 1)

Addition of new wording in Section 3 to clarify how cross-team supervision should be arranged, including formal approval requirements, governance expectations and clear accountability.

Addition of 'Information shared with the client' (6.2.2)

Addition 'Data protection and retention' (6.2.5)

Profession specific updates including relating to guidance, process and frequency. Addition of Music Therapist (Appendix 1)

Updated safeguarding legislation, expands supervision to all applicable cases (children and adults), and introduces clearer documentation standards including action plans and risk assessments (Appendix 2)

Removal of YIPP due to discontinuation of training

The External Supervisor contract and accompanying guidance have been developed and are provided in Appendix 4 and Appendix 5.

Separated out supervision-recording guidance into its own section to make LEAP recording requirements clearer. Requirement to record when supervision has occurred on LEAP. Individual supervision can be recorded by supervisor or supervisee. Group supervision by supervisor only but can be recorded in a single entry (Section4).

Updated the Quality of Supervision section to separate completion audit from professional-led quality review, with clearer governance and Professional Lead oversight (Section 7 and 8).

Plan for Implementation of Policy

Details on Implementation	Person Responsible
Implementation of Supervision Policy will be reviewed within the Trust quality governance structures including an annual report to Clinical Delivery Board.	Policy Leads

Contents

1. Introduction

Supervision is an essential support for all staff in delivering the best care to service users and their carers. It provides a protected space to reflect on practice, develop skills and competencies, and address any clinical or professional issues in a constructive and supportive way, enabling staff to respond effectively to the changing priorities of the organisation.

1.1 While there are differences in terms of frequency and balance of types of supervision depending on profession and job role (outlined below) it is expected that everyone uses supervision.

1.2 The Trust is committed to embedding anti-racism and cultural competence in all supervision. Supervisors must ensure that supervision provides a safe space to reflect on how race, ethnicity, culture and identity influence clinical work, team dynamics and staff wellbeing. Supervision should support anti-racist, culturally responsive practice for the benefit of staff, service users and our wider communities.

2. Purpose and Scope of Policy

The purpose of this policy is to outline the expectations for the supervision of staff within the Trust and to provide a framework for implementation and monitoring.

3. Supervision According to Role

3.1 Medical Staff and Social Work Staff

Medical consultants' supervision is compliant with the guidance of the Royal College of Psychiatrists and is monitored through revalidation. This requires Consultant Psychiatrists and other non-consultant career grade psychiatrists to be a member of a peer group (generally 4-8 psychiatrists per group) who should meet at least 4 times a year and individuals should carry out 2case based discussions a year (10 in 5 years for revalidation purposes). This is further detailed in appendix 1.

3.1.1 The supervision requirements of all qualified social workers and unqualified social care staff employed by the London boroughs of Lambeth, Croydon, Southwark and Lewisham are covered through their respective Local Authority employers. Those employed directly by SLaM are covered by this Supervision Policy.

3.2 All other Clinical Staff

It is a requirement that all clinical staff, irrespective of role, receive 1:1 supervision at least monthly (with the inclusion of unpaid honorary staff).

3.2.1 The form of the 1:1 meeting will vary according to their role, but it should be sufficient to ensure that they are supported to do their jobs and to raise any concerns they have.

3.2.2 Usually, supervision will consist of at least one hour of Teams or face to face meeting between supervisor and supervisee each month (part time staff may be pro rata). Where alternative arrangements are required these must be formally agreed with professional leads, and documented in advance.

3.2.3 Group supervision may be available for some dedicated groups working in specialist areas. This is in addition to the 1:1 supervision arrangement.

3.2.4 Some staff require clinical, managerial and professional supervision and these individuals may require more than 1 hour per month depending on caseload, level of training, and professional requirements.

Where staff have different supervisors providing clinical, managerial and/or professional supervision it is key that the supervision contract is clear between supervisors and supervisee about what the different types of supervision provided and what is covered and that supervisors work closely with one another to best support the supervisee.

3.2.5 The Trust is willing to enable professional leads to arrange cross-team supervision within SLaM at no additional cost or cross-charge. These arrangements must be formally agreed by the supervisee's service manager and professional lead and supported by clearly documented lines of accountability and decision-making. Liability, legal responsibility and case responsibility remain within the supervisee's line-management structure. Any cross-team supervision undertaken must also be discussed within the supervisor's own supervision.

3.2.6 Locum staff should be supervised as per the guidelines. Discretion (based on their experience and length of employment) should be used with regard to locums supervising other staff.

3.3 Non-Clinical Staff

It is a requirement that all staff, irrespective of role, receive line management supervision at least monthly. The form and duration of the 1:1 meeting will vary according to their role, but it should be sufficient to ensure that they are supported to do their jobs and to raise any concerns they have.

3.4 Staff engaged in research activities

It is a requirement that all staff engaged in research activities should receive professional supervision at least monthly. The form of the 1:1 meeting will vary according to their role, but it should be sufficient to ensure that they are supported to do their jobs and to raise any concerns they have. Academic supervision will be provided by a Principal Investigator or Trial Manager within the study that they are delivering. Where applicable, academic supervision can be provided by a core member of R&D – please contact slam-

ioppn.research@kcl.ac.uk. Individuals employed by KCL with honorary contracts in the Trust can both supervise and line manage SLaM employed research staff.

4. Recording of supervision

4.1 Supervision records should be:

- agreed by supervisor and supervisee
- recorded electronically by the supervisor or supervisee (recommendation is for this to be on LEAP)
- saved somewhere accessible to supervisor and supervisee, with notes available to be produced if requested.
- if stored outside of LEAP, it must be accompanied by a LEAP entry confirming that the supervision session has occurred.

4.1.1 The recommended platform for recording supervision is LEAP. If an alternative electronic platform (e.g. SharePoint) is preferred for storing notes or action trackers, the supervisor must still ensure that the session is recorded as having occurred on LEAP. This enables real-time monitoring of supervision completion.

4.1.2 The number of supervision meetings per year will be recorded in their annual appraisal with a requirement to state if supervision records are available for the past 12 months.

4.1.3 Individual supervision may be recorded on LEAP by either the supervisor or the supervisee, depending on what is most appropriate for the type of supervision and what is agreed between them. Group supervision is to be recorded on LEAP by the supervisor only, and the system will enable supervisors to record all participating supervisees in a single entry by selecting their names. This approach reflects current LEAP functionality and supports accurate, consistent monitoring across the Trust.

5. Definitions

For clinical and some other staff, there are three types of supervision. One or more may be provided to a supervisee and depending on their role, more than one may be required (see professional appendices). These different types of supervision may be provided by different individuals depending on the design of the role.

The “supervision” referred to throughout this policy will be, as a minimum, monthly managerial supervision. This monthly meeting may also include clinical and professional supervision elements.

A coaching approach is recommended to provide a supportive focus on the person’s development to achieve professional goals although sometimes a more directive approach, in which specific direction is given, may be required.

5.1 Clinical supervision

A regular, protected time for facilitated, in-depth reflection on, and development of, clinical practice as well as monitoring of caseload activity. It is generally led by the supervisee's agenda, although both supervisee and supervisor are responsible for ensuring, and recording, that evidence-base practice is followed. They must both ensure that supervisee is properly qualified to practice (including specialist interventions) and ensure that all the supervisees' clients are discussed regularly. Clinical supervision should always incorporate thinking around client risk and safeguarding. Clinical supervision should incorporate thinking around the trust values of trauma-informed care and anti-racism.

5.2 Managerial supervision

A planned collaborative process in which the supervisee's tasks are clarified and aligned with team / service / Trust objectives. The supervisor will support the supervisee to identify and overcome practice or patient safety concerns. The supervisor will support the supervisee to identify and address areas for development. The supervisor will support the supervisee to feel valued and will actively seek to explore and address any other concerns the supervisee might have, for example, about inequalities in the workplace related to protected characteristics (see 5.3 below).

5.3 Professional supervision

A focus on development of the supervisee within their discipline or profession. The supervisor will support the supervisee to develop as a particular kind of practitioner. There should be a focus career development with particular attention paid to any issues with inequality related to protected characteristics.

6. Roles and Responsibilities

6.1 Line Manager's Responsibility

- Ensure that all staff receive supervision taking account of profession specific requirements and what is feasible given the demands of their jobs.

- Monitor that supervision takes place for all staff and facilitate any necessary adjustments to assist staff in managing time effectively so that they can participate in regular supervision.

- Ensure LEAP is used to record that supervision has taken place, enabling real-time oversight of supervision activity.

- Negotiate with supervisors the number of supervisees they can reasonably be expected to support.

- Ensure all supervisors are trained and actively enquire about whether their supervisees:
  - feel valued
  - are physically and psychologically well
  - feel free to express their thoughts, conscience and religion
  - feel discriminated against

- have concerns which might lead to complaints, grievances or disciplinaries
  and act to address these concerns collaboratively with the supervisee and relevant others.

- Respond promptly and proportionately to issues raised in supervision that are brought to their attention by the supervisee or supervisor, where relevant in conjunction with Head of Profession, HR business partner or relevant others.

- Consider everyone's Continuing Professional Development, including supervisor training.

- Review feedback from Supervision Audit and provide / facilitate training or support as needed to ensure that supervision keeps staff feeling valued and supported in doing their jobs well.

6.2 Professional Lead Responsibility

- Support development of the supervisee within their discipline or profession.

- Advise on standards for supervision in conjunction with guidance from the relevant professional body.

- Commission appropriate training and other support as required.

- Liaise with clinical supervisors and advise on best practice requirements for clinical supervision.

- Liaise with managerial supervisors to best support the supervisee as required.

- Review feedback from Trust Supervision Audit and provide training/support as needed to ensure that the supervision staff receive helps them to do their jobs better and leaves them feeling valued.

6.3 All Supervisors' Responsibility

- Undertake Trust approved supervisor training.

- Agree with the supervisee who will record individual supervision on LEAP. Group supervision must be recorded on LEAP by the supervisor, who will be able to add all supervisees in a single entry. Notes and action trackers can be stored elsewhere electronically, but LEAP must be used to confirm that supervision has taken place.
- Supervision records for medical trainees are best recorded on the portfolio system from the Royal College of Psychiatrists.

- Adhere to the following <u>minimum standards</u>:
  - Prepare for the supervision and manage time effectively.

- Ensure that privacy is available for the supervision session.

- Provide time, a supportive environment, and an opportunity to reflect on all aspects of practice.

- Identify development needs. Give clear, consistent and constructive feedback.

- Support transparent, accountable and open practice.

- Acknowledge differences (including across the spectrum of race, ethnicity, gender etc), power imbalances and discrimination. Create safe space to explore the value of diversities. This should include encouraging reflections and, where appropriate, considerations of action, in relation to anti-racism, disability and diverse gender identities and gender-role non-conformity and other protected characteristics. Consideration should be given to issues around intersectionality.

- The Trust has an ambition to embed anti-racism in all that we do to ensure better experiences for our staff, service users and people we serve. Supervisors have a responsibility to make sure these conversations are brought into supervision. This is both in terms of wellbeing, but also to ensure supervisees are thinking and acting in ways that contribute to the Trust's aim to become an anti-racist organisation.

- Safeguard standards of safety and compassionate care.

- Praise and reward staff for the high-quality work they provide and ensure that they feel valued.

- Allow for issues and concerns to be raised and problem solved.
- Openly explore mistakes, accepting that making mistakes is human. Some mistakes will have consequences for which staff may need support. All mistakes are to be learnt from and require time to reflect.

- Facilitate the sharing of knowledge and information. Supervision is a mutual learning opportunity which enables the collaborative development of practice.

- Create a safe space for expressing feelings using a trauma-informed lens. Being aware of the supervisee's context and experiences and factors that may influence their use of supervision. This is most likely to be achieved if the supervisee does not fear recrimination and is actively supported to consider their physically and psychological well-being; express their thoughts, conscience and religion; consider whether they feel discriminated against; consider whether they have concerns which might lead to complaints, grievances or disciplinaries and collaboratively work to address these concerns. Supervisors

should seek to proactively anticipate difficulties arising for a supervisee and seek early resolution to problems.

- Evaluate the value of the supervision by intermittently discussing with the supervisee whether they are receiving the supervision and support that they need to do their job better.

- Allocate supervisor and supervisee considering relevant experience/ expertise and need. In most cases the supervisor will be senior to the supervisee but, it would not be unusual for staff of the same grade to enter into a supervisory relationship if one party has skills that can be shared in a supervisory context.

6.4 All Supervisee's Responsibility

- For individual clinical or professional supervision, the supervisee or supervisor may record the session on LEAP, depending on what is appropriate and agreed. For group supervision, the LEAP entry will be completed by the supervisor. Managerial supervision will normally be recorded by the supervisor.

- Prepare for the supervision session to ensure time is used effectively.

- Be prompt and manage time effectively during the session.

- Share information and experiences (including difficult ones) and associated learning. Be prepared to be open and transparent about their own needs for supervision and any challenges in their work.

- Be open to feedback and use it to change future practice.

- Work on any issues as agreed between sessions.

- Provide regular feedback on the quality of supervision e.g. to supervisor and completion of Supervision Audit.

- For clinicians it is necessary to enter patient specific critical issues which are discussed in supervision promptly on ePJS / IAPTUS or other appropriate records system.

6.5 Dealing with Difficulties

- Where disagreement arises about the supervision needs of an individual, or the most appropriate supervisor, the line manager and professional lead must reach agreement taking into consideration the individual's job requirements, professional guidance etc.

- If either the supervisor or supervisee believes that the other party is consistently not adhering to their responsibilities, or the standards set in this policy, the matter should be raised with the supervisor's line manager. This would usually be after the matter has been raised with the other party and

the matter remains unresolved. If either party finds this unacceptable, they should escalate their concerns to the service manager or director in the first instance who will discuss with their professional lead. All involved should seek early resolution to problems in order to avoid the need for escalation.

7. Quality of Supervision

7.1 Supervision Audit (Annual Completion Audit)

The organisation will undertake an Annual Supervision Audit to assess whether staff are receiving supervision in line with the frequency and recording requirements of this policy. This audit will focus on supervision completion and compliance (e.g., whether sessions occurred, whether they were recorded on LEAP, and whether supervision records are available).

7.1.1 The audit will be supported by the appraisal process, which will include a question on how frequently supervision has taken place and whether records for the preceding 12 months are available.

7.1.2 Findings from the Annual Supervision Audit will be reported annually to the Quality Committee, and shared with Professional Leads and Directorate Leads.

7.1.3 Directorates will report on their progress toward meeting the standards set out in this policy to the Quality Committee.

7.2 Quality of Supervision (Professional Lead Oversight)

Professional Leads will be responsible for reviewing the quality of supervision within their professional groups. Quality assurance activities may include supervisee feedback, themed reviews, reflective discussions, or focused audits.

7.2.1 The frequency and methodology of quality review may vary, to ensure it is proportionate, profession-specific, and aligned with existing governance processes. Findings will be shared with Directorates and, where appropriate, escalated through professional governance structures.

7.3 Confidentiality

- Supervision is a confidential process between the supervisor and supervisee.

- Any supervision notes must be treated as a confidential record and stored accordingly by the supervisor. Supervision records should be stored electronically and saved somewhere accessible to both supervisor and supervisee. LEAP must be used to record that supervision has occurred. Supervision notes may also be stored on LEAP which is the recommended platform. The supervisor is responsible for storing the supervision record and making it available, upon request, for audit or investigation. The supervisee must also have a copy of the supervision record each month for

their reference. The supervisee will need to store or destroy this record with consideration to the confidentiality of the material.

7.3.1 There are, however, limits to confidentiality where:

- There is concern about patient safety, the supervisor will need to alert the necessary local and statutory bodies.
- There is concern about the staff member's safety. These concerns will be discussed with the staff member and the supervisor will be transparent about who else will need to be informed e.g. Line Manager, Employee Relations Advisor.
- The supervisee has the responsibility to ensure that identified needs for practice development are fed into the appraisal process.
- Urgent training or development needs require prompt action.

7.3.2 Information Shared with Clients about Supervision

- Clients should be informed that their care will be discussed in supervision as part of routine clinical governance and quality assurance.
- The purpose of supervision is to ensure safe, effective, and reflective practice, and to support staff in delivering high-quality care.
- Discussions in supervision are confidential, subject to the same limits as all clinical information (e.g., safeguarding, risk, legal requirements), and do not require inclusion of patient-identifying information.

7.3.3 Supervision records:

- must be available for the purposes of investigation into complaints or serious incidents.
- patients' names should not be used; however, actions may be recorded against patient initials and/or trust ID.
- where a patient is discussed, the supervisee is responsible for updating ePJS accordingly within one week of supervision taking place.

7.3.4 In the above instances, only the relevant part of the record should be shared with those that have a legitimate reason to access it.

7.3.5 Change of Line Manager

If a staff member changes their line manager, the new manager will not have access to previous supervision notes. Access to historic supervision records remains restricted to the original supervisory relationship, except where disclosure is required for audit, investigation, safeguarding, or statutory purposes in line with this policy.

7.3.6 Data Protection and Retention

Supervision records are Trust records and must be created, stored and retained in line with UK GDPR and the Data Protection Act 2018. Retention and disposal must follow the Trust Records Management schedule (see Clinical Records Policy). When supervision records contain patient-identifiable information,

those notes must be minimal and any clinical actions recorded in the patient record (ePJS/IAPTUS) within one week.

7.4 External Supervision

This should not normally form a part of the SLaM supervision structure for junior staff. In exceptional circumstances, for example when an important gap in required clinical supervision is identified, then supervision from an external source may be arranged. However, if an individual accesses external clinical supervision they should ensure that patient details are not identifiable and that all clinically and risk relevant information is recorded electronically somewhere accessible to both supervisee and manager (LEAP is the recommended platform for this) so that their line manager is able to ensure that the requirements of this policy are fulfilled. Occasionally it may be appropriate for senior staff to receive external supervision if no appropriate arrangement can be made within the Trust. Appendix 4 contains the External Supervisor contract; guidance is in Appendix 5.

7.4.1 External supervisors must also adhere to the minimum standards set out for SLaM supervisors in section 5.3 and around confidentiality in 6.2. This should be explicitly written into any external contract with clear processes of escalation outlined in case needed".

7.5 Safeguarding Supervision Standards

- All staff will have a named supervisor, or be part of a formal supervision group.

- The Trust as an NHS provider is required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure board members, regulators and commissioners that these are functioning and effective. The London Child Safeguarding Children Procedures (2025) and Working Together to Safeguarding Children (2025) state that NHS trusts must provide both management and child protection supervision for clinical staff.

- Full guidance relating to Safeguarding Supervision can be found in Appendix 2 of this policy. As a minimum, Safeguarding children and Safeguarding Adult practice will be routinely reviewed in supervision in relation to every applicable case with the Clinical Supervisor ensuring that Practitioners are aware of and document the following:
  - The nature of any concern(s) about a child and/ or adult
  - The decisions agreed in response to the concern(s) discussed
  - The rationale for the decision is defined (remember a decision not to act or communicate a concern is regarded as a decision and should be clearly documented).
  - There is a follow-up action plan, which will also be reviewed.
  - Where required, risk assessments are updated and safeguarding information is recorded in the appropriate tabs on ePJS.

- Child and adult safeguarding is recognised and staff are clear about their roles and responsibilities
- The Safeguarding Children and Safeguarding Adults Policies and procedures are observed and applied.

- The clinical supervisor should reflect and recognise their own limitations and knowledge base around safeguarding and seek advice from a safeguarding lead where required.

- The supervisee should be encouraged to access specific safeguarding supervision within the directorate or service if the supervisor feels this is appropriate.

- Supervisors and supervisees will agree a formal, written contract for supervision at the outset of the relationship. This contract will be regularly reviewed at time periods agreed by the supervisor and supervisee.

  A sample of supervision notes may be audited to ensure they meet the standard set in this policy (with agreement of both supervisor and supervisee). Supervision records must still be made available for investigation of complaints or serious untoward incidents.

- Supervision records should be retained no longer than necessary and probably no longer than 7 years unless there is good reason.

- Safeguarding should be an agenda item for discussion in supervision for staff working on clinical trials and research activity within the trust. Supervisees should ensure staff are clear about their roles and responsibilities and the procedures that apply.
  Should a concern be raised, the following should be documented in the supervision notes:

  - The nature of any concern(s)
  - The decisions agreed in response to the concern(s) discussed
  - The rationale for the decision (remember a decision not to act or communicate a concern is a decision).

7.6 Performance Management

In some cases, a member of staff whose performance is being addressed will be being supervised by the same person who is addressing their performance. In these circumstances the supervisor needs to be very clear with the supervisee about which meetings are linked to the performance management process and which are supervisory in nature. Appropriate documentation of these events is essential.

In circumstances where supervisees have more than one supervisor it is recommended that the performance management process is supported by all individuals providing the supervisee with supervision.

8 Training

8.1 Training needs arising from this policy will be regularly reviewed by the Learning and Development team.

8.2 All supervisors must receive training. Supervision training uptake is monitored through assurance check in Trust training plan.

8.3 The uptake and effectiveness of the training will be monitored via the Learning and Development Board through the monitoring of the annual training plan. This training is used to ensure that the organisation fulfils its obligations to its insurers, NHS Resolution (NHSR). Supervisors should have the skills to deliver supervision according to the Supervision Policy.

9 Implementation

Implementation of Supervision Policy will be reviewed within the Trust quality governance structures including an annual report to Quality Committee.

10 Monitoring Compliance

What will be monitored i.e. measurable policy objective	Method of Monitoring	Monitoring frequency	Position responsible for performing the monitoring/ performing co-ordinating	Group(s)/committee(s) monitoring is reported to, inc responsibility for action plans and changes in practice as a result
Whether supervision is being completed in line with frequency and recording requirements (Annual Supervision Audit).	Annual audit reviewing supervision completion, LEAP recording, and availability of records.	Annually	Policy authors.	Clinical Delivery Board, Directorate Leads; Professional Leads

What will be monitored i.e. measurable policy objective	Method of Monitoring	Monitoring frequency	Position responsible for performing the monitoring/ performing co-ordinating	Group(s)/committee(s) monitoring is reported to, inc responsibility for action plans and changes in practice as a result
Quality of supervision (including supervisee experience, themed reviews, reflective discussions, focused audits).	Professional Lead quality assurance processes (e.g., feedback, themed reviews, reflective practice reviews, focused audits).	Aligned to professional governance cycles	Professional leads	Directorate governance structures; escalated to Quality Committee where appropriate
Supervisor training compliance	LEAP training compliance review	Annually	Policy authors, education and training	Education & Training Committee escalated to Quality Committee where appropriate

11 Associated Documentation

- Supporting Staff involved in Incidents, Complaints, Claims
- Registration Policy
- Continued Professional Development (CPD) Training Policy
- Safeguarding Adults
- Safeguarding Children
- Clinical Risk Assessment
- Attendance Management (formally Sickness) Policy
- Sickness
- Special Leave
- Disciplinary Policy
- Performance Improvement Policy
- Performance Development Policy

- Flexible Working
- Working Time Directive
- Employee Wellbeing and Stress in the Workplace
- Disability in the Workplace
- Equality Diversity and Inclusion

12 Documents Superseded and archived by this Policy

This policy supersedes the document ‘Clinical Supervision Guidelines, July 2002’ and ‘Clinical Supervision Policy 2014’ and all profession and Directorate specific supervision policies, which will now be archived.

13 Equality Impact Assessment

This policy has been assessed for its impact on equalities and found not to have any adverse effect on the identified groups.

14 Freedom of Information Act 2000

All Trust policies are public documents. They will be listed on the Trusts FOI document schedule and may be requested by any member of the public under the Freedom of Information Act (2000).

Appendix 1:

Profession-Specific Arrangements

For those professions regulated by the HCPC, please familiarise yourself with the HCPC guidance on the benefits and outcomes of effective supervision.

1. Psychology

Who Provides Supervision

Clinical and professional supervision should be provided by appropriately qualified practitioners, as agreed with professional lead. This will usually be a more senior psychologist in the same specialty and according to expertise.

For psychologists who are not eligible to lead on a specific aspect of a service (i.e. assistants, trainees and band 7 psychologists qualified for less than two years) it is recommended that there is no split between clinical, professional and managerial supervision.

Psychology staff can supervise trainees who are enrolled in an external training course once they have achieved the supervisory competencies prescribed by the course(s) whose trainees they supervise.

Content of Supervision

The contents of supervision sessions should meet the requirements of the Supervision Policy and consider:

i. cultural and/or ethnicity issues affecting service users, carers and staff;
ii. working within teams;
iii. working organisationally or systemically;
iv. managing caseload, throughput and discharge;
v. supervision of others by the supervisee;
vi. objectives set during the supervisee's last appraisal or other personal development plans, including CPD;
vii. service development issues and supervisee's roles in service development;
viii. supervisee's leadership roles in psychology service(s) and/or multidisciplinary teams and/or management teams;
ix. policies and professional practice information and their dissemination amongst staff;
x. audits and service evaluations.

Details of supervision by banding of staff

A) **Assistant Psychologists**

Clinical and professional supervision should be provided in combination by a qualified psychologist or by a psychological therapist/qualified mental health practitioner with Clinical Psychologist oversight. Frequency: weekly. Length: one hour

Management supervision should be provided by an appropriately qualified practitioner and agreed with the professional lead for psychology. If it is shared between a psychologist and an operational manager, the allocation and oversight of

psychological work should be provided by the psychologist and line management, appraisals and personal development planning should be done jointly by the psychologist and the operational manager. Management supervision should be monthly for one hour.

B) **Trainees**

Supervision for trainees who are enrolled in an external training course will ordinarily be agreed by the training scheme in advance of the placement. Psychology services offer placements to a range of specialists; therefore, these arrangements need to be clarified for each training scheme. Supervision of trainees who are directly employed by SLaM will be arranged as for Assistant Psychologists with the additional requirement that the contents of supervision will include matters relevant to the training and the trainee's progress.

C) **Clinical Associates in Psychology - CAPs (Apprentices and Qualified)**

Qualified CAPs: should be offered clinical and professional supervision by a Practitioner Psychologist (HCPC registered). Some additional clinical supervision may be provided by other appropriate Psychological Professionals but the main supervisor must be a Practitioner Psychologist. If there is oversight by a Psychologist then it is reasonable that this is 3 months direct supervisory review/contact with the CAP by a Practitioner Psychologist and regular supervision oversight by the Psychologist meeting with the direct supervisor. Frequency: fortnightly for qualified CAPs (pro-rated).

Management supervision should be provided by an appropriate psychologist. If it is shared between a psychologist and an operational manager, the allocation and oversight of psychological work should be provided by the psychologist and line management, appraisals and personal development planning should be done jointly by the psychologist and the operational manager. Management supervision should be at least monthly for one hour.

Apprentice CAPs: Placements must have a primary supervisor who is a registered practitioner psychologist and has overall responsibility for supervision of the trainee's placement experience. In addition, trainees may receive supervision on placement from other supplementary clinical or practice supervisors. These supervisors must be appropriately qualified, but may be registered in a different domain of psychology, or may be an experienced qualified associate psychologist or a qualified member of another profession. Frequency: min 1 hour weekly which can include but not be wholly provided in a group.

D) **Band 7 Applied Psychologist up to two years post qualification**

Clinical and professional supervision should be provided in combination by a more senior psychology colleague, with at least two years more seniority, who has completed formal supervision training. Frequency: Weekly for at least first year post-qualification; it may become fortnightly when supervisor and supervisee consider it appropriate. Length: one hour.

Management supervision should be provided by an appropriate psychologist. If it is shared between a psychologist and an operational manager, the allocation and oversight of psychological work should be provided by the psychologist and line management, appraisals and personal development planning should be done jointly by the psychologist and the operational manager. Management supervision should be monthly for one hour.

E) **Band 7 (more than two years post qualification)**

Clinical and professional supervision should be provided in combination by a senior psychology colleague. Frequency: At least fortnightly.

Management supervision should be provided by an appropriate psychologist. If it is shared between a psychologist and an operational manager, the allocation and oversight of psychological work should be provided by the psychologist and line management, appraisals and personal development planning should be done jointly by the psychologist and the operational manager. Management supervision should be monthly for one hour.

F) **Bands 8a and 8b**

Clinical and professional supervision may be provided in combination or separately by senior psychology colleague(s). Frequency: Fortnightly to monthly, depending on clinical caseload and professional responsibilities and leadership roles.

Management supervision should be provided by an appropriate psychologist. If it is shared between a psychologist and an operational manager, the allocation and oversight of psychological work should be provided by the psychologist and line management, appraisals and personal development planning should be done jointly by the psychologist and the operational manager. Management supervision should be monthly for one hour.

G) **Band 8c/d (if not Lead Psychologist of a service within a Directorate)**

Clinical and professional supervision may be provided in combination or separately by the Lead Psychologist of the service and/or a more senior psychology colleague in the same specialism. The more senior colleague may be at same band. Frequency: Monthly.

Management supervision may be provided by the Lead Psychologist of the service or may be shared between the Lead Psychologist and an operational manager. If it is shared, the oversight of psychological work should be provided by the psychologist and line management, appraisals and personal development planning should be done jointly by the psychologist and the operational manager. Management supervision should be monthly for one hour.

H) **Lead Psychologists of services within a Directorate**

Clinical supervision should be obtained from colleagues in the same specialism either within the Trust or external to it and it may be individual, group or peer supervision. Frequency: every 6 to 8 weeks.

Professional supervision should be provided by the Directorate Professional Head of Psychology and Psychotherapy. Frequency: at least quarterly.

The line manager should supervise, with frequency determined by mutual agreement. Appraisals and personal development planning should be done jointly by the Directorate Professional Head of Psychology and Psychotherapy and the line manager.

I) Directorate Professional Head of Psychology and Psychotherapy

Clinical supervision should be obtained from colleagues in same specialism either within the Trust, or if not availably internally then external to it. Clinical supervision may be individual, group or peer supervision. Frequency: monthly.

Professional supervision should be provided by the Trust Director of Psychology and Psychotherapy or Deputy Head of Psychology. Frequency: monthly.

Management supervision should be provided by the Operational Directorates/Service Director depending on needs, with the frequency agreed with the Director(s). Appraisals and personal development planning should be done jointly by the Trust Head or Deputy Head of Psychology and the relevant Clinical Director.

J) Trust Director of Psychology and Psychotherapy and Deputy Director of Psychology and Psychotherapy

Supervised by: Peer supervision from colleagues in same speciality either within the Trust or external to it. Professional and management supervision for Deputy Trust Head from Trust Director of Psychology and Psychotherapy. Professional supervision for Director should be from peers (external). Management supervision for the Director of P&P will be from the Chief Medical Officer.

Frequency: 6-8 weekly for clinical, as agreed with manager; managerial (within service 6-8 weekly), 3 monthly for professional.

K) Special Arrangements

Some psychologists will require additional specialist clinical supervision from another practitioner with a particular clinical skill/experience. Where possible, this should be through an agreed arrangement within the Trust (and should not be charged for).

If external supervision is required, this should be monitored by the Head of Service. The budget should be agreed with the appropriate service manager. External supervisors will be required to comply with SLaM standards for recording supervision. Where external supervision is arranged—whether paid or unpaid—the principles set out in the External Supervision Guidance (Appendix 5) and the

relevant sections of the External Supervisor Contract (Appendix 4) must be followed to ensure safe, consistent and clearly governed arrangements

Psychologists may be required to provide clinical supervision to staff not working within psychological therapy services, but carrying out psychological interventions. This will need to be formally agreed by the service manager, the senior psychologist in the service and the professional manager of the supervisee. The lines of accountability in decision-making must be clearly agreed and recorded. There must be clarity that liability, legal and case responsibility will remain within the line management structures of the supervisee. Records of supervision should be kept. The supervision undertaken by the psychologist in this situation should be discussed in his or her own clinical supervision.

L) Peer and Group Supervision

Psychologists who normally require individual supervision may engage in peer supervision when it is appropriate, but this does not replace individual supervision from a more senior staff member, which should also occur. There should be agreement with their clinical/ professional manager and clarity as to who is the clinical supervisor. The peer group should ensure that they have systems in place that meet the relevant responsibilities of supervisors and supervisees.

Group supervision on clinical issues may also be appropriate. If this is the case, then it should occur at the same frequency as individual supervision (according to grade), but should normally be for a longer period of time. It should not normally entirely replace individual supervision. Individual supervision should normally occur (as a minimum) after every 3 group supervisions. The supervisor and the group should ensure that they have systems in place that meet the relevant responsibilities of supervisors and supervisees. Each supervisee must ensure that the occurrence of group supervision is recorded on LEAP. LEAP remains the recommended platform for storing supervision records.

Joint or shared supervision (not more than two supervisees) may be undertaken if appropriate and if agreed to by both supervisees and the supervisor. The two supervisees should have similar needs and be at similar levels of development. Joint supervision may include clinical and professional issues but not management supervision. It should occur at the same frequency as individual supervision (according to grade), but should normally be for a longer period of time. It should not normally entirely replace individual supervision. Individual supervision should normally occur (as a minimum) after every 3 group supervisions and individual supervision time should be made available in between scheduled individual sessions if requested by a supervisee or the supervisor.

2. Psychotherapy

Arts therapists are registered with the HCPC, while other psychotherapists are registered with their own professional bodies. The Trust expects therapists to maintain their professional registration which includes receiving regular supervision in line with their organisation's CPD guidelines. Clinical supervision will usually be provided by a psychotherapist who is more senior and experienced in the therapist's treatment modality. Whereas this may the ideal scenario in many cases, it will not always be necessary for this therapist to be from the same psychotherapy profession (see details below).

Psychotherapists also provide clinical supervision to staff providing psychological therapy from other professional backgrounds (clinical or counselling psychology, nursing, occupational therapy, psychiatry). This will need to be formally agreed by the service manager and the professional lead of the supervisee. This will be limited to clinical supervision; professional and management supervision will not be the responsibility of the supervising therapist. The lines of accountability in decision-making must be clearly agreed and recorded. There must be clarity that liability, legal and case responsibility will remain within the line management structures of the supervisee. The supervision undertaken by the therapist in this situation should be discussed in his or her own clinical supervision.

A) **Adult Psychotherapist**

Frequency: minimum of monthly. "Registrants must restrict their practice within the limits of their own competence and seek professional consultation or supervision in any situation which may reach this limit. As a matter of good practice, registrants should exercise clinical judgment in considering whether to seek a medical opinion about a patient.

(Supervision) can be in the form of a seminar with a senior colleague or a peer group. Either may be institutionally organised or privately arranged. No criteria, such as frequency of sessions, are set regarding the clinical work undertaken providing it is psychoanalytic psychotherapy. Other forms of psychological or psychiatric practice are not included. It may, however, be private or institutional.

The minimum standard of clinical learning does not require 15 hours of direct presentation, although that may be the case, but it does require some direct presentation and participation in clinical discussion in which clinical skills are demonstrated." British Psychoanalytical Council (BPC) code of Ethics and CPD policy

Medical psychotherapists are supervised in line with medical supervision requirements.

B) Art Psychotherapist

The Trust fully supports the requirement for Arts Psychotherapists to receive clinical supervision in accordance with the standards set by their relevant professional bodies.

Clinical supervision is an integral component of Arts Therapies practice and is recognised by the HCPC (Art/Drama Psychotherapists and Music Therapists) and the UKCP (Dance Movement Psychotherapy), the regulating bodies, as essential for ensuring high standards of proficiency and professional practice.

According to the HCPC Standards of Proficiency for Arts Therapists (2013, 11.3): **"Registrant Arts Therapists must understand the role and value of ongoing clinical supervision in an arts therapy context."**

All Art Psychotherapists in SLaM must receive regular clinical supervision to review their clinical work in depth. This includes discussing therapeutic aims and expected outcomes, techniques used, the therapeutic relationship, and the therapist's emotional responses in order to understand issues such as transference and countertransference.

Frequency

Supervision frequency should be determined by clinical need and workload. As per BAAT guidance:

- **Weekly to fortnightly supervision** is required when working with **children**.
- For work with **adults**, frequency should reflect the number of clients seen weekly and the nature of the client group.
- **Minimum requirement:** monthly supervision for experienced practitioners with lower-intensity caseloads.
- Access to clinical supervision for **part-time staff** will be calculated **pro-rata**.

Supervisors

Supervisors are required to have **psychodynamic or compatible training** and will have **completed personal therapy** as part of their professional training (BAAT).

While the ideal arrangement is for supervision to be provided by a senior Art Psychotherapist or an Arts Therapist experienced in the same modality, this may not always be possible. In such cases, a supervisor from a related discipline who is familiar with clinical supervision principles may be appropriate.

It is **not recommended** that a therapist receives supervision from another therapist of the **same grading within the same service or department**, unless they are based in different teams and do not work alongside each other day-to-day.

Cross-team supervision

The Trust is willing to enable professional leads to arrange cross-team supervision within SLaM at **no additional cost or cross-charge**. These arrangements must be:

- Formally agreed by the **service manager** and **professional lead** of the supervisee.

- Limited strictly to **clinical supervision** (not management or professional supervision).
- Supported by clearly documented lines of accountability and decision-making.

Liability, legal responsibility, and case responsibility remain within the supervisee's **line management structure**. Any cross-team supervision undertaken must be discussed in the therapist's own supervision.

Professional Guidance (Art Psychotherapy)

- **"Supervision is required for good clinical practice, to ensure the continuing working development (CPD) of the Art therapist and for the protection and welfare of patients/clients."**
  British Association of Art Therapists (BAAT)

C) Music Therapist

The Trust fully supports the requirement for Music Therapists to receive clinical supervision as set out by their professional body, the **British Association for Music Therapy (BAMT)**, and as recognised by the HCPC.

Clinical supervision is a fundamental aspect of Music Therapy practice, ensuring patient safety, clinical effectiveness, and ongoing professional development.

As with all Arts Therapies, Music Therapists must receive **regular supervision** to discuss cases in depth, review clinical aims and techniques, reflect on the therapeutic relationship, and consider emotional responses arising in the work.

Frequency

Supervision frequency should be based on the **amount and nature of clinical work**, the therapist's experience, and the setting. Supervision must occur **regularly** and sufficiently often to support safe and reflective practice. Access for part-time staff will be **pro-rata**.

Supervisors

Where possible, supervision should be provided by a senior Music Therapist with appropriate training and experience. If this is not feasible, supervision may be provided by an Arts Therapist or other clinician who is familiar with clinical supervision principles and whose training is compatible.

Cross-team supervision arrangements must follow Trust processes:

- Formal agreement by both the **service manager** and **professional lead**
- Restricted to **clinical** (not management) supervision
- Clear documentation of accountability, case responsibility, and decision-making structures

- Liability and case responsibility remain within the supervisee's line management
- Cross-team supervision must be addressed within the supervisor's own clinical supervision.

Professional Guidance (Music Therapy)

- **"The principle aims of supervision are to protect service user safety and to reflect on and develop the clinician's practice. The supervisee remains responsible and accountable for their clinical work."**
  British Association of Music Therapists, 2008/2012
- **"Music therapy supervision provides a forum for support and an objective perspective on clinical work… and seeks to increase the effectiveness of music therapy practice, while ensuring that this is in line with current legislation and procedures."**
  British Association for Music Therapy (BAMT)

D) **Child and Adolescent Psychotherapist (CAPT)**

Frequency: Newly qualified or band 7 CAPTs should receive 2 hours per month from a consultant CAPT or senior CAPT. More experienced CAPTs should receive one hour per month, or ten hours per year, of individual or group supervision for at least five years post qualification. The ACP also recommends additional peer group supervision. Association of Child Psychotherapists CPD scheme September 2008.

E) **Drama Therapist**

Frequency: "…depends on the amount of direct clinical (drama therapy) work undertaken by the drama therapist. Ideally a full time post the recommended minimum is one and a half hours per month"

"A clinical supervisor is normally another Drama therapist or a practitioner in a related discipline who is familiar with the concept of clinical supervision in Drama therapy." British Association of Drama Therapists (BADTh) Supervision Statement for employers of Drama Therapists.

F) **Family Therapist**

Frequency – first three years post qualification – minimum 1.5 hours per month. "Usually face to face and from a supervisor who is registered with the FCSST section of UKCP" After three years, - minimum of twelve hours per year – usually monthly. Some supervision may be from another psychotherapy modality, but most should be from a supervisor who is registered with the FCSST section of UKCP. Some supervision may also be group, or team supervision. "The FCSST section recognises the creative possibilities of other forms of supervision as technological advances are taking place and new methods are evolving e.g. electronically communicated forms of supervision and video conferencing".

Association of Family Therapists CPD policy Jan 2008

G) **Play Therapist**

Clinical supervision must be provided by a BAPT qualified Play Therapist. Play Therapy qualifications not accredited by BAPT are not accepted. Clinical supervision of Full members should be provided by a Full member of BAPT. Where BAPT full members are not available to supervise due to geographical area, exceptions can be made - please see geographic location section below. Where no BAPT Full members are available for supervision, members may seek other appropriately qualified and experienced child therapists. This will include one of the following:

ACP/UKCP registered Child Psychotherapist or Psychotherapist; HPC registered Art Therapist; BADTh registered drama therapist; BPS Chartered Clinical Psychologist; UKCP registered Family Therapist; FRCP registered Child and Adolescent Psychiatrist

No other qualifications are acceptable. The above professionals must have also completed a minimum of 250 post-qualified therapy hours with children and/or young people. Professionals contained in the above list who have not completed this number of client hours will not be accepted as Supervisors." British Association of Play Therapists.

It is the appointing manager's responsibility to ensure there is appropriate supervision before appointing.

H) **Cognitive Behaviour Therapist**

Accrediting Body: British Association of Behavioural and Cognitive Psychotherapy (BABCP).

Supervision requirements: CBT clinical supervision should be provided by an appropriately qualified BABCP Accredited Practitioner. It is not the same as professional or managerial supervision (although these may be provided by the same person as clinical supervision). Supervision must include an element of "live" supervision or use of audio or video therapy tapes and use of formal skills rating scales such as the CTS-R is recommended.

Trainees: minimum one hour per week clinical supervision, provided by an appropriately qualified BABCP Accredited Practitioner. Supervision may be individual or group. If group, then individual supervision should also be available.

Trained CBT therapists: Minimum of one hour per month total clinical supervision time (norm = weekly/fortnightly for one hour), provided by an appropriately qualified BABCP Accredited Practitioner or equivalent. Supervision may be individual, in a CBT supervision group, the group must be no more than 6 members, all group members must present their own material regularly. If group, individual supervision should also be available.

3. Psychological Practitioners

Psychological practitioner roles exist across the trust and many are quite new. Registration and career pathways are still being developed for many of these newer roles. Psychological practitioners tend to be at bands 4-6 and many are in training roles in the trust. All Psychological Practitioners require clinical, professional and management supervision as all other trust staff. Professional and clinical supervision will often be combined.

A) CAMHS Senior Wellbeing Practitioner (SWP)

Registration with the British Association of Behavioural and Cognitive Psychotherapy (BABCP) or British Psychological Society (BPS) will be open from 2023.

Senior Wellbeing Practitioners must have a qualification in either PG Dip or PG Certificate Child Wellbeing Practitioner or PG Dip Educational Mental Health Practitioner and are therefore eligible to register with the BPS.

Frequency: SWPs in training should receive a minimum of 2 hours clinical supervision per month provided by a band 7 or 8a supervisor who has completed formal supervision training. The supervisor must have a core profession and recognised professional registration. Management and clinical supervision can be provided by the same supervisor with preference to be given to in-person supervision.

Management supervision: will be the responsibility of a B7 or B8a supervisor/ line manager and should be provided monthly and can include caseload management

Group and Peer supervision: see guidance page 11.

A minimum of 1 hour per month should be focussed on: Supervision of supervision from a Band 7 practitioner or above who is experienced and skilled in supervision. This allows the supervisee:

- A chance to support reflection, confidence, skills development and to provide practical support around their supervision of their supervisee.
- Suggest this is timed around their supervision of their supervisee for maximum benefit.
- Helpful if the person providing supervision of supervision also provides line management/case management for the SWPs supervisee
-

B) Child Wellbeing Practitioner (CWP) and Educational Mental Health Practitioner (EMHP)

Registration with the Wellbeing Practitioner (SWP)

Registration with the British Association of Behavioural and Cognitive Psychotherapy (BABCP) or British Psychological Society will be open from 2023.

Frequency: during training CWP/EMHPs should be offered weekly clinical supervision for one hour supported by fortnightly group supervision and/or clinical skills groups. Newly qualified practitioners should be offered fortnightly supervision of 1-hour supported by 1-hour group or peer supervision a month in their first two years post qualifying. This can be reduced to monthly 1-1 supervision supported by monthly group/peer supervision.

EMHP/CWP supervisors must have a minimum of 2 years' experience in a CYP mental health setting.

Clinical supervision should be provided by either:

- a more senior member of staff that is undertaking or has completed a PG qualification CYP- MH Supervisor
- a qualified or trainee Senior Wellbeing Practitioner.
- a senior member of staff with experience in supervising low intensity intervention or CBT informed interventions.

Clinical and professional supervision can be combined and can include caseload management.

Supervision of supervision: Safeguarding and risk management concerns arising in supervision must be discussed with a B7 or B8a practitioner when the supervisor is in training.

Children and Young People Wellbeing Practitioner (CWP) National Implementation Guide

Management supervision: will be the responsibility of a B7 or B8a supervisor/ line manager and should be provided monthly this can include caseload management.

Group and Peer supervision: trainees are expected to attend group supervision and or clinical skill groups facilitated by a trained supervisor which should take place every 2-4 weeks. Qualified staff are encouraged to attend monthly sessions.

C) **Psychological Wellbeing Practitioners (PWP)**

PWPs work in adult IAPT services and can hold registration with the British Psychological Society (BABCP). In training PWPs receive supervision both within their service and from their course. Supervision guidance for PWPs is set out in the IAPT manual.
PWPs should receive both case management and clinical skills development supervision. Supervision should be provided by an appropriately qualified and senior psychological practitioner who has a good understanding of the IAPT stepped care model, of low intensity ways of working and interventions and who has received training in PWP case management supervision. Frequency: case management supervision should be weekly for at least one hour (may be pro rata for part-time staff or when offered in an appropriate group format).

Clinical skills supervision may be offered in a group format and may be less frequent.
Management supervision should be offered at least monthly.

D) **Mental Health & Wellbeing Practitioners (MHWP)**

Supervision should be from an appropriate supervisor who is familiar with CBT principles ie Clinical/Counselling/Forensic Psychologists, CBT Therapists, CAPs, Counsellor (SCoPEd B or C), Adult Psychotherapist (SCoPEd C), Systemic Psychotherapists, and MHWPs >2 year post-qualified.

MHWPs, whilst in training, need weekly caseload supervision for at least one hour which can be provided by any qualified mental health professional. Whilst training, clinical supervision should be 30 min per week or 1 hour per fortnight in either individual or group format (min 30 mins per trainee per fortnight in a group). On qualification MHWPs, supervision should continue to meet the training requirements for the first two years post-qualification and then can be reviewed accordingly but there should be a minimum of either clinical or caseload supervision for 30 mins per week. Management supervision must also be provided at least once a month.

4. Occupational Therapy

The following supervision guidance is based on the Royal College of Occupational Therapists publication Supervision Guidance for occupational therapists and their managers (RCOT, 2015).

Different Types of Supervision:

Occupational Therapy supervision will most commonly be a combination of clinical and professional supervision and in some circumstances will also include line management supervision. However, it is more often the case that Occupational Therapists will be line managed by a Manager from a different professional background.

Occupational Therapists working in core occupational therapy roles should have access to a supervisor who is an Occupational Therapist in order to ensure caseloads are discussed and input is in line with accepted standards of professional practice.

Occupational Therapists working in non-core occupational therapy roles such as Community Practitioners or Mental Health Practitioners should ensure that they are able to discuss their clinical caseload as a combined managerial and clinical supervision. Professional supervision is not mandatory for this group of individuals however, it is recommended that they maintain links with their Professional Head to ensure they are able to maintain their professional registration with the HCPC.

Supervision should be documented in accordance with this policy including saving copies of supervision notes on the recommended platform LEAP.

OT Students and OT Apprentices:
Supervision of OT Students and OT Apprentices on placement will be informed by the guidance provided by the Student or Apprentice's University. As standard this is usually on a weekly basis with the named Practice Placement Educator or Mentor and is documented using the University's paper or online templates.

Preceptorship:
Newly qualified occupational therapists are expected to undertake preceptorship during their first 12 months of practice. This is a programme designed to make the transition from student to practitioner a smooth and reflective one. As the preceptee, they will be allocated a preceptor (this will normally be their OT supervisor) to guide and support them through this work-based programme.

Group Supervision:
In some circumstances Group Professional Supervision may be appropriate, for example where a group of occupational therapists working in the same specialism can come together for peer supervision or supervision facilitated by a senior practitioner.

Group supervision is when peers or a more senior practitioner meets with and facilitates a group for specific problem-solving and team development. This approach not only encourages open and professional attitudes to learning and uses the various abilities
within the group, but also supports the concept of collective practice and service delivery.

It requires a planned approach and places a shared responsibility on all members of the group to support the learning of colleagues, helping them to observe, reflect, analyse and plan.

Those participating in group supervision will need to be well prepared and clear as to what they want to give to, or receive from, the group. Using a reflective practice model can help to structure discussions.

Appraisals:
Where Occupational Therapists have more than one supervisor it is recommended that all those providing supervision are involved in the Appraisal process to ensure service and profession specific objectives and development goals and set and agreed.

Frequency of Supervision:

Weekly supervision is recommended for those that require more support, even for a limited or initial period e.g.

- Students
- New graduates
- New employees with limited experience
- Practitioners lacking in skills and/or confidence

Fortnightly supervision is recommended for those who have experience and work more autonomously but may still need guidance:

- Those new to their grade – i.e. with additional/unfamiliar responsibilities such as supervision of others
- New employees with experience
- Employees with a complex or high-risk caseload

Monthly supervision is recommended for more experienced, competent and confident practitioners. This is the standard frequency for the majority of occupational therapists.
For experienced and confident practitioners.

Who Can Supervise:

It is recommended that newly qualified occupational therapists (Band 5) do not supervise other staff until they have completed their preceptorship. They can, however, assist and provide ongoing support to colleagues and volunteers in an informal capacity.

Standard practice is to have a supervisor senior to the supervisee providing supervision however, in some circumstances it is permissible for the supervisor and supervisee to be of the same grade if the supervisor is more experienced and/or has a particular specialism/skill set.

Temporary Staff:

Temporary occupational therapists such as those from NHSP or via an agency should have access to supervision as outlined in this policy. For what ever reason this is not felt to be appropriate this must be agreed by the Professional Head for that Service/Directorate and adequate alternative provision put in place.

5. Physiotherapy

Supervisors and supervisees should reference supervision publications from the HCPC, as the regulating body for physiotherapists and guidance from the Chartered Society of Physiotherapy (CSP), an optional professional association.
Clinical and professional supervision should be provided in combination by a more senior physiotherapy colleague, with at least two years more seniority. It is recommended that senior staff carry out supervision according to the requirements of their job description, including physiotherapist employed via the Bank. Locum staff should be supervised as per the guidelines. This should be negotiated by the physiotherapy manager for the service.
Management supervision should be provided by an appropriately qualified practitioner and agreed with a lead physiotherapist. If management supervision is shared between a lead physiotherapist and a line manager, the allocation and oversight of physiotherapy work should be provided by a lead physiotherapist and line management, appraisals and personal development planning should be done jointly.

Supervision can take place in a variety of methods both informally and formally inclusive of group supervision when appropriate, however, formal management supervision must take place at a minimum of monthly. Supervision dates and methods should be arranged jointly between the supervisor and supervisee prior to the session, and can face to face or virtual.

Grade	Norm	Minimum acceptable*	Length Recommendation
Students and Volunteers	Weekly	Fortnightly	One hour
Band 5	Weekly	Fortnightly	One hour
Band 6	Fortnightly	Monthly	One hour
Band 7	2-3 weekly	Monthly	One hour
Band 8	Monthly	6 weekly	One hour

* Exceptional circumstances will be individually negotiated and recorded.

The frequency of supervision has some flexibility in accordance with the following criteria:

- The needs of the supervisee.
- The relevant experience of the supervisor and/or supervisee.
- Commensurate with number of contracted hours worked.
- Other support available on the across the team and/or department.
- Whether the supervisee works "single-handed" or closely with other physiotherapists.
- Other wider support available e.g. peer supervision, mentorship, ongoing daily contact/support.

CSP’s guidance around clinical supervision defines and describes the behaviours, knowledge & skills used by the physiotherapy workforce and uses the following principles:

Clinical Supervision should:

1. Support and enhance practice for the benefit of patients/service users.
2. Develop skills in reflection to narrow the gap between theory & practice.
3. Involve a supervisor & practitioner or group of practitioners reflecting on & critically evaluating practice.
4. Be distinct from formal line management supervision & appraisal.
5. Be planned & systematic & conducted within agreed boundaries.
6. Be explicit about the public & confidential elements of the process.
7. Facilitate clear & unambiguous communication, conducted in an atmosphere of beneficence.
8. Define an outcomes-based action plan. The outcomes could then be more broadly developed to assist the practitioner’s professional development through the appraisal process.
9. Be evaluated against set standards from the time it is initially developed & implemented

The Clinical Supervision process should:

10. Involve all individuals in the service, signed up to by staff & supported & resourced by
management.
11. Be developed in partnership with managers & practitioners.
12. Be supported by appropriate resources (time, training, replacement staff).
13. Facilitate practitioner access to their chosen model of supervision, as appropriate.
14. Support a local system for supervisors to further develop their skills in facilitation.
15. Be developed in parallel with collating a portfolio of learning, so that the practitioner is
supported to develop & demonstrate skills of reflection & evidencing learning from experience.

6. Dietitians

Supervisors and supervisees should reference the publication 'BDA Practice Supervision' from the British Dietetic Association (BDA).

Types of supervision

The combination of professional, managerial and clinical supervision may be provided by the Head of Nutrition and Dietetic Services.
Clinical and/or professional supervision may be provided by a more senior dietetic colleague, with at least two years more seniority.
For managerial supervision, the supervisor is the line manager, or the line manager's delegate, who will be an appropriately qualified practitioner and will be agreed with the professional lead for Dietetics.
Where supervision is shared between the lead dietitian and a line manager, the allocation and oversight of dietetic work and professional development should be provided by the lead dietitian. Management meetings may be held separately or jointly with the line manager. Appraisals, and personal development planning should be carried out jointly.

Frequency

Clinical Supervision – for clinical staff only

Standards:

Grade	**Norm**	**Minimum acceptable***
Students	Weekly	Weekly
Band 4	Weekly	Fortnightly
Band 5	Weekly	Fortnightly
Band 6	Fortnightly	Monthly
Band 7	Monthly	6 weekly
Band 8	Monthly	6 weekly

* Exceptional circumstances will be individually negotiated and recorded

The frequency of supervision has some flexibility according to the following circumstances:

- the length of experience of the supervisor and/or supervisee
- and the particular needs of the supervisee

Weekly - for those who require more support, even for a limited or initial period i.e. students; new graduates; new employees with limited experience; practitioners lacking in skills and/or confidence.
Every 2 weeks - for those who have more experience and work more autonomously but may still need guidance i.e. those new to their grade with additional/unfamiliar responsibilities; new employees with experience; employees with a complex or high-risk caseload.
Monthly - for experienced and confident practitioners.

· the number of contracted hours worked
· other support available in clinical areas
· whether the supervisee works in isolation from dietetic colleagues or closely with them
· other general support available e.g. peer supervision, mentorship
· ongoing daily contact

Managerial Supervision

At 4 to 6 weekly intervals, including appraisal and appraisal review.

Professional Supervision

At 4-12 weekly intervals

Who Can Supervise

It is recommended that Band 5 dietitians in their preceptorship year do not supervise other staff, but they can assist and provide ongoing support to colleagues
All senior grades: it is recommended that senior staff carry out supervision according to the requirements of their job description, including dietitians employed via the Bank.
All supervisors will have attended suitable supervision training for example provided by LEAP within 6 months of becoming a supervisor for dietetic staff.
Locum dietetic staff should be supervised as per the guidelines. This should be negotiated by the Nutrition and Dietetic manager for the service.

Type and duration of Contact

Standards :

- Supervision should be one to one or professional / clinical may be in a group.
- Contact should be face to face or via video link. In in exceptional circumstances, by telephone.
- A one to one session should be for one hour, and for group supervision between one to up to two hours.

7. Medical Staff

There is a distinction between the supervision arrangements for consultants, specialist doctors and trainees. The following table gives examples of the arrangements that doctors of all grades should have in place.

	Consultants	Speciality/Trust Grade Doctors*	Resident Doctors
Clinical	• Peer Supervision • MDT Case discussion • Specialist i.e. Psychotherapy. • Access to specialist networks	• 1:1 with named Clinical Supervisor (usually substantive team consultant) for 1hr/ week • Specialist ie Psychotherapy.	• 1:1 with named Clinical Supervisor (usually substantive team consultant) for 1hr/ week • Separate psychotherapy supervision for RCPsych psychotherapy competencies
Managerial	• Relationship with line manager • Annual appraisal • Job Planning	• Relationship with Consultant • Annual appraisal • Job Planning	• Included in weekly supervision with clinical supervisor (as above)
Professional	• CPD with Royal College scheme • Professional Development Peer groups	• CPD with Royal College scheme • Professional Development Peer groups	• Included in weekly supervision with clinical supervisor • Educational supervision sessions approximately three times/ year (see below)
Informal	• Use of mentors or specialists		

***Including Junior Clinical Fellows and Portfolio Fellows**

Standards

- All Consultants to describe and document in the annual appraisal with their appraiser what their peer group arrangements including supervision are.
- Consultants offering therapies will follow established or locally agreed supervision processes for that modality.
- Specialist grade doctors if it has been agreed work autonomously will follow the same procedures as consultants.
- All Speciality Doctors to receive weekly 1:1 supervision with their clinical supervisor
- All resident doctors receive weekly 1:1 supervision with their named GMC-accredited clinical supervisor (normally the substantive consultant psychiatrist of the clinical team they work in), addressing all areas of supervision. The delivery

of this is monitored through post-feedback and the GMC National Training Survey. Resident doctors also have a named educational supervisor who they meet three times/ year. The educational supervisor remains the same throughout the duration of either core or higher training to support educational progression and development and advise on wider training issues. pr Both supervisors contribute to work-place based assessments and reports for the Annual Review of Competency Progression (ARCP) process that is required for resident doctors to progress to the next stage of their training.

References:

Supervision for career-grade psychiatrists in managed settings (July 2010) Royal College of Psychiatrists

Psychiatry Silver Guide (August 2022) Royal College of Psychiatrists

8. Radiographers

Supervision every 2 weeks for new employees with experience. New starters will be supported by working with more experienced colleagues for the first six months, until familiar with all departmental imaging practices, at which point they can scan alone.
Monthly supervision for experienced and confident practitioners.
In addition, regular group supervision will be provided to cascade changes in clinical practice.

9. Speech and Language Therapists

SLTs are regulated by HCPC and additional guidance is offered by The Royal College of Speech and Language Therapists
(RCSLT). https://www.rcslt.org/members/delivering-quality-services/supervision
In accordance with this guidance, 1-1 clinical and professional supervision by a suitably qualified SLT is offered at least monthly for Band 6 and 7 SLTs. Additional managerial supervision is also offered where required, e.g. for roles that are embedded within a specific Team or ward.
Band 6 and 7 SLTs working in older adults and the Lishman Unit can also access additional peer supervision via Kings College Hospital 3 monthly.
The 8a also receives professional supervision from the Head of Speech and Language Therapy at KCH and managerial supervision from the Head of Therapies within PMOA & NDD Directorate.
Where it is needed, the frequency of supervision is increased, such as when someone is new in post or facing specific challenges. There is a weekly inpatient team meeting, where people can bring up any specific caseload or patient concerns.
Colleagues working in the community can access clinical supervision from the Head of SLT and also from with their MDTs and peer supervision in line with their areas of clinical expertise.

10. Nursing

A) **Registered Nurses (Registered Nurse (RN) & Nursing Associate (NA)**
Clinical, managerial and professional supervision will be made available to all Registered Nurses and Nursing Associates, depending on their role and clinical activities. The NMC Code (2015) requires nurses to “gather and reflect on feedback from a variety of sources, using it to improve practice and performance” (NMC, 2015)
The Nursing and Midwifery Council states that organizations should:

"...should develop the process of clinical supervision according to local circumstances. Ground rules should be agreed so that the supervisor and the registered nurse approach clinical supervision openly, confidently and are aware of what is involved. The NMC supports the principle of clinical supervision but believes that it is best developed at a local level in accordance with local needs." –
Professional supervision will be provided by senior nurses on the same part of the Register. Some of our clinical managers are not Registered Nurses, and may benefit from receiving professional supervision from a seni or nurse.
Some of the specific areas which could be addressed during professional supervision may be in relation to the NMC Code of Conduct, and moral and ethical issues related to patient care, and specific areas of competency required for different and /or changing roles.
All newly registered nurses and nursing associates are offered a period of preceptorship to help them with the transition from student to professional. They will work alongside an allocated Preceptor to support them to achieve the relevant competencies and programme outcomes.

B) **Students on NMC approved programmes**
The NMC Standards (2018) require that "all students on an NMC approved programme are supervised while learning in practice". All students must have a named. Practice Assessor (PA) and at least one Practice Supervisor (PS) whilst on clinical placement. The PA and PS must be two separate individuals who receive ongoing support to prepare, reflect and develop for effective supervision and contribution to, student learning and assessment, and have understanding of the proficiencies and programme outcomes they are supporting students to achieve. The level of supervision provided to students will reflect their individual learning needs and stage of learning.

All NMC registered nurses, midwives and nursing associates are capable of supervising students, serving as role models for safe and effective practice. Students may also be supervised by other registered health and social care professionals.

Reference:
Nursing and Midwifery Council (2018) Realising Professionalism: Standards for Education and Training – Part 2: Standards for Student Supervision and Assessment.
C) **Assistant Practitioners**
Assistant Practitioners will receive regular monthly supervision from either a band 5 or band 6 nurse.

- The Assistant Practitioner will be expected to complete training in supervision in clinical areas. This will be through shadowing and taking up a co-supervisory role in supervising appropriate band 2 or band 3 Clinical Support Workers and signed off as competent; and to use own supervision to support this development role.
- It is good practice for each Directorate to have monthly peer supervision for Assistant Practitioner, to assist in the development of this new role.

D) **Clinical Support Workers**

Clinical support workers will also receive supervision to at least the minimum required by the policy for clinical staff, and include time to reflect on clinical work. The recent Francis Report has highlighted the need for regulation and support for the clinical support workers in the NHS. All of our support workers will receive clinical and managerial supervision.

E) **Professional Nurse Advocate**

The Professional Nurse Advocates (PNA) is a new professional clinical leadership and advocacy role introduced to deploy the A-EQUIP model for registered nurses The role supports staff through a continuous improvement process that builds personal and professional clinical leadership, improves the quality of care delivered and supports professional revalidation. In summary, the PNA involves:

- deploying the A-EQUIP model
- supporting and developing the nurse advocacy role
- guiding and supporting nurses through actions that will benefit other nurses, patients and families
- facilitating support and feedback to improve, advance and solidify the capabilities of the nursing workforce

The A-EQUIP model stems from the three functions of clinical supervision in Brigid Proctor's 1987 clinical supervision model:

normative – managerial aspects concerning practice, learning and core mandatory training

formative – educational aspects: developing knowledge and skills in professional development and self-reflection

restorative – supportive aspects, including personal development, improving stress management and mitigating burnout.

Any nurse can access a Qualified PNA to arrange a session these are not recorded, not mandatory and totally self-selected. The PNA adhered to the confidentiality expectations outlined in the main body of the policy. You can book a session by emailing - PNA@slam.nhs.uk

11. Peer Support Workers

A) **Band 3&4 Peer Support Workers**

Clinical and professional supervision to be provided by an appropriately qualified member of the MDT in which the Peer Worker is based as agreed with the Lead for Peer Support. This will usually be a ward manager, qualified psychologist or OT. Those providing supervision to Peer Workers are encouraged to attend specific training on Peer Worker Supervision. Supervision should be recorded on LEAP.

B) **Band 6 Peer Worker Coordinators**

For the Central Peer Worker Coordinators (employed within corporate services) clinical and professional supervision to be provided by the Trust Lead for Peer Support. For Peer Worker Coordinators directly employed by directorates or services clinical supervision will be provided by a suitable qualified person based in the employing service and professional supervision will be provided by Trust Lead for Peer Support.

C) **Lead for Peer Support**

Supervision to be provided by Associate Director of Strategy, Strategy and Transformation.

Content of Supervision

The contents of supervision sessions should meet the requirements of the Supervision Policy and consider:

- cultural and/or ethnicity issues affecting service users, carers and staff;
- relationships with team members and colleagues;
- workload;
- work issues;
- short/medium/long term objectives;
- personal development;
- personal issues affecting work;
- Training;
- annual leave;
- policies

Peer Mentoring

In addition to supervision, Peer Workers also receive monthly Peer Support mentoring which is provided by a Peer Worker Coordinator. Peer mentoring focuses on using lived experience at work competencies associated with peer support practice as outlined by Health Education England. Peer mentors use a template to ensure that peer workers can discuss what has gone well, what has been difficult and consider future career goals.

Group Supervision

Peer workers can access a weekly supervision that is held on TEAMS. This is open to all Peer Workers working for SLaM and is an opportunity for individuals to talk to their colleagues around the Trust. It is a space to identify issues, reflect, share good practice, and work together to think of strategies to overcome some of the challenges that occur.

12. Pharmacy

Clinical and professional supervision is provided by a more senior staff member, usually in the same professional role (pharmacist/pharmacy technician).

Content of supervision

The content of the supervision should include the requirements set out in the Supervision Policy, and may also consider:

- Multidisciplinary team working
- Clinical cases
- Supervision of others by the supervisee
- Objectives set at the last appraisal
- CPD or other professional development plans
- KPIs
- Audit and service evaluation
- Service development
- Maintaining minimum hours of practice

Peer and group supervision

Peer and group supervision may be provided by discrete services (e.g. medicines advice) but this does not replace individual supervision from a more senior staff member.

Revalidation

To practise in Great Britain, pharmacy professionals (pharmacist and pharmacy technicians) must be registered with the General Pharmaceutical Council (GPhC). Registration must be renewed annually, a process that includes submission of

revalidation records to the GPhC. Peer discussion is a compulsory part of the revalidation framework.

A) **Trainees**

Trainee pharmacists are allocated a designated pharmacist supervisor and a designated prescribing practitioner. The designated supervisor is responsible for co-ordinating trainee's supervision, overseeing their progress, and signing them off as fit to practise at the end of the final period of the foundation training year. The designated prescribing practitioner is responsible for overseeing the prescribing activities for the trainee, assessing whether the prescribing activities have been satisfactorily completed, determining the sufficient hours required have been achieved and confirming that all elements of prescribing assessment are completed, and the trainee pharmacist is therefore suitable for registration as a prescriber. Both supervisors are responsible for supporting trainees in line with GPhC guidance.

Detailed guidance for supervision of trainee pharmacists is outlined in 'Pharmacy Department – Supervision and Tutoring Expectations for Trainee Pharmacist Foundation Year Training'. This includes 1h of supervision every two weeks by the designated supervisor or education supervisor.

B) **B6 – 8b**

Supervision should be provided to B6 – 8b pharmacists by a more senior pharmacist who has completed trust supervision training.

Frequency: monthly, or pro-rata at the discretion of the supervisor.

C) **8c – 8d and consultant pharmacists**

Consultant pharmacists, and pharmacists working at 8c or above, should document in their annual appraisal their peer group arrangements for supervision.

D) **Prescribing pharmacists**

Prescribing pharmacists should be supervised in line with the requirements set out in the Non-Medical Prescribing Policy.

E) **Pharmacy Technicians and Assistant Technical Officers (ATOs)**

Supervision for pharmacy technicians and ATOs will be provided either by the direct line manager, or a more senior technician.

Frequency: monthly, or pro-rata at the discretion of the supervisor.

F) **Pre-registration Training Pharmacy Technicians**

Supervision of student technicians is provided by the designated Education and Training technician.

G**) Student Pharmacists**

The GPhC Standards for the initial education and training of pharmacists (2021) require that "There must be systems and policies in place to manage the delivery of the MPharm degree, including the periods of experiential and inter-professional learning.". All students on clinical placement will have a named supervisor (a suitably qualified pharmacy team member) who will sign off learning outcomes as outlined by the education provider. They will have an understanding of the proficiencies and programme outcomes they are supporting students to achieve. The level of supervision provided to students will reflect their individual learning needs and stage of learning.

All GPhC registered pharmacists and pharmacy technicians can supervise students, serving as role models for safe and effective practice. Students may also be caps

H) **Locums**

Locum pharmacists or pharmacy technicians will receive supervision in accordance with this guideline. They may be permitted to supervise other staff at the discretion of the site lead pharmacist or lead technician, based on experience and length of employment.

13. Physician Assistants (previously Physician Associates)
Physician Assistants must not provide psychiatric supervision to resident doctors and/or specialty doctors.

Physician Assistants working in mental health settings for the first time should complete an inceptorship year with weekly supervision and should complete training relevant for their role.

The regulator (GMC) has developed detailed guidance on the supervision of Physician Assistants, which includes recommendations to do with day to day supervision as well as professional development and appraisals for PAs. The RCPsych recommends this guidance. In addition to this guidance the RCPsych also recommends:

- Weekly supervision of PAs on Inceptorship
- An analysis of competence and scope to determine long term supervision, not less than once per month for the most experienced PAs.
- There should be a named supervisor on every shift through whom a PA can escalate concerns.

Physician Assistants working in mental health settings should receive clinical supervision from a consultant psychiatrist or specialty and specialist (SAS) psychiatrist. The appropriate level of clinical supervision should be tailored to ensure patient safety and meet the developmental needs of individual PAs.

Ref Report and Recommendations of the RCPsych Physician Associates Task and Finish Group, 4 July 2025

14. Social Work
Published in 2019, the current Social Work professional standards became the standards for all social workers in England. They are specialist to the social work profession and apply to registered social workers in all roles and settings. The standards are the threshold standards necessary for safe and effective practice**.** They can be found on Social Work England website on Professional standards - Social Work England

Standard 4 states 'Maintain my continuous professional development' which includes:

***4.2** Use supervision and feedback to critically reflect on, and identify my learning needs, including how I use research and evidence to inform my practice.*
Evidence of continuous professional development (CPD), including professional supervision, is a requirement for registration as a social worker with Social Work England.

1. Guidance on supervision for social workers

Providing a safe space for social workers to critically explore and reflect on their work with adults, children and families through supervision is essential for safe and quality practice.

It is recommended that each social worker has access to professional supervision from a social worker more senior social work colleague.

1. Frequency

Band	Frequency
Social Work trainees/ students	Weekly
Newly Qualified Social Worker (NQSW) in their Assessed and Supported Year of Employment (ASYE)	1. Every week for the first 6 weeks 2. Every two weeks until the 6-month point – shared between the onsite supervisor and offsite assessor 3. 2- 4 weekly until the end of the ASYE
Band 6 social workers	Monthly for 1 – 1.5 hours
Band 7 social workers	Monthly for 1 – 1.5 hours
Band 8 and above	6 – 8 weekly for 1 – 1.5 hours

The above applies to full and part-time permanent and agency staff although the length may reduce for part-time staff.

2. Professional Supervision Options

Individual Professional Supervision

Social workers should have access to individual professional/clinical supervision. This can be provided as part of the line management supervision if the manager is of the same profession, if not then this should be arranged through another way, e.g. with a manager of the same profession, accessing professional supervision from a social worker in another service area, or through professional group supervision.

The professional supervisor should also be included in a social worker's appraisal, or professional development, through three-way discussions with the line-manager.

Professional/Clinical Supervision should be in line with identified professional standards and include the following areas:

- Reflection on application of the knowledge and skill and domains within the social work Professional Capabilities Framework ('the fan') The Professional Capabilities Framework (PCF) | www.basw.co.uk
- The application of specific theoretical frameworks and evidence-based practice and updating knowledge andskills and relating this to practice.
- Professional leadership of practice of complex work i.e. safeguarding vulnerable adults.
- Reflection on profession-specific input to contribute to the overall objectives of the multi-professional team.
- Maintenance of registration and professional standards to assure competence in carrying out the professional role.
- Compliant with the ASYE (Assessed and Supported Year in Employment) programme if a social worker is newly qualified.

Research in Practice has also delivered training to some experience social workers in the Trust to support development of practice supervisors and professional supervision standards within a mental health setting.

Group Supervision

Within some service areas it may not be possible to provide monthly individual supervision. It may be that the professional structure within the service area does not include a more senior social worker, or there is only one social worker in the team, or the professional practice supervisor is managing a large staff group which makes monthly supervision not possible. Group supervision may therefore be considered and led by a more senior social worker, using structured group supervision models.

Peer supervision

Peer reflective practice can be highly complementary but should not be the only professional supervision available, especially for newly qualified social workers or less experienced social workers.

Peer supervision involves those who are at the same level of the work hierarchy and serve in a similar role providing support, reflection and feedback for professional growth in a reciprocal process.

Reflective practice sessions

Some teams hold reflective practice group sessions and is of particular benefit within a multi-disciplinary (MDT) setting. Reflective sessions, either one to one or in groups, provide a space for practitioners to reflect and consider the emotional impact of their work, the unquestioned assumptions, and biases they bring, varying perspectives (including theoretical perspectives) and ethical dilemmas inherent in practice. This approach enables practitioners to develop self-awareness, critical thinking and sound decision making.
It is also a requirement of the ASYE programme.

Quality Assurance

Quality assurance provides governance and ensures that both the Trust and staff are receiving supervision that is of a high quality, is enabling and supports ongoing development and good practice.
A framework for quality assurance is developing and this framework may include:

- Trust Annual Social Work Staff Supervision Survey
- Feedback from the Trust's social work forum

Appendix 2: Safeguarding Supervision Guidance

The Trust as an NHS provider is required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure board members, regulators and commissioners that these are working.

The London Safeguarding Children Procedures (2025) and Working Together to Safeguarding Children (2025) state that NHS trusts must provide safeguarding supervision for clinical staff.

Arrangements regarding supervision include:

Effective supervision arrangements for staff working with children / families or adults at risk of abuse or neglect.

Supervision is a process of professional support, peer support, peer review and learning, enabling staff to develop competencies, and to assume responsibility for their own practice. The purpose of clinical governance and supervision within safeguarding practice is to strengthen the protection of children and young people by actively promoting a safe standard and excellence of practice and to avoid staff feeling unable to discharge their duty of care.

Purpose of Safeguarding Supervision

Effective Safeguarding Children supervision has a significant function in maintaining the focus on the child and is therefore integral to providing a child centred service where a child's lived experience is acknowledged and addressed. This may incorporate a 'Signs of Safety' approach. Supervision enables all staff working with children or adults at risk to see "the whole picture" by "thinking family" and to recognise the impact that parental, family/network, circumstances and social networks have on children, young people and adults who may be at risk of abuse or neglect. Supervision can provide an independent and objective safeguarding lens enabling clinicians to identify signs of safety, strengths, resilience and any ongoing risks

Supervision Roles

Managers

Managers are responsible for ensuring staff have access to supervision that supports their safeguarding practice. Those in a supervisory role should maintain their own safeguarding knowledge and skills in order to provide effective supervision. Managers should also recognise their limitations and where more complex safeguarding advice is required, they should advise and encourage staff to seek support from a safeguarding lead or to attend specific safeguarding group supervision provided by the safeguarding lead within the service or directorate. Managers should respect the need for staff having protected time to participate with this.

Clinical Staff

Staff are responsible for ensuring that their competence in safeguarding is up to date via mandatory training which is in line with requirements set out in the Intercollegiate documents and professional revalidation requirements. They should be made aware of what training and supervision is available to them.

Named Safeguarding Leads within Adult and CAMHS Directorates

The Safeguarding leads are responsible for ensuring that the Trust can offer responsive supervision and guidance to staff, as part of their substantive role. The Safeguarding Lead will provide group supervision to staff. They will support line managers in supervisory roles to access training where required and advise them on Safeguarding supervision they deliver to staff when necessary. The Safeguarding Leads will maintain a record of frequency and the type of supervision sessions delivered. This data will be reported at committee level in order to provide assurance to the Trust Board and health/social care commissioning partners

Accountability

Safeguarding supervision is underpinned by the principle that each practitioner remains accountable for his/her own practice and professional judgement; this includes his or her own decisions or actions within or following supervision.
The principle is supported by professional Codes of Practice for disciplines within health and social care delivery. Safeguarding supervision does not replace nor should it delay the individual's responsibility to refer to statutory agencies where there are concerns that a child or adult may be at risk of significant harm or abuse. In such cases staff are expected to follow the Safeguarding Children & Adult Policies. The safeguarding supervisor does not take on this responsibility but supports colleagues through the provision of supervision, support and advice.
If the supervisee feels that safeguarding supervision is not meeting their needs, or the requirements of their role or the Trust, a discussion with the supervisor should occur in the first instance. If the issues are not resolved, further advice should be sought from the Trust-wide Safeguarding Leads

Key components of Safeguarding Supervision:

- Providing a supportive and analytical supervisory environment.

- Improving the capacity of the individual to remain resilient in the face of challenging case work through their ability to recognise personal triggers and to feel confident in seeking support with this.

- Enhancing the ability of staff to build constructive relationships with fellow professionals to avoid isolation and enhance multi-agency working and collaboration.

- Encouraging the individual to focus on the events and/or situations where they can facilitate change, so they feel empowered regarding safe and effective practice.

- Facilitate ‘professional curiosity’ in relation to cases being discussed. Professional curiosity relates to the capacity and the communication skills of practitioners to explore and understand what is happening within a family rather than making assumptions or accepting things at face value

- Improve the ability of all front-facing staff to communicate regarding concerns so they can be escalated effectively.

Documentation

All supervisees who discuss specific service users in safeguarding supervision are responsible for the timely and contemporaneous recording of the discussion and agreed actions in the service user’s ePJS clinical record
This applies to all types of safeguarding supervision and additionally any consultation, whether this be scheduled on a one-to-one basis, within group supervision, by phone, email or virtually/remotely. Records should include salient points from the discussion about the concerns and risk and clearly state any planned actions, including details of staff members/services responsible for actions.
Escalation arrangements should be recorded if necessary.
Risk assessments should be updated to incorporate any identified concerns.
The safeguarding supervisor may wish to make their own record on ePJS in regard to safeguarding considerations.

Minimum Recommended Frequency & Format

Format	Supervisor	Frequency
One to one	Line Manager/ Team Leader/ nominated supervisor	I hour monthly
Group	Safeguarding Designated Lead- supported by Team Leader	I hour every 3 months

Additional safeguarding supervision may be requested and negotiated with Safeguarding leads, Trust wide Safeguarding Leads, Borough, Directorate or Service leads.

Appendix 3: Supervision Record

Supervisee Name:	
Supervisee Job title:	
Supervisor Name:	
Line Manager (of supervisee) Name:	
Date of Supervision:	
Date of next supervision:	
Team:	
Directorate:	

Type of supervision:

Clinical

Managerial
Professional

Please refer to relevant Supervision Guidelines

Actions from last supervision
1.
2.
3.
4.
5.

Current Supervision Items

Items	Summary	Actions

*To be completed as needed by your area's guidance document

Sign-off of Supervisee

Sign-off of Supervisor

Appendix 4: External Supervision Contract

CONTRACT FOR EXTERNAL SUPERVISION SERVICES:

Insert Supplier

and

South London and Maudsley NHS Foundation Trust

CONTRACT SCHEDULE

Agreement dated:

Between Authority South London and Maudsley NHS Foundation Trust
Bethlem Royal Hospital
Monks Orchard Road,
Beckenham
Kent
BR3 3BX

Supplier:

Address:

Commencement date:

Expected completion date:

Excluded periods:

Total fee (excluding VAT):

The fee schedule is:
(excluding VAT) is:

Invoicing frequency
(payment will be in arrears):

Reimbursements (e.g. travel):

Nature of services:

Facilities/Equipment provided:

By authority:

By supplier: All equipment required to fulfil the contract.

Notice Period for early Termination: 7 days

Terms and conditions agreed: NHS Standard terms for the supply of services PO version (February 2025).

Contract Delivery Particulars

Contract Delivery Particulars	[Details of Supervision to be provided]
Supervisor	[Insert name], [Professional Title], [Contact Details]
Supervisee	[Insert name], [Role], [Contact Details]
Location of Supervision	[Specify location, e.g., Trust premises, online]
Frequency and Duration of Sessions	
Start Date	
End Date	
Reporting Requirements	[e.g., periodic feedback to line manager]
Scope of Support	For full scope of support please see Annex 1.

Confirmation of CEST Tool Where Applicable

CEST Tool Confirmation	
CEST Assessment completed on	[Insert date]

Outcome	[e.g., Outside IR35 / Employed for tax purposes / Self-employed for tax purposes]
Assessed by	[Name/Role]

1. Provision of Supervision Services

1.1 The Supervisor will provide clinical/professional supervision to staff as agreed, ensuring that the Supervisor possesses the necessary skills, qualifications, and professional accreditation required by the Trust.

1.2 The Supervisor may, *in exceptional circumstances* and at their own expense, enlist substitute or additional supervisors, provided the Trust is reasonably satisfied with their suitability. The Supervisor remains responsible for the conduct and obligations of any substitute.

1.3 Any changes to the assigned Supervisor (planned or unplanned) must be communicated to the Trust immediately. If the Supervisor cannot provide supervision, a suitable substitute must be offered, subject to Trust approval. If neither the original nor an acceptable substitute is available, the Trust may terminate the agreement.

1.4 The Supervisor is an independent professional and may undertake other contracts, provided this does not conflict with their obligations to the Trust.

2. Supervisor's Obligations

2.1 The Supervisor must not engage in conduct detrimental to the Trust, including actions that could bring the Trust into disrepute or result in loss of business.

2.2 The Supervisor must comply with all relevant statutory rules and regulations, including health and safety, and any essential Trust procedures notified to them. Where supervision is delivered on Trust premises, the Supervisor must adhere to the Trust's health and safety and security policies.

2.3 The Supervisor must promptly notify the Trust in writing if they become insolvent or subject to dissolution.

2.4 The Supervisor agrees to maintain confidentiality, provide a psychologically safe space, and escalate any concerns regarding patient safety, staff safety, safeguarding (including children and adults), or serious professional issues immediately to the supervisee's line manager and clinical lead.

3. Equipment and Resources

3.1 The Supervisor will provide, at their own cost, all necessary equipment for the satisfactory delivery of supervision, unless otherwise agreed.

3.2 If Trust equipment is provided, the Supervisor is responsible for its security and condition, and for any loss or damage.

4. Method of Delivery

4.1 The Supervisor will use professional judgement and initiative in delivering supervision, while cooperating with the Trust and complying with reasonable instructions.

4.2 Supervision sessions may be scheduled at mutually agreed times, ensuring that they meet the needs of the supervisee and the Trust.

4.3 The Supervisor is responsible for their own tax and national insurance obligations.

5. Confidentiality and Record-Keeping

5.1 Supervision is confidential except where safety, safeguarding (children or adults), or serious professional concerns arise. While discussions should respect confidentiality, supervisors should maintain appropriate records to support the supervisee's professional development, appraisal, and accountability. Notes must avoid identifiable patient information; use initials or another agreed anonymised identifier where necessary to ensure a clear audit trail (e.g., for legal or court proceedings).

5.2 Supervision notes must be stored securely and be available for audit if requested.

6. Review, Funding, and Termination

6.1 The agreement will be reviewed annually or sooner if concerns arise. The Trust reserves the right to terminate the agreement if standards are not met.

6.2 External supervision funded by the Trust will only occur in limited circumstances, as agreed by senior leadership.

6.3 NHS Terms and Conditions for the Provision of Services (Purchase Order Version, February 2025) apply to this agreement. This document acts as the specification/tender response.

nhs-terms-conditio
ns-provision-of-serv

Signed for and on behalf of the Authority	
Name	
Signature	
Date	

Signed for and on behalf of the Supplier	
Name	
Signature	
Date	

Annex 1.

Support proposal.

[Insert here a summary of the supervision support to be provided, including the number and frequency of sessions, format (e.g., online or face-to-face), key topics to be covered, reporting requirements, and any specific objectives or deliverables agreed between the Supervisor and the Trust.]

Pricing Schedule

Description	Amount	Unit cost	Vat	Total cost
Supervision sessions – 1hr				
Add chargeable line items as necessary.				
Total Cost				

Attach outcome of CEST tool.

Appendix 5: External Supervision Guidance

Guidance for External Clinical Supervision Arrangements | December 2025

This guidance document accompanies the External Clinical Supervision Contract and provides practical instructions for supervisors, supervisees, and managers. It ensures safe, effective, and compliant supervision practices in line with NHS and Trust standards.

1. Purpose

External clinical/professional supervision supports reflective practice and professional development. It is permitted only when internal options have been exhausted and must be approved by the supervisee's line manager and professional lead, with funding agreed by an appropriate budget holder.

2. When External Supervision is Appropriate

External supervision may be approved for specialist accreditation, access to expertise not available internally, or specific professional development needs, or where it is required for senior staff. All requests must be agreed by the supervisee's line manager and professional lead.

3. Approval and Governance

Approval requires confirmation that internal options have been explored, agreement from relevant managers, and evidence of the supervisor's professional accreditation. Approval also requires payments must not exceed £120 per hour. Communication and feedback arrangements must be documented.

4. Responsibilities

Supervisors must adhere to Trust standards, maintain confidentiality, escalate concerns promptly, maintain registration and hold relevant and appropriate qualifications. Supervisees must record clinically relevant discussions on Trust systems and notify changes in role or supervision needs.

5. Practical Arrangements

Contract delivery particulars should include names, roles, session frequency, location, start/end dates, and reporting requirements. Annex 1 of the contract should include full scope of support.

Where external supervision is provided on an unpaid basis, the same principles apply. Relevant elements of this guidance and the accompanying contract should be used to establish clear and safe supervision arrangements.

6. Confidentiality and Record-Keeping

Supervision is confidential except where safety or professional concerns arise. Notes must be securely stored and available for audit if requested.

7. Escalation and Safeguarding

Any concerns regarding patient or staff safety, or serious professional issues, must be escalated immediately to the supervisee's line manager, relevant clinical lead and safeguarding lead.

Supervisee's Line Manager - Name:	

Job Title:	
Email:	
Telephone:	
Professional Lead (or equivalent) - Name:	
Job Title:	
Email:	
Telephone:	
Safeguarding Lead - Name:	
Job Title:	
Email:	
Telephone:	

8. Funding and Endorsement

Trust-funded external supervision is only available in limited circumstances and must be agreed by senior leadership with funding agreed by an appropriate budget holder.

9. Review and Termination

The agreement will be reviewed annually or sooner if concerns arise. The Trust reserves the right to terminate the agreement if standards are not met.

10. CEST Tool (Tax Status)

Where applicable, complete the HMRC CEST tool to confirm employment status for tax purposes. Record the outcome in the contract.

11. Step-by-Step Checklist for Off-Payroll Worker Engagement

This checklist provides the correct order of steps for managers and supervisees when engaging off-payroll workers. Each step must be completed before moving to the next. Relevant links are included for quick access.

1. Discussion with Manager

Member of staff to discuss with manager request for external supervision. External supervision must be requested due to one of the following reasons and where all internal options have been explored:

- Specialist accreditation
- Access to expertise not available internally
- Specific professional development needs
- Due to seniority of role.

2. Procurement Process

Staff member to make contact with potential external supervisors with proposal of work. Obtain competitive quotes where practical - assess responses. Choose the best value provider.

3. Approval

Member of staff to obtain approval from their manager, professional lead and budget holder to commence the contracting and procurement process with the chosen external supervisor. Off payroll payments must not exceed £120 per hour

4. Set-up with external supervisor

Member of staff to share with the external supervisor the External Supervisor Contract for completion as well as External Supervisor Guidance and Supervision Policy. Agreement made regarding the contracted delivery particulars and added to contract.

5. New Supplier?

If the external supervisor is a new supplier to the Trust complete the new supplier detail form. If external supervisor is a personal services company (PSC) (they are the sole director and share holder for the company / are a sole trader) move to 6. If supplier is not a PSC move to 8.

6. Off-Payroll Guidance Form

Member of staff (or administrative support) to complete the Off-Payroll Worker Application and Assessment Form.

7. CEST Assessment

Member of staff (or administrative support) to complete the HMRC CEST tool (not the external supervisor) to check employment status for tax. Link: https://www.gov.uk/guidance/check-employment-status-for-tax

8. Supplier detail form

If new supplier, member of staff (or administrative support) to ask Supplier to complete the Trust Supplier Detail Form.

9. Submit to Procurement

Send all documentation to Procurement for review and adjudication: helpdesk@smarttogetherlondon.nhs.uk

10. Ordering Process

Once the supplier is set up, raise a requisition via eProcurement member of staff (or administrative support) to obtain a purchase order (PO) number. If either need help with the requisition or PO process, contact eProcurement@slam.nhs.uk Ensure the PO number is provided to the supplier for invoicing.

11. Confirmation

Insert PO number into the contract along with the other details of the engagement and request the external supervisor signs the agreement. Member of staff to send to their service director to counter sign, send a copy to the external supervisor and keep your own record.

12. Engagement

Commence supervision sessions once all approvals and documents are in place.

13. Invoice Submission

Member of staff (or administrative support) ensures the supplier submits invoices quoting the PO number to payments@slam.nhs.uk .

14. Payment

Accounts Payable will process payment only after all documentation is complete and attached in the Finance System. Payments on 30 day terms, (payment will be made within 30 days of submission of a valid invoice) and are in arrears.

15. Monitoring and Review

Monitor the engagement for any changes in working arrangements. Repeat the CEST assessment if the engagement changes or is extended.

Please note: Each step must be completed in order. Do not proceed to the next step until the previous one is fully complete.

Appendix 6: Equality Impact Assessment

PART 2: Equality Impact Assessment

1. Name of policy or service development being assessed?
Supervision Policy

2. Name of lead person responsible for the policy or service development?
Helen Winter

3. Describe the policy or service development
What is its main aim? To ensure all staff have access to support through supervision at least monthly
What are its objectives and intended outcomes? To ensure all staff are fully supported to achieve their job requirements, feel valued for the work they do and are able to get help with any concerns that they have
What are the main changes being made? There are no major changes in this review, the primary focus has been updating legislation and profession specific guidance where needed. We have also created a contract and guidance for external supervisors. There is now a requirement to record on LEAP when a supervisions session has taken place.
What is the timetable for its development and implementation? Clinical Delivery Board in February 2026, Clinical Policy Working Group in March 2026. Once ratified the policy will be shared across professional groups and operational leadership meetings for implementation.
Review of supervisor training with E&T once policy has been ratified.

4. What evidence have you considered to understand the impact of the policy or service development on people with different protected characteristics?

Consultation with representatives of each professional group as well as non-clinical colleagues. Feedback requested from all networks and key stakeholders (including Staff Support and HR)

Following discussion with the involvement manager about the changes that will not materially impact on service users/ carers it was agreed that service user and career engagement was not warranted as would not be meaningful.

2024 NHS Staff Survey benchmarking data for South London and Maudsley NHS Foundation Trust, including People Promise elements and Workforce Race/Disability Equality Standards (WRES/WDES). The detail we had access to in this survey was not at the granular level previously available.

5. Have you explained, consulted or involved people who might be affected by the policy or service development?
Consulted with professional groups, Directorates, key stakeholders who have shown interest.

Aligned to Policy for supporting staff involved in incidents, investigations, complaints or claims.

6. Does the evidence you have considered suggest that the policy or service development could have a potentially positive or negative impact on equality, discrimination or good relations for people with protected characteristics? *(Please select yes or no for each relevant protected characteristic below)*		
Age	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts: Positive impact by encouraging supervisors to consider the impact of age on working experience of staff and provide support if necessary/requested.		

Disability	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts: Positive impact by encouraging supervisors to consider the impact of disability on working experience of staff and provide support if necessary/requested. The Trust Staff Survey shows that staff with long-term health conditions continue to report less positive experiences, especially regarding discrimination and equal opportunities for progression. The proportion of staff reporting discrimination or harassment remains higher among staff with disabilities		

Gender re-assignment	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts: Positive impact by encouraging supervisors to consider the impact of gender re-assignment on working experience of staff and provide support if necessary/requested.		

Race	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts: Positive impact by explicitly encouraging supervisors to consider the impact of race on working experience of staff and provide support if necessary/requested. The Trust Staff Survey shows that staff from minority ethnic backgrounds continue to report less positive experiences, especially regarding discrimination and equal opportunities for progression. In addition the proportion of staff reporting discrimination or harassment remains higher among staff from minority ethnic backgrounds.		
Pregnancy & Maternity	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts: Positive impact by encouraging supervisors to consider the impact of pregnancy/maternity on working experience of staff and provide support if necessary/requested.		
Religion and Belief	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts: Positive impact by encouraging supervisors to consider the impact of religion/belief on working experience of staff and provide support if necessary/requested.		

Sex	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts: Positive impact by encouraging supervisors to consider the impact of sex/gender on working experience of staff and provide support if necessary/requested.		

Sexual Orientation	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts: Positive impact by encouraging supervisors to consider the impact of sexual orientation on working experience of staff and provide support if necessary/requested.		
Marriage & Civil Partnership *(Only if considering employment issues)*	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts: Positive impact by encouraging supervisors to consider the impact of marriage and civil partnership on working experience of staff and provide support if necessary/requested.		

Other (e.g. Carers)	**Positive impact:** Yes	**Negative impact:** No
Please summarise potential impacts: Positive impact by encouraging supervisors to ensure carers are considered.		

7. Are there changes or practical measures that you can take to mitigate negative impacts or maximise positive impacts you have identified?
YES: *Please detail actions in PART 3: EIA Action Plan*

- Continue to review and update supervisor training, ensuring it addresses equality, diversity, and inclusion for all staff groups, including non-clinical staff.
- Use available EIA and staff survey data to inform training and policy review.
- Monitor and address areas where staff with protected characteristics report less positive experiences, especially regarding discrimination, harassment, and career progression.
- Encourage reporting and open discussion of equality issues in supervision.

Note:

- The 2024 survey highlights the need for ongoing focus on anti-racism, disability inclusion, and support for staff with caring responsibilities.

8. What process has been established to review the effects of the policy or service development on equality, discrimination and good relations once it is implemented?
(*This may should include agreeing a review date and process as well as identifying the evidence sources that can allow you to understand the impacts after implementation)*

- The effects of the policy will be reviewed during the next policy review cycle (April 2027).
- Ongoing monitoring will use the annual NHS Staff Survey, WRES/WDES data, and feedback from staff networks and stakeholders.
- Any significant changes in staff experience or equality outcomes will inform further policy updates.

Date completed: December 2025
Name of person completing: Helen Winter
Operational Directorate/Borough: Corporate

PART 3: Equality Impact Assessment Action plan

Potential impact	Proposed actions	Responsible/ lead person	Timescale	Progress
Supervisor Training (mandatory eLearning)	Review training. Consider EIA data in supervision training review.	Policy Lead and L&D team	By mid 2026	
Pilot in person skills based supervisor training using VR	Develop and pilot in person skills based training for supervisors	Policy Lead and L&D team	By mid 2026	
Review actual equality impacts of policy	Review EIA during next policy review	Policy Lead	April 2026	

Date completed: December 2025
Name of person completing: Helen Winter
Operational Directorate/Borough: Corporate
Service / Department: Corporate
Please send an electronic copy of your completed action plan to:
15 arleen.elson@slam.nhs.uk
16 Your Operational Directorate/Borough Equality Lead

Appendix 7: Human Rights Act Assessment

To be completed and attached to any procedural document when submitted to an appropriate committee for consideration and approval.
If any potential infringements of Human Rights are identified, i.e. by answering Yes to any of the sections below, note them in the Comments box and then refer the documents to SLaM Legal Services for further review.

For advice in completing the Assessment please contact Tony Konzon, Claims and Litigation Manager (Anthony.Konzon@slam.nhs.uk)

HRA Act 1998 Impact Assessment	Yes/No	If Yes, add relevant comments
The Human Rights Act allows for the following relevant rights listed below. Does the policy/guidance NEGATIVELY affect any of these rights?		
• **Article 2 – Right to Life** (Resuscitation /experimental treatments, care of at risk patients)	No	
• **Article 3 - Freedom from torture, inhumane or degrading treatment or punishment** (physical & mental wellbeing - potentially this could apply to some forms of treatment or patient management)	No	Line managers and all other supervisors are required to take part in Supervision Training to promote psychological and physical well-being of staff
• **Article 5 – Right to Liberty and security of persons** i.e. freedom from detention unless justified in law e.g. detained under the Mental Health Act (Safeguarding issues)	No	
• **Article 6 – Right to a Fair Trial, public hearing before an independent and impartial tribunal within a reasonable time** (Mental Health Act Tribunals/complaints/ grievances)	No	Line managers and all other supervisors are required to take part in Supervision Training to identify any problems early and support staff to avoid disciplinary, complaint or grievance procedures
• **Article 8 – Respect for Private and Family Life, home and correspondence/ all other communications** (Right to choose, right to bodily integrity i.e. consent to treatment,	No	Work-Life balance encouraged in Supervision Policy

HRA Act 1998 Impact Assessment	Yes/No	If Yes, add relevant comments
Restrictions on visitors, Disclosure issues)		
• **Article 9 - Freedom of thought, conscience and religion** (Drugging patients, Religious and language issues)	No	Line managers and all other supervisors are required to take part in Supervision Training to broaden awareness of diversity of staff and need to support this
• **Article 10 - Freedom of expression and to receive and impart information and ideas without interference.** (withholding information)	No	Line managers and all other supervisors are required to take part in Supervision Training of skills to promote freedom of expression
• **Article 11 - Freedom of assembly and association**	No	
• **Article 14 - Freedom from all discrimination**	No	Line managers and all other supervisors are required to take part in Supervision Training of skills to understand and support staff who are discriminated against

Name of person completing the Initial HRA Assessment:	Helen Winter
Date:	5th January 2026
Person in Legal Services completing the further HRA Assessment (if required):	
Date:	