Bradford Hospitals and Community Trusts

Clinical Supervision Workshop

Feedback Summary and Action Points

Index

Contents

1. Overview of Presentation

1.1 The Importance of relating clinical supervision to nurses clinical performance

(a) **Self regulation**
Nursing is a self regulating profession. Through the act of registration with the UKCC, and subject to the Council's code of professional conduct, nurses are accountable through the UKCC to the public for all actions and omissions in delivering professional nursing care.

(b) **Performance Management**
It is extremely difficult to build in performance targets for professional nursing practice into performance management systems such as individual performance review. Moreover the UKCC Code applies regardless of employment circumstances, and there could therefore be conflict between self regulation and corporate expectations.

(c) **Accountability**
This is further hindered where nurses are managed by non nurses, and where professional accountability lies outside managerial structures.

(d) **Consumerism**
The rise of consumerism within the thinking of New Public Management across all political parties means that public expectations of public services and of the professions, will require more open public scrutiny of mechanisms for protecting their interests, and ensuring that they receive the best services possible.

(e) **Risk Management**
This is further supported by the NHS Trusts interest in developing risk management strategies to maximise service potential within an acceptable framework for risk, that incorporates minimising reasons for patient complaints and litigation.

1.2 Reasons for clinical supervision

1.2.1 The benefits of clinical supervision are claimed to be that it increases morale and motivation thus enhancing job satisfaction, it reduces stress and burnout which in turn improves patient outcomes and reduces staff turnover. Moreover, the supervisory process aims to improve nursing care.

1.2.2 However there is little research into whether Clinical Supervision actually achieves these benefits. Moreover, the model of supervision adopted by the profession has the potential for significant cost implications. One to one supervision can be implemented in a way that requires significant time from both the supervisee and supervisor, time which is not being spent on direct care. Whilst the value of that time in terms of improving care can be argued, there must be an optimum balance between achieving the proposed benefits and impact of the costs on patient care. Further more there is confusion about the difference between clinical supervision and the two related concepts of mentorship and precentorship.

1.2.3 In summary Clinical Supervision is needed to:

a) Protect Patients
b) Ensure Competence
c) Safeguard Standards
d) Maximise the Therapeutic effect of the nurse -patient relationship
e) Enable nurses to develop their abilities in coping, caring and comfort.

1.3 Definitions

1.3.1 There is no one accepted definition of clinical supervision. Those available offer a range of approaches to the concept dependant on the philosophy of the profession proposing the definition. For example:

"An intensive interpersonally focused one-to-one relationship in which one person is designated to facilitate the development of the therapeutic competence in the other person"

Loganbill et al 1982.

"An exchange between practising professionals to enable the development of professional skills"
Butterworth 1993

"Supervision is a meeting between two or more people who have a declared interest in examining a piece of work. The work is presented and they will together think about what was happening and why, what was done or said, and how it was handled - could it have been handled better or differently, and if so, how?"
Wright 1989

(all the above in Faugier and Butterworth 1994)

"Clinical Supervision is a collaborative dynamic process which goes beyond the pastoral nurturing role and positively works towards "ENABLING" the Supervisee. It requires all parties to participate actively towards :-

a) Ensuring the needs of the client / patient are being monitored and addressed.
b) The supervisee becoming a more competent practitioner."
Morcom & Hughes 1993

1.3.2 A preferable description of Clinical Supervision is ***a relationship that further enables the practitioner to put professional knowledge into practice*** because it focuses primarily on the process and experience of nursing.

1.3.3 This expands the previous definitions by focusing on the development of individual's understanding. The relationship is not just about the expert guiding and teaching the novice. The relationship is more subtle than that. Because the nursing is enacted through the particular relationship between the nurse (the practitioner) and the patient, any facet of the nurse's personality and value set will impact on that relationship. Clinical supervision should enable the practitioner to make the best use of his / her personal beliefs and behaviours in developing a therapeutic relationship through which to care.

1.4 Labels

1.4.1 The labels "Clinical" and "Supervision" seem inappropriate to the concepts described above and to the phrases that people use when describing this process. A number of key words are used when describing clinical supervision:

- *Help*
- *Support*
- *Development*
- *Counsel*
- *Facilitate*
- *Advise*
- *Guide*

1.4.2 These, and the above definitions seem at odds with the literal definitions of the words:

- ***Clinical***
  dictionary definitions use words such as 'treatment'; dispassionate; coldly detached!

- ***Supervision***
  dictionary definitions related to this use terms such as 'direct', 'oversee', 'maintain order'!

Something along the lines of ***'professional guide'*** would be preferable.

1.5 Related Notions

1.5.1 So what is the difference between clinical supervision and mentorship / precentorship? In Homer's Odyssey Odysseus entrusted his friend Mentor with the upbringing of his son Telemachus whilst he was away fighting the Trojan War. This depicts a paternal relationship in a culture in which men took responsibility for the whole community. It conjures up a notion of a relationship that was built on strength, caring, accountability, openness, authority, and a degree of intimacy.

1.5.2 Darling (1984) describes a mentor as

- an envisioner
- a standard prodder
- a challenger

Mentorship enhances skills and learning. It has more of a teaching function to it than supervision. The expert / novice relationship is apparent, whereas supervision may take place between peers. It is also a lasting relationship, built on a level of intimacy, confidentiality and trust. Mentorship is an optional process which many individuals pursue outside their employment situation. (It is worth noting that many nurses experience of mentoring as a student nurse does not reflect the true nature of mentorship, which is a relationship that should be built up a over a period of time, rather than the few weeks of a clinical placement).

1.5.3 Precentorship has emerged as a result of mentored student nurses requiring a form of support once qualified, on a different footing than mentorship. The novice expert set up is still apparent but it is played out in a relationship that hinges more on guidance and role modelling. It enables the nurse to mature as a practitioner. The UKCC describes precentorship as offering support and guidance, as being a colleague providing both professional and personal support. They propose that this support should last approximately for the first four months of practice as a registered nurse (UKCC 1993). Precentorship is provided within an employment setting and relates to the employment role as much as to the person.

1.6 Types of Supervision

1.6.1 Supervision will encompass some or all of the following:

- **Managerial**
  this helps the supervisee see round the blind spots in their implementation or interpretation of nursing care. These blind spots can take the form of difficulty in putting theory into practice; prejudice and pre-conceptions; relying on ritual; lack of understanding of team dynamics.

- **Educational**
  develops skills and understanding in the supervisee.

- **Supportive / Personal**
  deals with stressors and difficulties that the supervisee perceives.

1.7 Approaches

Supervision can be:

- Self (usually through personal reflection)
- One - to - one (Supervisee to supervisor)
- Team (between a set of individuals who work as a team with an internal or external supervisor))
- Group (between a set of individuals who do not necessarily work together, but have other common factors with a supervisor)

1.8 Models of Supervision

There are a number of models described in the literature:

- Richards et al (1990) describes three models of supervision:
  Apprenticeship Model
  Growth Model
  Role Systems Model

These are models developed in the Social Services and further detail is contained in Richards M, Payne C, and Shepperd A (1990) Staff Supervision in Child Protection Work.

- Faugier (1993) describes the 'Growth & Support Model'.
  This has the following features:
  Generosity, Rewarding, Openness, Willingness to learn, Thoughtful and thought provoking, Humanity, Sensitivity, Uncompromising, Personal, Practical, Orientation, Relationship, Trust.

- Proctor (1986) describes clinical supervision as being:
  Formative
  Restorative
  Normative.

- Frankham (1968) expands on the Proctor Model to describe the features as:
  Monitor, Manager, Teacher, Mentor, Therapist, Analyst, Mirror, Trainer, Evaluative, Reviewer, Facilitator, Professional Representative.

- Hawkins & Shohet (1991) describes a matrix model with two elements:

  a) practice is reflected on and reported on in the supervision session.

b) the process of nursing is focused on as it is reflected (or played out) in the supervisory process, ie the nurse's relationship to the supervisor, or interpretation of the supervision process can reflect the way he / she undertakes his / her nursing function.

A more detailed description of models (b) to (e) is provided in Faugier and Butterworth (1994) Clinical Supervision: a position paper.

1.9 Types of supervisor

1.9.1 Manager as Supervisor

The individual's manager also provides supervision outside the performance appraisal system.

1.9.2 Supervisor within the same team, but is not the manager.

A peer from the same setting and with whom the individual works in delivering care acts as the supervisor. This supervisor does not have a managerial function in relation to the supervisee, but would be chosen because of their understanding of the work related issues, and their ability to meet the supervisee's needs. There is always the potential for the work relationship to get in the way of the supervisory relationship in this option. However, the supervisor would have first hand experience of the work setting, patient needs, and supervisee's skills, and would thus be well informed in the supervisory session.

1.9.3 Supervisor from another team in the unit.

This would ensure that the supervisee has no managerial relationship, nor would they have a personal interest in the supervisee's abilities in nursing outside the supervisory function. The supervisor would have an experiential understanding of the work setting, and would thus be able to bring this to the supervisory session.

1.9.4 Supervisor is an expert from elsewhere.

The supervisor would not bring first hand experience of the workplace setting, but would also not bring any potential bias or prejudice about that setting. They would bring expertise in the field that the supervisee would like to explore through supervision.

1.9.5 The model selected will depend on the nature of the management system in operation and the line of professional accountability. Since supervision is about the practice of nursing, a non - nurse will not be able to bring the required depth or expertise to the supervision as it relates to nursing. Likewise it is all too easy to assume that a manager who happens to be a nurse, is the easiest and most cost effective option. There is undoubtedly potential for conflict if the manager is also the supervisee, as the very nature of that relationship will restrict the supervision. The supervisor as expert from elsewhere could be seen as more 'pure' but less pragmatic than the previous options.

1.10 Forms of supervision

1.10.1 Supervision can take the form of:

- The use of development contracts
- Guided reflective practice

1.10.2 Learning contracts contain a small number of objectives; identified resources and methods for achieving objectives; identified evaluation criteria; evaluation dates for each objective.

1.10.3 Reflective practice enables practitioners to get access to a personal knowledge of practice, by reflecting on experience.

1.11 What supervision should offer

Supervision should offer:

- Regular contact
- A negotiated process
- Exploration of experience
- Consideration of alternatives
- Motivation
- Agreed record keeping

1.12 Practicalities

1.12.1 Clinical Supervision of nursing ensures professional development within a professional code of conduct. The needs of the supervisee may relate to the individual's needs in

a) conceptualising nursing practice
b) advancing the philosophy of their practice
c) exploring ethical \ moral dilemmas

1.12.2 The Clinical Supervisor takes on responsibilities related to addressing the individual supervisee's needs within a professional code of conduct and mindful of the employer's rights. These responsibilities mean that the supervisor will require training, and potentially supervision themselves related to ensuring that their supervision is in the best interest of the supervisee as a professional and as a person.

1.12.3 Both Supervisee and supervisor have rights and responsibilities within the supervision which must be articulated at the outset in the form of a contract for supervision. This contract will cover:

- Practicalities
  Where, when, how and note taking.

- Fundamentals
  How supervision is to be reported to the supervisee's manager; how changes in practice are to take place; how each party can assess performance and terminate the contract.

- Theoretical foundation
  The model to be used; the approach to be taken.

- Ethical considerations
  Confidentiality; the personal and professional interface; what to do in instances of high risk activity and malpractice; what happens when supervision is required outside the supervisor's competence.

1.12.4 Crucial to the whole process is the relationship between personal development plans, clinical supervision and individual performance review, which must be clarified.

2 Morning Group Work - where are we now?

2.1 What does clinical supervision offer us?

" A formal system which allows us to constantly review and develop practice for every individual nurse"

- a more effective workforce; increased standards of care; improved morale
- self awareness and a questioning approach to our practice.
- guidance and individual growth.

The group felt that the words 'clinical supervision' gave the wrong impression. They implied control, someone standing over your shoulder checking up on you, distance and authority. Our understanding of clinical supervision is one of support and guidance. It was agreed at the end of the day that we are stuck with the title because it is widely used and the literature relates to those words, but that we would need to clarify our interpretation for nurses in the Trust.

There seemed to be agreement that the model must be contextual, that is it must reflect local circumstances and prior experiences.

Finally, it must be put in properly to work.

2.2 Do we need it?

Yes, but we don't all realise we need it.

2.3 What benefits will it bring to me and to the team?

The benefits to individuals are:

- increased personal professional awareness
- identifying potential problems and addressing them
- positive feedback

The benefits for the team were:

- improved relationships
- identifying potential problems
- increasing reflective skills
- it could improve interdisciplinary teamwork, particularly as we begin to access other professionals for supervision.

2.4 How will it affect the quality of patient care?

It will be difficult to measure the impact of clinical supervision, partly as it will take some time for the benefits of supervision to impact care, and partly because it is impossible to remove all the other variables to demonstrate that clinical supervision is responsible for x or y improvement. However, it should be possible to look at trends in indicators of patient care, interpret these within the context of the situation, and attribute part of the trends to supervision. A proxy indicator will be in relation to job satisfaction.

The group were convinced that it would improve the patient outcomes. It should improve staff motivation and morale evidenced by decrease in sickness and absenteeism, which it has been demonstrated will improve nursing care. it should bring a reduction in complaints related to nurses practice. There should be improvements in communications, and more sharing of knowledge.

2.5 What models of clinical supervision are currently in operation in Bradford?

- statutory supervision in midwifery
- child protection model.
- IPR / appraisal
- team meetings, case review.
- precentorship
- mentorship
- networks
- peer review

All of these are happening but at different levels

"It is about making all the informal, current systems formal."

2.6 What is our perception of these - advantages / disadvantages?

Advantages	Disadvantages
Recognition of clinical supervision in some areas	Not consistent across the Trust
Close links with IPR	Short existing timescale of supervision
Supportive	No clear definition
Consistent approach to poor practice issues	Big brother approach
	Current attitudes to IPR
	Fragmented uncoordinated approach

2.7 How receptive are clinical staff to the idea of clinical supervision?

The range of attitudes accentuate the need for careful planning in implementing clinical supervision, recognising the features of the change process

> Note from Becky: Rogers (1962) 5 phases of change awareness, interest, evaluation, trial, and adoption. Kelly and Corner (1979) uninformed optimism, informed pessimism, hopeful realism, informed optimism, and rewarding completion. Lewin (1951) unfreezing (an awareness of the need for change), moving (working towards change) and refreezing (the integration and stabilisation of change).

2.8 What mechanisms for performance review are there within the Trusts?

- IPR
- Precentorship
- Learning contracts
- Peer review
- Audit / standards

When developing clinical supervision within the Trusts, it must complement the existing performance management systems, and build on those akin in philosophy to clinical supervision.

2.9 What is our conceptual framework for nursing?

This is articulated through the Trusts strategies for nursing.

3. Afternoon Group Work - answering the questions

3.1 Who will be the supervisors

The groups spent a lot of time discussing this issue. They identified a number of points:

- potentially every nurse should be a supervisor,
- they must 'opt-in', and have a range of skills,
- clinical nurse specialists who want to will automatically have the skills to supervise in the area of their clinical practice,
- personal characteristics will make some more suitable than others,
- the individual must be committed,

There should not be a mandate to be a supervisor, but we should be encouraging nurses to opt in.

3.2 How will we choose the supervisors?

They should self select. People will identify themselves through the IPR process. There may be a need to choose supervisors. It will need to be delivered in different ways for different staff groups. Whoever the supervisors are to be they will need training.

3.3 Should there be a role description for the supervisor?

We should identify our expectations of the individual and the process. There are a number of qualities of a supervisor, rather than an actual role.

3.4 What qualities do we expect the supervisor to have?

These qualities were identified as:

- active listening
- appropriate skill set - up to date!
- good teaching and motivational skills
- interpersonal
- supportive
- trustworthy
- confidential
- objective
- flexible
- committed
- self aware
- gives positive feedback
- challenging
- encourages enquiry
- same value set.
- recognises where supervisors role ends and management starts.

We need to assess what we do now that could be interpreted as supervision if set within a framework. We need to develop our thinking on supervision, over what is acceptable and what is not, where we will compromise, how we can use group and team supervision, and where we should use individual. This is particularly pertinent when we go on to consider the time needed for supervision.

3.5 What are our expectations of the supervisor and of the supervisee?

The framework for making these expectations of both supervisor and supervisee explicit will include:

- the supervisory process fulfils the purpose of supervision,
- boundaries are negotiated and maintained,
- there should be mutual learning,
- outcomes should be agreed and monitored.

Expectations for both supervisor and supervisee are:

- Commitment.
- Recognise personal limitations.
- Honesty.
- The time spent on supervision meets the purposes of the supervisory process
- Supervision should be for work based issues.
- The process should facilitate mutual learning and growth.
- The process should be based on a mutually agreed contract.

Additional expectations of the supervisor were that they would act with integrity, empathy and tact

There will be no choice in taking part in supervision, but there will be some choice about who with.

3.6 How much time does it / should it take? How will we find the time for supervision?

- We need quality not necessarily quantity.
- We should formalise the time we already.
- There should be an agreed minimum (suggestion of 1 hour per month)
- Time should be liberated as a result of the supervision process.
- It should be negotiated as part of the PDP.
- It should be an integral part of everyone's job, not an add on.
- There should be flexibility in determining how much time is spent on supervision.

3.7 How will we assess the quality of supervision?

We need to have identified objective measures of outcomes in terms of process'. These should be part of the audit cycle. However, the groups noted that the results may well not be immediate. A proxy measure of outcome could be staff job satisfaction, which can be measures through sickness and absenteeism rates, satisfaction questionnaires, and complaints against staff attitudes. We do need to be gaining an understanding of the cost / benefits of supervision.

The main outcome should be improved client care. The difficulty will be in determining which improvements are due to supervision, and which are part of the practice development momentum within the Trusts. It should be possible to incorporate a user view (note from Becky - was this user as in supervisee, or user as in patient/client?) One outcomes of the supervision process should be an increased awareness of accountability - is it possible to measure that?

The most important indication that supervision is working is that we change the culture.

(note from Becky - there are tools for assessing and evaluating an organisations culture that you may want to use before and after implementing clinical supervision)

We need baseline measurements before we begin

3.8 How will we meet the needs of the supervisor?

- every supervisor should have a supervisor!
- support group for supervisors
- external facilitation
- time commitment
- networking
- commitment to training

We should ensure that supervisors are aware of the organisation and profession's expectations of them, and the purpose of supervision. Supervisors need to be aware of what resources are available to support them.

3.9 How confidential should supervision be?

Supervision should take place within the requirements of the Code of Professional Conduct (UKCC). This will ensure that any misconduct unearthed as part of the supervisory process, will be subject to normal reporting mechanisms. There needs to be agreement on the reporting relationship to the performance management system. There were a range of views as to whether the individual being supervised is responsible for that reporting relationship, or whether it is a three way relationship (supervisor, supervisee, manager). The parameters for confidentiality need further consideration by the Trusts.

3.10 Should all supervision be face to face/ should we have group, team, or individual supervision?

We will need a mixture of all of these, dependant on local circumstances. All models should be embraced.

3.11 What should we include in a contract for supervision.

If we are to empower practitioners to opt into becoming supervisors, and to choose their own supervisors, then we must set some ground rules for the process to ensure that it is effective as it can be, and to protect both parties.

The contract should:

- Be a written document
- Set the ground rules for engagement / boundaries.
- Include personal details of the supervisor and supervisee.
- Include individuals rights
- Include the supervisee and supervisor's expectations of each other and personal knowledge and experiences.
- Include the agreed objectives and outcomes of the supervision process.
- Define the process for termination of the contract.
- Set out the confidentiality of the information.
- Encompass equal opportunities.
- The reporting mechanism / relationship with the supervisee's personal profile and development plan, and their performance review process.
- Include a record of all formal supervision sessions, held by the supervisee, and agreed as a correct record by both parties(in group supervision the group should agree where the record is held)

3.12 Should there be an appeals process?

If the contract determines the process for that contract's termination, and if we are aiming to enable practitioners to take personal responsibility, will we need an appeals process. What will they be appealing against? There may be the need for calling in some mediation, this could be ut into the ground rules within the contract. It could be that supervisee's could appeal against the lack of outcome? Any appeals procedure would need criteria.

4. Personal development plans, IPR and clinical supervision

During the feedback we considered a framework for personal development plans that could help in making the distinction between IPR and supervision.

- Managerial / Coordinating skills
  eg decision making, change management, delegation, quality assurance.

organising self — managing team

- Nursing Practice skills
  eg designing and implementing plans of care; new skills to meet new demands; 'specialist' expertise.

generalist — specialist

- Research Skills
  eg critique; awareness; implications of research for practice; undertaking literature searches; using research methods.

research awareness — carrying out research

- Educating skills
  eg providing an learning environment, teaching patients and staff, developing learning material, presentational skills.

learning environment — teaching

Within IPR the Manager (Non Nurse) will be able to set objectives in relation to managerial / coordinating skills, possibly educating skills, and some of the research skills. This will be complemented by a professional line of accountability which will assess performance in relation to nursing practice skills and fill in any other gaps.

5. Action Plan

The groups agreed this draft outline action plan in the last half hour of the day.

- Core agreement.
  The two Trusts will reach an agreement on the 'core' principles for clinical supervision in Bradford. This will include a definition, the purpose, qualities and skills of the supervisor.
  March 1995

- Organisational commitment.

Both Trusts have signed up to the concept as part of their nursing strategies. The boards need to be made aware of what clinical supervision will mean in practice.

March 1995

- Implementation strategy
  Once there are agreed principles then the key nursing practice groups (practice development group/ nursing advisory group) will need to determine the strategy for implementation. This will include awareness raising, and determining the local process. The implementation will include a half day session for non- nurses (managers, PAMs and doctors) and a half day session for clinical nursing staff. These sessions will be held in April 1995.

- Training.
  The training programme for supervisors will be available from April 1995.

- Testing & Learning
  Clinical areas will be asked to 'opt in' as demonstration sites, testing out various approaches and sharing the lessons learnt. This will take place in the summer, with a day conference in 1 years time to share progress.

APPENDIX I

BRADFORD HOSPITALS AND COMMUNITY TRUSTS

CLINICAL SUPERVISION CORE PRINCIPLES

1 Introduction

At the clinical supervision workshop held in 1994, the two Trusts agreed to develop a set of core principles for clinical supervision in Bradford. The core principles include the:

* definition of clinical supervision
* purpose of clinical supervision
* qualities and skills of the supervisor
* aspects of implementation

It is expected by nurses in the Trusts that clinical supervision will improve morale and motivation, as well as patient outcomes. There will be improved communications, and sharing of knowledge, and it could lead to better inter-disciplinary teamwork.

2 Definition of Clinical Supervision in Bradford

The definition adopted by the Trusts is:

"An exchange between practising professionals to enable the development of professional skills."

Butterworth 1993

This definition incorporates the concepts of facilitation, helping, guidance, support, growth and advise.

3 Purpose of Clinical Supervision in Bradford

The purpose of clinical supervision is to:

* Protect patients/clients
* Ensure competence
* Safeguard standards
* Maximise the therapeutic effect of the nurse-patient relationship
* Enable nurses to develop their abilities in coping, caring and comfort

It is a formal system which allows us to constantly review and develop practice for every individual nurse.

The aims of clinical supervision in Bradford are:

* To improve the quality and effectiveness of nursing care
* To contribute to improvement in morale and motivation of nursing staff
* To contribute to professional development

Clinical supervision offers self awareness and fosters a questioning approach to our practice.

4 The Qualities and Skills of the Supervisors in Bradford

The Supervisors in Bradford will have the following qualities:

* Generosity
* Ability to recognise and reward ability
* Openness
* Willingness to learn
* Thoughtful and thought provoking
* Humanity - to reflect the essential humanity of nursing
* Sensitivity
* Uncompromising rigour - incorporating commitment to the process, and recognising where supervision ends and management starts
* A personal approach to the supervisory relationship that includes honesty and integrity
* Practical
* Orientation towards reconciling opinions with client needs, and towards

the clinical care of the clients

* Offers a relationship that reflects the nature of the therapeutic nurse-patient relationship
* Trustworthy

(from Faugier 1993)

The supervisors in Bradford will have the following minimal skill set:

* Reflective practice skills
* Training in supervision
* Clinical competence

5 Other principles for implementation of clinical supervision in Bradford

A number of other principles apply to the two Trusts:

1 Every nurse will take part in clinical supervision.

2 There will be an agreed minimum commitment of 1 hour per month to clinical supervision.

3 Clinical supervision should be integral to everyone's job, not an add on.

4 Clinical supervision should be restricted to work based issues.

5 The process will be based on a mutually agreed contract between supervisor and supervisee (App I).

6 All supervisors will be offering training.

7 Clinical supervision takes place within the requirements of the Code of Professional Conduct (UKCC). This ensures that any misconduct identified as part of the clinical supervisory process is subject to normal reporting mechanisms.

8 Supervisors and supervisee's will provide 6 monthly reports to the supervisee's line manager on progress.

APPENDIX II

CONTRACT FOR CLINICAL SUPERVISION WITHIN THE BRADFORD TRUSTS

This Contract will:

* Be a written document.

* Set the ground rules for engagement/boundaries.

* Include personal details of the supervisor and supervisee.

* Include individual rights.

* Include the supervisee and supervisor's expectations of each other and personal knowledge and experiences.

* Define the process for termination of the contract.

* Set out the confidentiality of the information.

* Encompass equal opportunities.

* The reporting mechanism/relationship with the supervisee's personal profile and development plan, and their performance review process.

* Include a record of all formal supervision sessions, held by the supervisee, and agreed as a correct record by both parties (in group supervision the group should agree where the record is held).