

# Scotland's Position Statement on Supervision for Allied Health Professions

# Contents

# Page

1.	Introduction and Aim of this Statement	1
2.	Background and Context	1
3.	Definition of Supervision	2
4.	Core Principles of Supervision	2
5.	Purpose of Supervision	3
6.	Delivery of Supervision	4
6.1	Components of Supervision	4
6.2	Frequency of Supervision	6
6.3	Methods of Delivering Supervision	7
6.4	Managerial, Professional and/or Operational Lead	7
6.5	Responsibilities of Supervisors and Supervisees	7
6.6	Learning and Development for Supervision	7
6.7	Interpersonal Relationship within the Supervision Context	7
6.8	Confidentiality	8
6.9	Use of Patient/Client Records	8
6.10	Storage of Records	8
6.11	Supervision Implementation Plan	8
7.	Monitoring and Evaluation of Supervision	8
8.	Professional Governance	8
9.	Review	9
10.	References and Supporting Documents	10

## 1. INTRODUCTION

Scotland's Position Statement on Supervision for Allied Health Professions (AHPs) has been developed in partnership with the AHP Directors Scotland Group, the AHP Federation Scotland, NHS Education Scotland (NES) and the Scottish Government AHP Chief Health Professions Office.

### Purpose of this Statement

This statement offers principles and guidance to support the provision of supervision for all AHPs and AHP Health Care Support Workers (HCSWs) working across health and social care in Scotland; in the NHS; Local Authority and Health & Social Care Partnerships.

- It is applicable to all roles and levels of practice.
- It articulates the overarching principles of supervision.
- It offers guidance which should then inform local supervision policy and practice including any specific uni-professional requirements.
- It sets the direction for AHP staff, their professional leads and line managers to ensure processes and systems are in place to support supervision.

## 2. BACKGROUND AND CONTEXT

There are approximately 12,000 AHPs and 2,250 AHP HCSWs employed in Scotland. Their contribution is essential to providing safe, effective and person-centred services across the health and social care sector.

National policy and drivers<sup>1</sup> recognise that a well-educated, motivated, capable and supported workforce is vital to achieving Scotland's vision for health and social care by 2020 and beyond. Effective supervision can contribute to the continued development of healthy organisational cultures, ensure sustainable AHP practice, the embedding of emerging AHP roles and support staff engagement and morale. Ultimately this has a positive impact on the people who use our services.

In the context of the integration of health and social care services in Scotland and wider public sector reform, AHP staff are being asked to work in new roles and deliver new models of service. This requires robust clinical and professional governance arrangements to be in place to support staff.

Based on the well-documented benefits of supervision (Dawson, 2013) this statement takes the position that **all AHP practitioners, irrespective of their level of practice or experience, should have access to, and be prepared to make constructive use of supervision.** Indeed, many of the AHP Professional Bodies state that access to regular supervision should be available for all staff. The Health & Care Professions Council (HCPC) advise that access to good quality supervision is a supportive structure to enable a registrant to meet the HCPC standards for continuous professional development (CPD). Guidance on the HCPC website <http://www.hcpc-uk.org/registrants/cpd/activities/> includes supervision as one of many CPD activities.

Whilst HCSW staff are not registered by the HCPC, it is intended that the practice outlined in this statement should extend to all non-regulated staff. This is consistent with the Induction Standards for Health Care Support Workers (2009) and the Scottish Social Services Council (SSSC) Code of Practice for Social Workers and Employers (2016).

---

1 For example, Everyone Matters: 2020 Workforce Vision (2013), Social Services in Scotland: a shared vision and strategy 2015-2020 (2015), the National Clinical Strategy for Scotland (2016) and the National Health and Social Care Workforce Plan (parts 1 and 2) (2017)

### 3. DEFINITION OF SUPERVISION

Whilst there is no agreed best or single definition of supervision, there are common purposes attributed to supervision. These include ensuring competent and safe practice, promoting wellbeing and professional practice and developing knowledge, skills and values (Dawson, 2013; Daly and Muirhead, 2015). What evidence there is points to effective supervision being associated with job satisfaction, organisational commitment and retention of staff (SCIE, 2013).

Supervision is described by the Department of Health as:

*“a formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety of care in complex clinical situations. It is central to the process of learning and to the expansion of the scope of practice and should be seen as the means for encouraging self-assessment and analytic and reflective skills...” (1993)*

The (SSSC (2015)) describes effective supervision as:

*“Reflecting on practice [It] provides staff with support in the complex, responsible and emotionally challenging work they undertake. It should be conducted in the context of a supportive learning environment that actively encourages the continuous development of good practice and skills. Regular, high quality, organised, supervision is key to developing staff skills, knowledge and values.”*

Kavanagh et al (cited in Dawson, 2013) defines supervision as:

*“A working alliance between practitioners in which they aim to enhance clinical practice, fulfil the goals of the employing organisation and the profession and meet ethical, professional and best practice standards...while providing personal support and encouragement in relation to professional practice.”*

### 4. CORE PRINCIPLES OF SUPERVISION

The quality of supervision can be understood to have a direct bearing on the quality of service delivery and outcomes for people. The following core principles underpin effective supervision practice:

- Supervision should be an active process which both supervisor and supervisee agree to and where appropriate, should be underpinned by an evidence based model.
- Supervision has an important underpinning role in enacting the health and social care values in Scotland. For more information, see [Care and Support in Scotland, NHS Scotland Values and the Allied Health Professions Scotland Consensus Statement on Quality Service Value](#).
- Supervision must ensure the effective management of practice by developing and supporting staff and promoting staff engagement within the organisation.
- All staff members, irrespective of their role, have the right to receive effective, quality supervision.
- Protected time should be allocated.
- The supervisory process should promote and protect the best interests of staff and service users irrespective of differing diversity of experience, including all protected characteristics under equality legislation.
- All staff members bear responsibility for the quality of their own work and are required to prepare for, and make a positive contribution to the supervisory process. They are not passive recipients.
- Supervision should be available to all AHP staff in four areas of professional activity: **Practice, Professional, Managerial, and Operational**, on an interpersonal and supportive basis.
- Employers have a responsibility to promote effective supervision that is consistent with this statement and to ensure learning and development opportunities are provided for both supervisors and supervisees.

## 5. PURPOSE OF SUPERVISION

The overall intention of supervision is to improve professional self through lifelong learning, improve professional practice and to feel, and be supported as a member of staff (NHS Lanarkshire, 2010). As previously noted, these ultimately support the delivery of safe, effective and person-centred care to the people who use health and social care services.

Proctor's model of supervision (cited in Clinical Supervision Toolkit, Helen and Douglas House, 2014) remains a useful way of thinking about the purpose and benefits of supervision. This model (see diagram 1 below) identifies three elements of supervision;

**Normative (Accountability):** This element focuses on supporting individuals to develop their ability and effectiveness in their clinical role, enhancing their performance for and within the organisation. The aim is to support reflection on practice with an awareness of local policy and codes of conduct.

- Supports delivery of a high standard of safe and effective care
- Enhances performance

**Formative (Learning):** Learning is also referred to as the **educative** element. It enables participants to learn and continually develop their professional skills fostering insightfulness through guided reflection. It focuses on the development of skills knowledge, attitudes and understanding.

- Supports personal and professional development
- Encourages and supports lifelong learning
- Identifies further learning and development needs

**Restorative (Support):** This element is concerned with how participants respond emotionally to the work of caring for others. It fosters resilience through nurturing supportive relationships that offer motivation and encouragement and that can also be drawn upon in times of stress.

- Supports self-care and wellbeing
- Provides insight into our emotional responses
- Enhances morale and working relationships

Diagram 1 Proctor's model of supervision

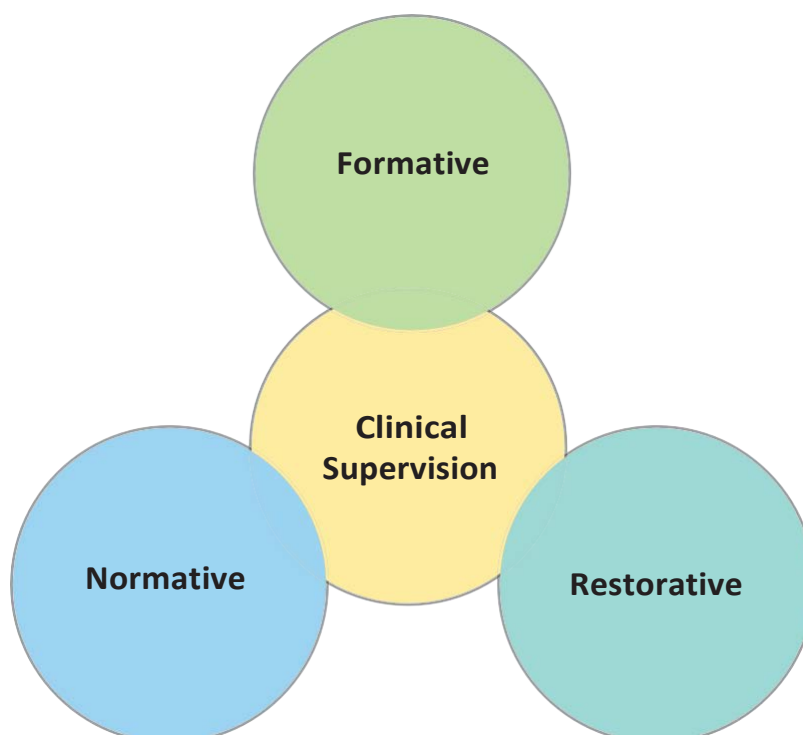


Table 1 below summaries what is traditionally considered to be covered in the purpose and intent of supervision and what is not.

Table 1 Summary of what supervision is and is not

Supervision	Supervision is <u>not</u>
<ul style="list-style-type: none"> <li>• Supports development of knowledge, skills, values and practice within a role or area.</li> <li>• Benefits people who use the services, their families and carers.</li> <li>• Promotes staff wellbeing by provision of support.</li> <li>• Provides a safe place for professional development, growth and accountability through the use of appropriate questioning, challenge, affirmation and structured reflection.</li> <li>• Leads the individual to identify their own solutions.</li> <li>• Supports AHPs through challenging and complex situations.</li> <li>• Supports reflective practice and clinical reasoning taking account of professional standards, the legislative context and eligibility criteria for service delivery.</li> </ul>	<ul style="list-style-type: none"> <li>• Psychotherapy, therapy or counseling. (although it can be therapeutic)</li> <li>• An opportunity to ‘police’ staff and check up on their actions.</li> <li>• Dictated by hierarchical relationships and positions within the organisation.</li> <li>• An opportunity for performance management or assessment (although effective and supportive supervision may identify that a practitioner is struggling/poorly performing, enabling the supervisor to provide early support to prevent a small problem becoming a big problem).</li> <li>• Controlled, managed and delivered by the supervisor and/or manager.</li> <li>• A place for blame, gossiping or moaning.</li> <li>• A place for pejorative judgement on practice.</li> </ul>

(adapted from Helen and Douglas House Toolkit, 2014 and NHS Lanarkshire, 2010)

## 6. DELIVERY OF SUPERVISION

### 6.1 Components of Supervision

Within practice, the term ‘supervision’ can be problematic. Whilst many people do share a common understanding of what it means and what it looks like in practice it can’t be assumed that this is necessarily the case. For some the word ‘supervision’ can mean being watched or monitored, for others it is about support and professional development. Many individual AHP professional bodies have guidance on supervision that provides valuable additional support. This statement takes the position that, regardless of the terminology used, all AHP staff should be in receipt of regular support which is underpinned by the elements in the Proctor model and which covers the four interconnected components outlined below (and summarised in Table 2):

**Practice/Clinical Supervision:** Aims to ensure best practice in relation to the care, support and treatment provided to people who use our services. Includes assessment, treatment, clinical reasoning, therapeutic intervention, decision making, consultation, and other clinical activities. Or, for some AHPs, aims to ensure best practice in relation to health protection, health improvement and improving services for populations. It also includes surveillance and assessment; policy and strategy development and implementation; strategic leadership and collaborative working. Can be achieved through reflection, discussion and review of tasks and relationships with people and their families and carers. Ideally, the AHP supervisor should be from the same profession and, where possible, have experience in the same (or related) clinical area. If this is not possible then it may be appropriate to ensure supervision is provided from outwith the organisation. The professional or operational leads/managers should agree streamlined approaches to the supervision of AHPs in rotational posts/split posts to avoid the need for multiple supervisors and ensure clarity of approach.

**Professional Supervision:** All AHPs should have access to a Professional Lead/Manager of the same profession for issues relating to scope of practice and role, CPD, professional and ethical issues. This ensures that standards for Conduct, Performance and Ethics (2016), CPD (2012) and Proficiency (2013), as set down by HCPC, are met. This type of supervision focuses on developing professional competence, meeting regulatory CPD requirements, providing feedback on performance, identifying development needs, supporting knowledge into practice, delivering service improvement and new models of practice in response to national policy and drivers.

**Managerial Supervision:** Ensures that the management (competent, accountable performance) function is met. Focuses on ensuring that organisational/professional policies and procedures are understood and adhered to, ensures quality performance e.g. appraisals take place and objectives are reviewed, case notes are audited, statutory responsibilities are met. Also covers workload management and prioritisation (based on experience and skills of practitioner and the service need), risk management and caseload management as appropriate.

**Operational Supervision:** Focuses on staff engagement with the organisation's function. It may include communicating about organisational changes and initiatives, resourcing issues, policy clarification, representing staff needs to management, offering feedback on how organisational policies/practice are perceived, and negotiating on differences which may arise between supervisors and other professionals, teams or service. For AHPs working in a devolved structure and operationally managed by someone outside their profession, there may be situations that the operational manager requires to seek support and guidance from the profession specific Professional Lead. It is recommended that operational managers always work collaboratively with the Professional Lead to support individual staff members.

**Table 2 Summary of components of supervision**

1 Practice/Clinical	2 Professional	3 Managerial	4 Operational
Mainly relates to the care, support and treatment provided to people who use our services.	Mainly relates to scope of practice, ensuring best practice to deliver high quality care, professional development, identity and professional issues.	Mainly focuses on ensuring competent, accountable performance.	Mainly focuses on staff engagement with organisational function.
Often linked together and referred to as Practice or Clinical supervision.		Often linked together and referred to as line management.	
<p>Accountability (normative)</p> <p>Learning (formative)</p> <p>Support (restorative)</p>			



Sometimes the four components of supervision will be covered by the same supervisor from within the supervisee's profession, but this will not be the case for many staff. Where managerial/operational supervision is carried out by a supervisor from a different professional background there will be a need for a colleague from the same profession to undertake practice and professional supervision separately. The professional and operational managers should ensure that there is an appropriate balance in terms of the time given to each component of supervision and will need to share information and work in partnership to achieve this.

It is recognised that alongside formal supervision all AHPs engage in processes of informal supervision. Whilst acknowledging the importance, and indeed necessity of this activity, this should not in any way replace the formal supervisory requirement.

**Formal supervision** should be available on a regular basis and be consistent with the guidance outlined in this statement.

**Informal supervision happens on an ad hoc, day-to-day basis and can take many different forms.** For example, peer support, team meetings, informal discussions, review meetings, etc. See [Community of Practice](#) for further examples.

Supervision can be used as evidence of continuous professional development as required to maintain HCPC registration. AHPs can access guidance on reflection and keeping a portfolio at [www.hcpc-uk.org](http://www.hcpc-uk.org)

## 6.2 Frequency of Supervision

In line with professional standards, each professional and operational lead will decide on the frequency of supervision. There is no clear evidence regarding the specific number of supervision sessions required (Pollock et al, 2017). However, in practice, it is anticipated formal supervision will be available at least 4-6 times per year.

The frequency of supervision will depend on:

- the experience of the supervisee
- their length of service
- the nature and complexity of their work
- the individual's support needs ([SCIE, 2017](#)).

There will be times when supervision is needed with greater frequency, such as, for newly qualified staff joining the workforce who will benefit from preceptorship/enhanced supervision in the period immediately following graduation. [Flying Start NHS®](#) is a development programme that supports AHP graduates commencing in their first post in Scotland. Increased supervision will also support staff moving into new roles or work environments and during times of organisational change/service redesign.

Those working in a psychological setting with people who have experienced abuse or trauma or working with child or adult safeguarding concerns will require more frequent supervision. In addition, AHPs using specific therapeutic interventions may require supervision for that particular intervention. This type of supervision will depend on the requirements/expectation of the model or intervention (e.g. Cognitive Behaviour Therapy or psychotherapy).

The HCPC publication "Preventing small problems from becoming big problems in health and care" (HCPC 2015) highlights poor or infrequent supervision as a potential trigger for disengagement. The consensus views on ways of preventing problems include: good supervision; regular appraisal and performance management; buddying schemes; mentoring; preceptorship; professional networks; reflective practice and keeping up to date. Other triggers for disengagement that may highlight the need for increased supervision include: workload pressures, professional isolation and personal circumstances.

Time allocated per supervision session should be adequate to address the aims and objectives of the specific session. The evidence suggests that most supervision sessions are for approximately one hour (Holmes et al 2010, Dawson 2013, Lambley and Marrable 2012). This will vary according to circumstances.



### 6.3 Methods of Delivering Supervision

There are several ways supervision can be organised, the most common being one-to-one discussions or meetings. Other methods which may be appropriate are group supervision, team supervision or action learning sets. Methods of delivery are appropriate for different situations and each have their own benefits or limitations.

### 6.4 Managerial, Professional and/or Operational Lead

AHP Professional Leads have overall responsibility to ensure all professional staff within their remit have access to appropriate supervision. In order to support their own professional practice/supervision requirements, AHP Directors/Associate Directors/Leads are able to seek advice from the Chief Health Professions Officer's team.

To allow for provision of supervision, it is anticipated that managers/leads will commit to offering protected time so that staff can plan for and engage meaningfully in their supervision sessions.

### 6.5 Responsibilities of Supervisors and Supervisees

Supervision requires a supportive relationship that is formed between equals (Faugier and Butterworth 1994, cited in Dawson 2013). From the outset, the supervisor and supervisee should be clear about their expectations and agree and maintain their roles and responsibilities within the supervisory relationship.

This will include:

- Working together to ensure creation of a safe environment which may include a supervision contract and agreeing ways of working.
- Planning: including agreed items for discussion are drawn up at the start of each supervision meeting with contribution from both supervisor and supervisee.
- Reviewing and agreeing decisions made at previous supervision meetings.
- Methods of recording.
- Supervision should be seen as a priority, which the supervisor and supervisee have committed to. Any postponed or cancelled sessions should be reconvened at the earliest opportunity.

### 6.6 Learning and Development for Supervision

The provision of supervision carries learning and development implications for all practising AHPs. The skills, values and competence of a supervisor and supervisee are crucial to the effective quality. These will build on existing communication, facilitation approaches and skills learned through informal and formal education, professional development and experiential learning. It is recognised that the most confident and competent supervisors are those who have received good quality supervision themselves.

Supervisors and supervisees must have access to learning and development opportunities to enable them to engage with their supervisory roles. Supervisors at all levels will undertake learning related to supervision within an agreed timescale of taking up their first supervisory role. Check what local opportunities and resources exist. National support is available from NES to facilitate the implementation of supervision processes and the support and supervision section of the [Post Registration Career Development Framework resource](#) has a variety of resources which learners may find helpful. The [NMAHP Clinical Supervision](#) resource has been created to support all healthcare practitioners develop relevant knowledge and skills for participating in clinical supervision. Staff should be appropriately trained for any supervisory role that they are asked to undertake.

AHPs new to the supervisory role may benefit from shadowing an experienced supervisor to gain some experience of the process, as deemed appropriate and with consent of all involved. Time should be made available for supervisors to attend appropriate introductory and advanced training courses. Ongoing CPD should be available to supervisors to consolidate skills and update practice.

### 6.7 Interpersonal Relationship within the Supervision Context

It is important that AHPs are supported to be aware of how working with varying client groups can impact upon themselves and their colleagues, and to be mindful of the implications of this on their practice and wellbeing. In light of this AHPs should have access to ways and means that allow them to reflect upon and to process such issues.

The supervisor should ensure that staff are supported to address any issues such as work related stress, personal issues, team dynamics and relationships. There may be times when personal experiences and issues cannot be dealt with within the supervisory relationships. In such instances, there may be a need for some additional support in line with local policies and procedures.

## 6.8 Confidentiality

Supervision sessions are, in general, confidential exchanges between supervisor and supervisee. However, the supervision record is an organisational document which may be seen by others if required. The record may also be used where there are situations like grievances or disciplinary proceedings, without the consent of the parties involved. The supervision agreement process should clarify the constraints upon confidentiality and where records are kept in electronic format, security access levels will need to be agreed. All data must be kept and managed in accordance with relevant legislation and the organisation's data handling policies and procedures.

**All parties must be informed of the intention to disclose, before revealing confidential information.**

Examples of circumstances where information may need to be shared include:

- When it is agreed that there is a specific issue or learning point that would be beneficial to share.
- Disclosure relates to harm or risk to self or others.
- Contravention of law, professional code or conduct or local policy comes to light.

In considering confidentiality, supervisors and supervisees need to consider duty of candour legislation and associated HCPC standards. This may include the requirement to be open and honest when things go wrong and escalate concerns they have about safety and wellbeing.

## 6.9 Use of Patient/Client Records

Where supervision is focused on case discussions/review or application of clinical reasoning, patient/client records may be used to support this activity. This will be particularly relevant to new graduates and to aid complex case discussions. Where this happens, the staff code of ethics and confidentiality will apply.

Organisations employing professional staff members who make such records are the legal owners of those records.

## 6.10 Storage of Records

Each organisation has its own policy for the safe storage of records. All staff members should be mindful of his/her professional accountability with regards to the principles of confidentiality of information.

## 6.11 Supervision Implementation Plan

Each organisation should have an agreed plan for the implementation of supervision practices for AHPs based on the guidance highlighted in this statement. These should be agreed with appropriate professional and operational line managers.

## 7. MONITORING AND EVALUATION OF SUPERVISION

Ongoing monitoring and evaluation of supervision activity is essential to ensure that supervision policies and procedures are meeting service need and that they are addressing all four components of supervision. It is also necessary to monitor the benefit to individual staff, clients and the organisation, since the quality of supervision activities can influence effectiveness, reduce risk and promote safe and effective care.

Local arrangements need to be developed to determine what information requires to be gathered to give AHP Directors/Associate Directors/Leads assurance that supervision is in place and effective.

## 8. PROFESSIONAL GOVERNANCE

Each Health Board area and Health & Social Care Partnership has Professional Assurance Frameworks that will articulate local professional governance arrangements. Scotland's National Statement on Supervision for AHPs has been designed to support local frameworks and is underpinned by the professional standards detailed by the HCPC and individual AHP professional bodies.

## 9. REVIEW

Given the importance of supervision, this statement should be reviewed by the AHP Directors Scotland Group every two years and amended in accordance with clinical governance standards and relevant professional and government guidelines.

There is recognition of the increasing demands on AHP services. This statement is not prescriptive in nature but aims to support staff to undertake supervision.

## 10. REFERENCES AND SUPPORTING DOCUMENTS

Daly, E., Muirhead, S. (2015), Leading Change in Supervision, Messages from Practice, The Institute for Research and Innovation in Social Services (IRISS)

Dawson, M. (2013), Allied Health Professionals Perceptions of Clinical Supervision, Doctorate Thesis, Doctor of Public Health, La Trobe University, Victoria, Australia

Department of Health (1993), A Vision for the Future: The Nursing, Midwifery and Health Visiting Contribution to Health and Health Care, HMSO, London

Health Care Professional Council (2012), Standards of Continuing Professional Development, HCPC, available at <http://www.hpc-uk.org/registrants/cpd/>

Health Care Professional Council (2013), Standards of Proficiency, HCPC, available at <http://www.hcpc-uk.org/aboutregistration/standards/standardsofproficiency/>

Health Care Professional Council (2016), Standards of Conduct, Professionalism, and Ethics, HCPC, available at <http://www.hcpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics/>

Health Care Professional Council (2015), Preventing small problems from becoming big problems in health and care, HCPC, available at <http://www.hpc-uk.org/publications/research/index.asp?id=1009>

Helen & Douglas House (2014), The Helen & Douglas House Clinical Supervision Toolkit, available at [http://www.helenanddouglas.org.uk/get\\_information/useful-resources/](http://www.helenanddouglas.org.uk/get_information/useful-resources/)

Holmes, L., Munro, E.R. and Soper, J. (2010), Calculating the cost and capacity implications for local authorities implementing the Laming (2009) recommendations, Loughborough: Centre for Child and Family Research, Loughborough University

Lambley, S. and Marrable, T. (2012), Practice enquiry into supervision in a variety of adult care settings where there are health and social care practitioners working together, Report to SCIE, Brighton, University of Sussex

NHS Lanarkshire (2010), High Challenge High Support, Professional/Clinical Supervision Handbook for Allied Health Professionals

Pollock, A. et al (2017), A systematic review of evidence relating to clinical supervision for nurses, midwives and allied health professionals, JAN, Vol, 73, Issue 8

NHS Education for Scotland, NMAHP Clinical Supervision resource  
<https://learn.nes.nhs.scot/3580/clinical-supervision>

NHS Education for Scotland, Post Registration Career Development Framework <http://www.careerframework.nes.scot.nhs.uk/support-and-supervision.aspx>

Scottish Government (2009), Mandatory Induction Standards and Codes, Scottish Government, available at <http://www.hcswtoolkit.nes.scot.nhs.uk/resources/hcsw-standards-and-codes/>

Scottish Government (2013), Everyone Matters: 2020 Workforce Vision, Scottish Government, available at <http://www.workforcevision.scot.nhs.uk/vision-development>

Scottish Government (2013), Allied Health Professions Scotland Consensus Statement on Quality Service Values, Scottish Government

Scottish Government (2014), Care and Support in Scotland, Scottish Government, available at <http://www.gov.scot/resource/0045/00453891.pdf>

Scottish Government (2015), Social Services in Scotland: a shared vision and strategy 2015-2020, Scottish Government, available at <http://www.gov.scot/Topics/People/social-services-workforce/SWSSF/visionandstrategy>

Scottish Government (2016), National Clinical Strategy for Scotland, Scottish Government, available at <http://www.gov.scot/Publications/2016/02/8699>

Scottish Government (2017), National Health and Social Care Workforce Plan - Part 1 a framework for improving workforce planning across NHS Scotland, Scottish Government, available at <http://www.gov.scot/Publications/2017/06/1354>

Scottish Government (2017), National Health and Social Care Workforce Plan - Part 2 a framework for improving workforce planning across NHS Scotland, Scottish Government, available at <http://www.gov.scot/Publications/2017/12/2984>

Scottish Social Services Council (2015), Leadership learning pathways for Scotland's social services, SSSC, available at [http://www.stepintoleadership.info/assets/pdf/what\\_is\\_supervision.pdf](http://www.stepintoleadership.info/assets/pdf/what_is_supervision.pdf)

Scottish Social Services Council (2016), Social Services Codes of Practice for Social Service Workers and Employers, SSSC, available at <http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications/37-about-the-sssc/information-material/61-codes-of-practice/1020-sssc-codes-of-practice-for-social-service-workers-and-employers>

Social Care Institute of Excellence (SCIE), (2013) (updated 2017), Effective supervision in a variety of settings, SCIE Guide 50, SCIE available at <http://www.scie.org.uk/publications/guides/guide50/contextforeffectivesupervision/index.asp>

## Acknowledgments:

Adapted with permission from the Regional Supervision Policy for Allied Health Professionals, Department of Health, Social Services and Public Safety (Northern Ireland).

This resource may be made available, in full or summary form, in alternative formats and community languages. Please contact us on **0131 656 3200** or email [altformats@nes.scot.nhs.uk](mailto:altformats@nes.scot.nhs.uk) to discuss how we can best meet your requirements.



NHS Education for Scotland  
Westport 102  
West Port  
Edinburgh  
EH3 9DN

[www.nes.scot.nhs.uk](http://www.nes.scot.nhs.uk)

© NHS Education for Scotland 2018. You can copy or reproduce the information in this document for use within NHSScotland and for non-commercial educational purposes. Use of this document for commercial purposes is permitted only with the written permission of NES.