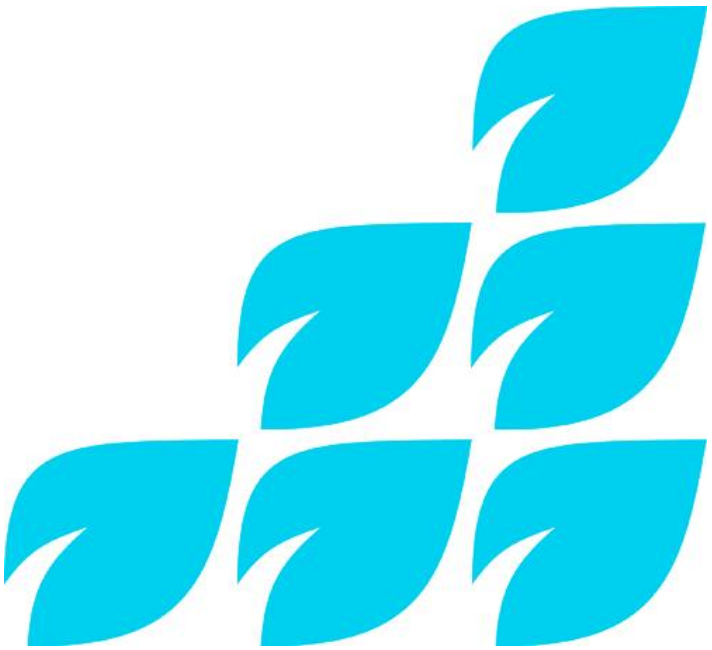
The Association of UK Dietitians

Practice Supervision guideline for the dietetic workforce



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Contents

Introduction

This guideline has been developed through extensive member engagement and is relevant for all dietitians and the support workforce across all four nations of the UK.

It details the definitions and process of supervision, gives examples of scenarios that may be encountered and provides some practical tools that can be used when implementing supervision in any environment.

The BDA recognises the importance of supervision at all levels and recommends a robust supervision structure is in place to support the dietetic workforce throughout your career.

What is supervision?

Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individuals to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety of care. This is discussed in more detail under *Defining supervision.*

Aim of the guideline

This guideline aims to support you and your employer to:

- better appreciate the different forms of supervision and the governance by which it is supported
- learn more about the models and theories which underpin supervision

- appreciate that definitions of supervision vary between professions, regulatory bodies, and employing organisations
- appreciate and value the role that supervision plays in supporting practitioner well-being and lifelong learning
- understand the importance of accessing safe and effective supervision
- seek opportunities to develop your supervisory skills through training and participation

Why should I have supervision?

The BDA strongly recommends that the whole dietetic workforce partakes in regular, effective supervision to ensure safe practice, and support the wellbeing of practitioners. The role that supervision plays in wellbeing has come to the forefront in recognition of the immense pressure experienced by staff working in health and care services during and in the aftermath of the COVID-19 pandemic[1]. Research into the impact of the pandemic on health and care staff has primarily focussed on doctors, nursing and ambulance staff but is likely to be seen across all professions. It demonstrates that exposure to distressing events over a prolonged period results in moral distress and moral injury which is likely to be harmful to a person's wellbeing[2][3][4]. Supervision can provide a safe space for this to be explored which can reduce the likelihood of events impacting negatively on wellbeing.

The benefit of supervision is also recognised by regulatory bodies. In 2019, the Health and Care Professions Council (HCPC) commissioned a rapid evidence review that identifies the clear benefits of supervision for health and care staff and the detrimental impact that is seen when it is absent[5]. The evidence within the review demonstrates that effective supervision has a positive impact on staff retention, job satisfaction and staff wellbeing. It has been linked to an ability to promote innovation, confidence, and an improved leadership potential, as well as reducing stress and anxiety. Staff, service-users and employer's all benefit, as the overall impact is seen through an increased quality of care delivery. This is demonstrated for those in both clinical and non-clinical roles.

The HCPC Standards of Proficiency were updated in 2023 to require all registrants to take steps to support their own wellbeing to ensure they are mentally fit to practise. Engaging in

[1] https://www.nursingtimes.net/roles/newly-qualified-nurses/using-restorative-supervision-to-help-nurses-during-the-covid-19-pandemic-14-02-2022/
[2] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/creating-a-healthy-workplace/moral-distress-in-the-nhs-and-other-organisations
[3] https://www.rcn.org.uk/magazines/bulletin/2021/may/moral-distress
[4] https://pubmed.ncbi.nlm.nih.gov/36276556/
[5] https://www.hcpc-uk.org/globalassets/resources/reports/research/effective-clinical-and-peer-supervision-report.pdf?v=637147781260000000

regular supervision, with particular focus on its restorative function, is therefore an effective way to do this.

Registered dietitians

Dietitians registered with the Health and Care Professionals Council (HCPC) are required to meet all the regulatory standards to practise within the UK. Whilst there is no specific requirement surrounding supervision, the HCPC standards recognise that supervision plays an important part in professional development and lifelong learning. Registered professionals are required to meet HCPC Standards for Continuing Professional Development (CPD) and at each renewal, you will be asked to sign to confirm that you continue to meet these. If you are selected for CPD audit, being able to demonstrate that you have regularly participated in supervision is an important way to evidence that you meet the standards. Supervision is, therefore, a specific and crucial type of CPD.

Non-registered support workforce

While the non-registered support workforce is not required to meet the HCPC standards, participation in regular supervision is important and supports staff development and safety in practice. There are also considerations around supervision and delegation. This is discussed further under *Dietetic Support Workforce.*

Your employer's responsibility

For practitioners employed within services providing regulated activities, such as NHS organisations or private organisations delivering NHS care (for example GP practices and primary care networks), the employer has a responsibility to ensure that there are structures in place to allow the opportunity for staff to access supervision.

In Northern Ireland, the Department of Health states in the regional supervision policy[6] that:

"...it is important that effective governance and accountability arrangements are maintained to achieve and assure safe and effective care. Good quality supervision underpins high quality safe practice".

It is outlined in the Health and Social Care Act (England & Wales)[7], Regulation 18: Staffing which states;

[6] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-rev-reg-supervision-policy-ahp-march-2022.pdf
[7] https://www.cqc.org.uk/guidance-providers/regulations/regulation-18-staffing

"Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities".

In Scotland, a position paper[8] on AHP supervision states:

"All AHP practitioners, irrespective of their level of practice or experience, should have access to, and be prepared to make constructive use of supervision".

Defining supervision

There are different types, purpose and functions of supervision but no single agreed definition which can lead to confusion and misunderstanding. A definition frequently used within health and care professionals quoted by the Department of Health (1993)[9] states;

'(clinical) supervision is a term used to describe a formal process of professional support and learning, which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety or care in complex clinical situations. It is central to the process of learning and to the scope of practice and should be seen as a means of encouraging self-assessment and analytical and reflective skills'.

It must also be recognised that professional bodies and organisations may use different terminology for types, purpose and functions of supervision. Dietitians will frequently receive supervision as part of a multi-professional team and where differing terminology is being used, this can add to the confusion. As such, communication between practitioners should focus on confirming the purpose, or function, of the supervision, rather than what it is called. To do this, it can be helpful to consider popular theoretical models that underpin supervision.

Theoretical models of supervision

There are many theoretical models that can be used to underpin the implementation of supervision within your own workplace. A popular framework often quoted within nursing and which many other models are based on is 'Proctor's three function model' (also known as the 'supervision alliance model')[10].

[8] https://learn.nes.nhs.scot/6852
[9] Department of Health. (1993). A vision for the future: The nursing, midwifery and health visiting contribution to health and health care. Department of Health.
[10] https://www.nhsemployers.org/articles/clinical-supervision-models-registered-professionals

This describes three separate purposes or 'functions' of supervision, that together ensure practitioners are considering their personal wellbeing alongside their professional development.

Function 1- *Normative* which focuses on the managerial aspects to learning which could include mandatory training and continuing professional development (CPD).

Function 2 – *Formative* which focuses on the educative aspect of developing knowledge and skills in professional development and using self-reflection for self-awareness development. The aim is "to become increasingly reflective upon practice" within the supervision process developing self-awareness through reflective practice. This builds the practitioners self-reliance to develop their own knowledge and skills.

Function 3 – *Restorative* focuses on the health and well-being of professionals who may be working constantly with stressful and distressing situations. It has a supportive function that can improve stress management, allow personal development, and prevent burnout.

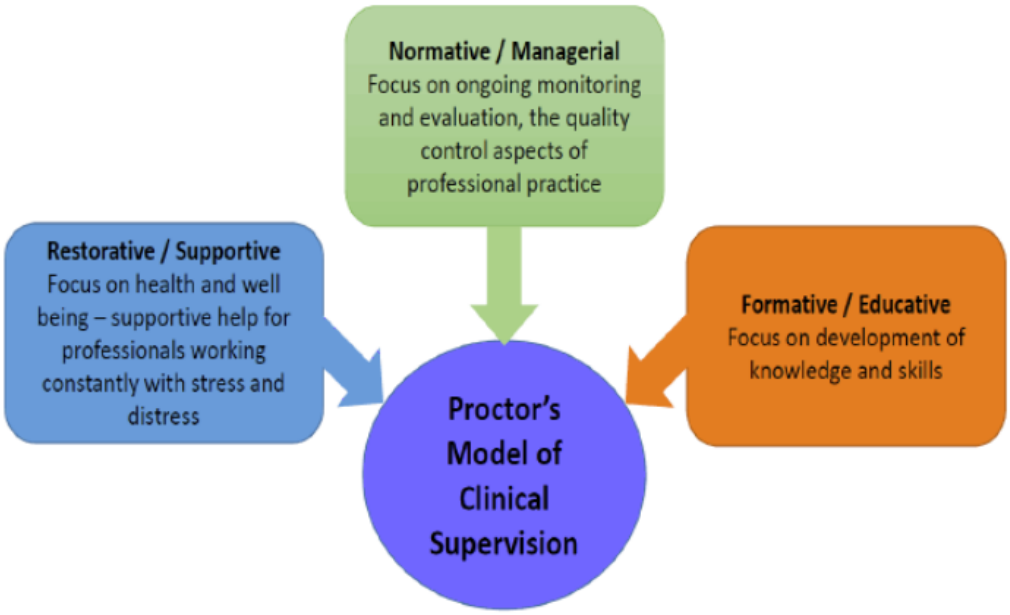

Fig1. Proctors Model of Supervision (taken from Annex B - Advanced nursing practice - transforming nursing roles: phase two - gov.scot (www.gov.scot))

Exploring the different terms used in supervision

This section aims to define the terms that the BDA uses for supervision, alongside a description of purpose. This should aid practitioners in considering the type of supervision they require and allow a shared understanding when approaching supervision sessions.

Practice and clinical supervision - These terms are often used interchangeably and are used here to describe the same thing. The BDA uses the term 'practice supervision' rather than 'clinical supervision' to ensure inclusivity of the whole of the dietetic workforce. Clinical supervision may align more with those who deliver clinical care or work within NHS services, but many dietitians will be a 'practising' dietitian, even if they do not deliver clinical care. For example, a dietitian working in academia as a lecturer for a pre-registration dietetic programme. As such, using the term practice, rather than clinical, recognises this. Practice supervision is also the term used by the HCPC with the following definition;

"...supervision is a process of professional learning and development that enables individuals to reflect on and develop their knowledge, skills, and competence, through agreed and regular support with another professional" (HCPC, 2021[11])

Purpose of practice supervision - Practice supervision is about supporting and enhancing practice, by enabling a person to reflect upon and review their work. It should take place on a regular basis (see *Frequency of supervision*), to enable continued support. Unlike management supervision, practice supervision should be led by the supervisee so that they can identify individual training and development needs. It does not need to be facilitated by a supervisor working at a higher level, but they do need to be competent to provide the supervision and have the relevant skills qualifications and knowledge[12]. In most cases, they do not need to be from the same professional background*, but they must still understand a dietitian's scope of practice and delegate to another supervisor where necessary.

Practice supervision aims to:

- establish a confidential learning environment with guided reflective practice that allows the individual to learn from positive and challenging experiences
- enable a continuous improvement approach by supporting practitioners to discuss areas of their work or service that they feel are both effective and less effective

[11] https://prod.hcpc-uk.org/standards/meeting-our-standards/supervision-leadership-and-culture/supervision/what-is-supervision/
[12] https://www.hcpc-uk.org/standards/meeting-our-standards/supervision-leadership-and-culture/supervision/approaching-supervision/guidance-for-supervisors/

- assist practitioners in reflection to narrow the gap between theory and practice. This exercise may use recognised reflection models, such as Gibbs Reflective Cycle[13].
- support CPD by helping to identify and respond to any learning needs which will help a practitioner ensure that their skills and knowledge are up to date
- reflect on professional issues which may be causing concerns, with an aim to promote own health and well-being, reduce stress and risk of burnout and improve service-user experience
- assist practitioners in ensuring their practice is evidence-based
- promote confidence within practice
- Provide a space to discuss and reflect on complex cases, including safeguarding discussions.
- Support practitioners to maintain safe practice within their scope and adhere to the HCPC professional standards.

*Within mental health settings, such as eating disorders and CAMHS, the quality standards[14] recommend that supervision is delivered by someone from the same profession with appropriate clinical experience and qualifications. As such, the BDA position is that dietitians working in these environments should receive practice supervision by a suitably experienced dietitian.

Management supervision – Is usually conducted by someone in a position of authority who may or may not be working at a higher level. They may have line management accountability for the supervisee and so this supervision may also encompass appraisal and performance review. They may or may not be from the same professional background. This supervision, although still collaborative, is more likely to be led by the supervisor.

Purpose of management supervision – Management supervision may be more focussed around service needs and the contribution that the supervisee plays in this. It may be used to formulate job plans, agree annual leave and sickness monitoring, discuss recruitment, review mandatory training compliance, discuss caseloads, and risk assessments. It may also include personal matters by agreement, such as personal concerns that may require management support. An example may be if an individual requires a temporary adjustment to their working pattern.

[13] https://portal.e-lfh.org.uk/LearningContent/LaunchFileForGuestAccess/642117
[14] https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/eating-disorders-qed/qed-community-standards---third-edition.pdf?sfvrsn=e8b3aebc_4

Management supervision aims to:

- support practitioners to adhere to the HCPC professional standards
- enable practitioners to meet their formal appraisal objectives by collaboratively establishing personal development plans that identify and meet their development needs
- monitor progress collaboratively and identify professional development needs in relation to service delivery
- provide advice on managing key performance indicators, caseloads, and issues that may cause problems in the day-to-day functioning of a service, such as in planning annual leave and other absence
- Ensure practitioners are aware of the expectations within their job description and enable practitioners to fulfil these.

Restorative supervision - Aims to support the needs of practitioners working with clinically complex caseloads or in roles which are emotionally demanding and require difficult decision making. Examples within the dietetic workforce could include working in mental health settings or with terminally ill people. Most practitioners at some point in their career will work with people experiencing psychological distress. Restorative supervision provides a place to explore this to ensure that unspoken feelings do not impact on your wellbeing.

Restorative supervision can be facilitated by a dietitian suitably trained with appropriate counselling and reflective skills. It can be of benefit to receive supervision from a clinical psychologist (if available) as their skillset is focussed on creating a safe space for discussion and reflection which can be particularly valuable for this process.

Purpose of restorative supervision – The predominant purpose and function of restorative supervision is that of supporting people with the emotional demands of their role. It is well documented[15] that when practitioners undertake complex clinical work, they may experience anxiety, fear or stress. This can lead to compassion fatigue[16] and burnout. It is for this reason that restorative supervision aims to support practitioners to process these feelings that then allow the focus to shift to identify solutions that develop and preserve resilience. It may be, for some practitioners, that this restorative function is met through existing practice or management supervision sessions. In some specialist areas, restorative supervision may be needed on a regular basis.

[15] 93f92d1d-0cdf-4898-b47b-28f00bbcde42_NESD0835_UNIT 1- FUNDAMENTALS OF CLINICAL SUERVISION(v4) (1).pdf (windows.net)
[16] https://journals.sagepub.com/doi/full/10.1177/09697330211003215

Restorative supervision aims to:

- build up compassionate resilience, which can support those working in roles where they are experiencing significant emotional demand
- reduce stress and burnout and increase compassion satisfaction
- have an immediate positive impact on the well-being of staff

These definitions demonstrate that each type of supervision has a distinct purpose, therefore a practitioner may need to link in with different supervisors to keep these elements separate. This will enable a practitioner to openly reflect and improve practice while being able to maintain and distinguish clear boundaries. If it is not possible for practice, management, and restorative supervision to be delivered by different people, there should be clear communication between the supervisor and supervisee about the nature of the session to ensure transparency and shared understanding of purpose.

Informal supervision – Also termed 'professional support' by HCPC, this is more focussed on everyday work practices. It is provided on an ad hoc and less formal basis and is unlikely to be with the named supervisor. It may be provided from a wide variety of people, groups, and sources.

Purpose of informal supervision – Informal supervision is essential to enable individuals to learn about the daily workplace practice and procedures through exchange of information and sharing of expertise. While practitioners and managers at all levels of experience benefit from this, it is particularly important for newly qualified practitioners (NQP), non-registered staff to aid delivery of delegated care, those new to an organisation/team/role and those working in isolation. The nature of informal supervision – being ad hoc and not documented – may mean that it is not always recognised as supervision.

Informal supervision aims to:

- support practitioners in managing their day-to-day cases and workload
- reduce stress by providing means to discuss distressing or complex situations
- provide joint working opportunities through open discussion to identify where this would benefit the service user and practitioner(s)
- provide informal peer learning opportunities and peer support
- provide opportunities to access specialist advice where this is needed to support clinical judgement and decision making e.g. "can I run this scenario past you?"

For informal supervision to be effective, services need to create a culture of openness and trust where individuals feel empowered to ask for support. There needs to be honest 'open door policies' so that individuals needing support do not feel that they are a burden to others. This is of the highest importance considering the sustained pressure experienced within health and care services over recent years and is key to retaining our workforce[17].

One disadvantage of informal supervision, however, is that the time needed for considered discussion may not be held equally by both parties. Its impact should be sensitively monitored to ensure that accessing support to those in need does not negatively impact on those who provide it.

As with all supervision, informal supervision needs to be confidential and non-judgmental.

A few real-life scenarios are given below to highlight the difference between management, practice, restorative and informal supervision.

Example 1 – caseload management for inpatient wards

Management supervision – During your regular supervision session with your team leader, you are asked to discuss how you are coping with your caseload. This is important for the team leader to understand as there is a need to consider whether extra work can be distributed across the team because there are vacancies, and one person is on long-term sick leave. This discussion may relate to how your caseload compares to departmental standards or waiting times. It may consider what the identified Key Performance Indicators (KPI) are, what the BDA safe staffing document details and how the referral rate compares. You may then discuss your job plan and determine if there is scope for making changes, on a short-term basis while staffing is poor, to improve overall performance against the standards. You highlight to your line manager that you feel you are at capacity, and you discuss whether additional resources, such as an extra session with a dietetic support worker may be helpful. As you are new to your current rotation and are currently supporting a dietetic learner, you agree that no changes will be made to your job plan, and this will be reviewed again at the next session. The agreed actions from this management supervision session are documented on your supervision template.

Practice supervision – As a newly qualified dietitian, your regular practice supervision session is with a more experienced dietitian. As practice supervision is led by the supervisee, you suggest that you would like to discuss caseload management. You reflect

[17] https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/#3-retain-embedding-the-right-culture-and-improving-retention

on how the high caseload expectation in your current rotation can sometimes make you feel overwhelmed and that you seem to struggle and worry about this more than others. This means that you often leave the office later than your finish time and you have sometimes been worrying about work at the weekend. You know that the caseload expectation for you is the same as your other colleagues, but you seem to worry about it more than them.

You find that sharing these feelings is helpful as your supervisor has constructively challenged and encouraged you to reflect on this scenario meaning you can generate solutions that may improve this situation. This discussion also helps you to identify that you seem to worry more about the caseload when there are high numbers of a certain type of referral so it may be that you have a learning need in this area. Your supervisor suggests that you may find it helpful to spend your next CPD session researching or shadowing a more experienced colleague to identify and address any gaps in knowledge and to see how their practice may differ to yours. You also agree that you will present a Case Based Discussion on this at your next supervision session. These agreed actions are documented on your supervision template to revisit at your next formal practice supervision session.

Informal supervision – While on the ward, you are asked to provide a feeding regimen for a new service user who has been transferred from the nearby mental health hospital. You are advised that they have met the criteria for compulsory admission and treatment under the Mental Health Act and that a nasogastric tube has been inserted for feeding. Whilst you are familiar with nasogastric tube feeding and regimens, you have never been involved in a situation where the treatment is compulsory. As such, you phone a more experienced dietetic colleague for advice. This support and guidance enable you to confidently put an appropriate care plan in place and means you will feel more comfortable if presented with this scenario in future. You may find that imposing this type of feeding on this service user has left you with uncomfortable feelings. This sort of scenario may be explored through **restorative supervision** that ensures unspoken feelings do not impact on your wellbeing or your decision making.

Example 2 - Transitional roles

Management supervision – Three months ago, you transitioned from a role in adult dietetics to paediatric dietetics. Your regular supervision session with your team leader is due and as you have been in your new role in paediatrics for 3 months, you are preparing for your initial performance review. You are asked to discuss how you are finding the transition into the new role which is important for the team leader to understand to establish if your job plan is appropriate. This discussion may highlight that more clinical activity needs to replace the dedicated time you were scheduled in your job plan for

shadowing and self-directed learning in the first 3 months. Your team leader may highlight that you have a lot of outstanding annual leave to take before the end of the year which needs to be scheduled so that the new clinical activity can be booked around this. You may discuss that you have identified a specific CPD opportunity that would enable you to provide a better service for users. The agreed actions from this management supervision session are documented on your supervision template.

Practice supervision – Your regular practice supervision session is between yourself and an experienced paediatric dietitian. As practice supervision is led by the supervisee, you suggest that you would like to discuss the differences between working with adult and paediatric service users. You reflect on how challenging it can be to meet the expectations of both the service user and the parents/carers, especially for older children and that this was not something you had considered prior to moving into the role. You discuss that you are aware of how much social media influences some of your service users which you feel is different to working with adults.

You find that sharing these feelings is helpful and your supervisor has encouraged and constructively challenged you to reflect on this scenario. This means you can generate solutions that may help you more easily manage your interactions with the service user and the parents /carers. You identify that spending time with a paediatric professional outside of your specialist area may help you to enhance your communication skills with parents and you therefore agree to schedule this into your next CPD session. These agreed actions are documented on your supervision template to revisit at your next formal practice supervision session.

Informal supervision – While attempting a telephone review, a parent becomes verbally abusive and won't allow you to speak with the service user. They then hang up the telephone, you call back immediately but there is no answer. You have never experienced this before and therefore go into the office to discuss with one of your colleagues. As well as providing informal peer support, this provides you with guidance that allows you to consider the options available to you so that you can take the appropriate next steps. You may find that being verbally abused in this way has left you with uncomfortable feelings. This sort of scenario may be explored through **restorative supervision** that ensure unspoken feelings do not impact on your well-being.

Management, practice and restorative supervision

As previously defined, management, practice and restorative supervision all have different functions, therefore, to be effective, they need to be delivered by different people. In

instances where this cannot be achieved, providing a clear delineation and description of its purpose and focus ahead of each scheduled session will be necessary.

Whilst some topics can easily be identified as management, practice or restorative, others may overlap or be looking at the same topic through a different lens. It is for this reason that both the supervisor and supervisee must be able to recognise when the boundaries overlap which may then signal that a review of the supervision agreement or escalation is required. For instance, in *Example 1 – caseload management for inpatient wards)* at the next practice supervision, your concerns around managing your caseload may have worsened. This may then necessitate escalation to the team leader who has the authority to consider making changes to your job plan.

Supervision throughout your career

Supervision is important at all stages of your career, regardless of your role. The type, frequency and intensity of supervision required will change as you develop your skills. For example, for newly qualified practitioners (NQP), the first 12months of registration is a period of rapid professional development to make the transition from learner to a novice autonomous professional. Supervision at this stage of career development is therefore likely to be required more frequent than someone who has been qualified for many years. It can take many forms including supervision with a more experienced dietitian at the same level or a dietitian at a higher level. There may be opportunities for peer learning and journal clubs with other newly qualified dietitians. Informal supervision may be required multiple times daily initially, becoming less frequent as you become familiar with organisational procedures. Formal practice supervision sessions should also be scheduled on a more regular basis initially.

For this reason, the BDA does not recommend that NQP work as locums, undertake bank work or work in independent / freelance practice without there being a clear structure in place for supervision with an appropriate registered dietitian. To meet this requirement, you may need to source this independently at personal cost, see *What does good supervision look like?* and *How to identify a suitable supervisor.*

Supervision is likely to look different for more experienced dietitians. They may be looking to extend their scope and take on a specific skill or task not traditionally undertaken by a dietitian which would require multi-professional supervision. For example, a dietitian may be upskilling to undertake dysphagia assessments and require supervision from a competent Speech and Language Therapist. They may be learning to place nasogastric tubes and retaining devices therefore it may be that a competent nutrition nurse is the

supervisor. These skills are acquired through training and assessment and may require intense, direct supervision for a period (see *Levels of supervision*).

There may be occasions where dietitians find that they are the most senior or the most experienced clinical dietitian in their team, service or organisation. There may even be occasions when they are the only dietitian in their organisation. This is sometimes seen in primary care, in eating disorder or mental health services. Those working in private practice are also likely to be working in isolation. These situations highlight that there should not be a 'one size fits all' approach to supervision and that a flexible approach is often needed to ensure that the supervisee derives the intended benefit that allows practice to be enhanced.

Dietetic Support Workforce

Dietetic Support Workers (DSW) work alongside dietitians but are not regulated by the HCPC. Similarly to registered staff, to develop the relevant knowledge and skills necessary to competently carry out their role, they require regular supervision. As DSW are non-registered staff, tasks and responsibilities they perform will be delegated to them by a registered professional. It is a HCPC requirement that the registered professional takes responsibility to provide appropriate supervision and support to whom they delegate work[18]. This can be met by ensuring access to informal supervision whenever it is required, which may be multiple times daily, weekly or less frequently depending on the experience of, and caseload delegated to, the DSW. This will ensure that the DSW is confident and competent in completing delegated tasks but also meets the HCPC standards of proficiency for safe practice[19].

Equally important though is access to formal practice, restorative and management supervision. DSW are likely to be exposed to the same challenging and distressing situations as their registered colleagues and the restorative function of supervision, is therefore, similarly needed. Whilst a registered dietitian does need to fulfil the supervision requirements of delegated care, experienced DSW who have had appropriate training could facilitate practice supervision for other DSW colleagues. Training is discussed under *Training for supervisors*.

Dietetic managers

Managers who are registered dietitians are still required to meet the HCPC Standards, even if they are in a non-clinical role. As such, access to supervision will still benefit their learning and wellbeing. Dietetic managers are more likely to access supervision from peers

[18] https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/
[19] https://www.hcpc-uk.org/standards/standards-of-proficiency/dietitians/

who are outside their profession or other dietetic managers in their region. They may also benefit from coaching and mentoring which is different to supervision. As with all supervision, the mode should be led by the individual based on their identified learning need.

Modes of Supervision

While people may often think of formal supervision as taking place in one-to-one meetings, it can take many different forms. As practice supervision is supervisee led, it will be for the supervisee to agree with the supervisor their preferred mode of supervision. This should be clearly detailed in the supervision agreement and reviewed regularly to ensure it continues to be fit for purpose.

Modes can include:

- one-to-one supervision
- group supervision in which two or more practitioners discuss their work with a supervisor
- peer supervision where practitioners discuss work or clinical cases with each other with no-one acting as a formal supervisor

Supervision does not need to be conducted in person, it can also be conducted by telephone, through video calls or a combination of all of these. Choosing the most appropriate delivery mode and channel may depend on the *Levels of supervision* required.

Levels of supervision

The level of supervision[20] refers to the proximity your supervisor has to your practice. For supervision to be effective, it does not require your supervisor to observe your practice but there are times when this will be appropriate and necessary. An example would be if you are undertaking an extended scope task and your supervisor needs to demonstrate, observe, and assess you performing the task. Another example could be where you have moved into a new clinical speciality, and you have agreed with your supervisor to take turns consulting with service users. This provides opportunities for new learning, immediate feedback, and reflection.

Levels of supervision are:

- direct, where a supervisor provides face to face guidance and support

[20] https://www.hcpc-uk.org/standards/meeting-our-standards/supervision-leadership-and-culture/supervision/approaching-supervision/guidance-for-supervisees/

- indirect, where a supervisor is readily available and within close proximity to provide support
- remote, where a supervisor will be available for support, but will not directly oversee the tasks being undertaken. This may be undertaken through video conferencing or phone call

As with all aspects of supervision, the level required will vary based on the remit of the supervision relationship and should be captured in the supervision agreement.

What does good supervision look like?

Access to good quality supervision is essential to enhance an individuals practice and support lifelong learning but how do we know what good supervision looks like? The HCPC commissioned Newcastle University to undertake a literature review[21] to answer this

Ten characteristics of effective supervision:

1. When supervision is based on mutual trust and respect.

2. When supervisees are offered a choice of supervisor with regard to personal match, cultural needs and expertise.

3. When both supervisors and supervisees have a shared understanding of the purpose of the supervisory sessions, which are based on an agreed contract.

4. When supervision focuses on providing staff support the sharing/enhancing of knowledge and skills to support professional development and improving service delivery.

5. When supervision is regular and based on the needs of the individual (ideally weekly, minimum fortnightly). Ad-hoc supervision should be provided in cases of need.

6. When supervisory models are based on the needs of the individual. This may include one to one, group (peer supervision), internal or external, distance (including the use of technology)or a mix.

7. When the employer creates protected time, supervisor training and private space to facilitate the supervisory session.

8. When training and feedback is provided for supervisors.

9. When supervision is delivered using a flexible timetable, to ensure all staff have access to the sessions, regardless of working patterns.

10. When it is delivered by several supervisors, or by those who are trained to manage the overlapping responsibility as both line manager and supervisor.

[21] https://www.hcpc-uk.org/resources/reports/2019/effective-clinical-and-peer-supervision-report/

question by establishing what makes supervision effective. This review identified 10 characteristics;

Figure 2: Key characteristics of effective supervision, Rothwell et al; 2019

In establishing or reviewing the supervision offered within your service, these 10 key characteristics should be considered and embedded where practicable.

Other considerations relate to the environment and logistics of the supervision session and include:

Environment – A neutral, safe space that facilitates confidentiality is key to building an open and trusting relationship between supervisor and supervisee. Ideally this will be in a mutually convenient location, away from the usual workplace to minimise disturbance. For those working in different locations, this should be negotiated and clarified within the supervision agreement.

Time – Both parties need to respect and keep to the allocated time given for the session, particularly where people have different start and finish times to their day. These should only run over if absolutely necessary and by both parties' agreement. Time to undertake informal supervision can be a particular challenge where this may not be held equally by both parties.

Confidentiality – All content discussed in sessions must be kept confidential. The only exceptions are where there are concerns about a practitioner's conduct, competence, physical or mental health. Where appropriate, permission should be sought to share content with others outside of the supervision partnership, see *If concerns are raised during supervision*.

Documentation – It is good practice to document supervision sessions. It should be written into the supervision agreement who is responsible for this and how it will be stored. All records must be considered confidential and stored in an appropriate way to ensure security. Both parties need to be clear when the records could be requested and for what purpose. Templates for supervision documentation can be found in the Appendix of this document.

Monitoring and evaluation – The supervision activity should be monitored and evaluated on a regular basis to ensure it continues to meet service need and is addressing the 'three functions'. As individual practitioners develop, their supervision needs will change, and this may necessitate a different supervisor or amendments to the supervision agreement. Since the quality of supervision activities can influence effectiveness, ongoing monitoring

and evaluating ensures there is continued benefit to individual practitioners, service users and the organisation.

There are specific questionnaires, such as the Manchester Clinical Supervision Scale[22]developed to measure the efficacy of supervision from the perspective of the supervisor but arrangements for how supervision activities are monitored and evaluated to provide assurance of efficiency should be agreed locally.

Frequency of supervision

There is no defined frequency or duration for supervision, but it is recognised in the '10 characteristics' *above* that it needs to take place on a regular basis to be meaningful. The frequency of supervision should not be prescribed as a 'one size fits all' approach as it will depend on the career stage of the practitioner, whether in a transitional period or if taking on an extended scope task. While monitoring the frequency of the supervision is important, it is the quality and timing of the supervision – being available when necessary – which may be more significant.

The frequency of supervision needs to reflect the supervisees experience and competence within the relevant specialism and their work context (such as working part time, returning from maternity leave, working in isolation or in a team). The table below is a suggestion for the minimum frequency and duration of practice supervision, but individuals should feel able to ask for more or less based on their needs. It may be appropriate to adjust this pro rata for part time employees.

Practice supervision

Practitioner	**Minimum amount suggested**
Dietetic Support Workforce	Informal supervision available daily to manage delegated tasks. Formal practice supervision = 1 hour monthly.
NQP	Informal supervision available daily. Formal practice supervision = 1 hour weekly during the first 3 months, 1 hour monthly thereafter. Preceptorship should be **in addition** to this.
Other dietitians after NQP period	Formal practice supervision = 1 to 1.5 hours every 4 – 6 weeks.
Taking on an extended scope task	Intense, direct supervision is likely needed whilst developing competence. Frequency thereafter should be agreed as part of the supervision agreement.

[22] https://whitewinstanley.com/mcss26/

Restorative supervision should be available for the whole workforce as required. For those working in mental health settings, this is recommended to be a minimum of 1-1.5 hours every 6 weeks.

It is anticipated that management supervision will be offered in addition to the above, where possible by a different individual.

Responsibility of the supervisee and supervisor

The supervisor and supervisee are equal partners within a supervision agreement and both parties have responsibility for successful navigation of the session. The responsibility of the **supervisee** is:

- preparing for supervision sessions by keeping a log of events and identifying experiences and topics to bring to the session
- presenting issues in a way that allows the most economical use of the allocated time available
- setting and monitoring their own learning aims
- being open to discussion with the supervisor
- being open to feedback, learning to identify what is useful
- providing feedback to the supervisor to ensure the relationship stays meaningful
- take responsibility for self-directed learning that includes a commitment to ongoing professional development
- protect time for supervision. Sessions should only be cancelled in extenuating circumstances. Being 'too busy' should not be considered a reasonable reason to cancel. The restorative function of supervision means it allows the development of resilient and knowledgeable practitioners that ensures safety and wellbeing
- be aware that the supervision relationship may take time to develop and needs to be reviewed and adapted to meet your changing needs

For the **supervisor**, the responsibilities may include:

- building a safe supportive space through ensuring a welcoming environment and listening without judgement or prejudice
- clarifying and negotiating the supervision agreement to ensure shared understanding of its purpose
- having the appropriate skills and knowledge to facilitate supervision.
- respectful challenge
- giving and receiving feedback
- respecting feelings and experiences

As both partners have an equal position in the relationship, the logistics – including documentation, booking meeting rooms, scheduling appointments etc - should be discussed as part of the supervision agreement.

Training for supervisors

As with any element of practice, you should only offer supervision if it is within your scope of practice[23] meaning that supervisors must have the required knowledge, skills and experience. To obtain this, the BDA would encourage dietitians to access training in supervision skills.

Key skills and knowledge that should be obtained prior to providing supervision may include an understanding of:

- supervision definitions and purpose
- different models of supervision
- models of skills acquisition
- learning models, styles and preferences
- communication skills including facilitation, coaching, negotiation, resolving conflict and strategies for difficult conversations, creating the conditions for effective supervision, providing feedback
- reflection; theories, models and frameworks
- clinical and professional governance

How to identify a suitable supervisor

Given that the supervision relationship is based on mutual trust and respect, getting the right supervisor is crucial to facilitate high quality interactions that deliver meaningful benefits. Supervisees should be able to choose their own supervisor for all types of supervision other than management. Dietitians early in their career (especially NQP), the support workforce and those new to a service may require help to identify an appropriate supervisor and may initially require one to be allocated to them.

As practice supervision is your choice and supervisee led, the selection for this should be based on identifying someone who can support you to meet your required learning need. The choice of supervisor, therefore, needs to be relevant and applicable to the area of practice and the function of the supervision being provided. This doesn't necessarily mean that they need to be working in the same clinical speciality or profession (except for those

[23] https://www.hcpc-uk.org/standards/meeting-our-standards/supervision-leadership-and-culture/supervision/what-our-standards-say/

in mental health settings that require profession specific supervision). What you are getting from each supervision element will depend on the learning needs that you have identified and the *Levels of supervision* required to meet that learning need. For example, if you are working as an experienced dietitian with line management responsibilities, you may identify that you would benefit from supervision to develop your leadership skills. In which case you may look for supervision from a more experienced leader. They may work in a different dietetic speciality or even be from a different profession to you.

Where the supervisor is from a different profession or specialist area, it would be expected that they understand the profession and role, that they are aware of the scope of that role and identify the limitation to the supervision they can provide. For example, if the dietitian supervisee is a non-medical prescriber and the supervisor is not, then there needs to be recognition that supervision relating to prescribing cannot be part of the agreement. In this instance, the expectation is that the supervisor can recognise that this is beyond their scope of practice and advice from a more appropriate supervisor for that element should be sought.

Sometimes dietitians early in their career are asked to supervise members of the support workforce, particularly where delegating care while working closely with them. While this can be appropriate, it is important to recognise that at this stage of your career, you are likely to have had minimal exposure to supervision yourself which may make it difficult to confidently supervise others. As with any task, you should only be supervising others if you have the relevant knowledge and skills to ensure that you continue to practice within your scope. Dietitians who are providing practice supervision to the support workforce should read the relevant section in this document under *Dietetic Support Workforce.*

As well as the key skills and knowledge developed through training and experience (see Training for supervisors), supervisors should demonstrate the following:

- be aware of individual learning styles and adapt accordingly
- be competent and have the relevant knowledge and experience in the area being supervised
- understand relevant guidelines / policies and procedures
- recognise own scope of practice and limitations of the supervision arrangement
- good communication and active listening skills
- be culturally competent
- maintain confidentiality
- be actively engaged in their own supervision

It must be remembered that what constitutes good quality supervision is personally defined as every individual will have a different perspective. Open and transparent dialogue between the supervisor and supervisee, and regularly reviewing the supervision agreement, will help maintain the quality.

Supporting people with learning differences

To provide a supportive and effective supervision environment for all, there needs to be an ability to recognise and learn about an individual's learning style and learning differences. Supervisors may need to modify their methods accordingly and will need to be adaptable based on constructive feedback from the supervisee. Further information can be seen on the HCPC website here[24].

If concerns are raised during supervision

Supervisors should have a good understanding of how to appropriately escalate any concerns identified during sessions. While maintaining confidentiality is an essential part of the supervisee: supervisor relationship, exceptions may be required. For example, where there are concerns identified about a practitioner's conduct, competence, physical or mental health. The supervisor may need to disclose information from a supervision session to an appropriate person, such as a line manager.

Issues relating to performance or capability should be addressed as soon as they become apparent through providing formal feedback and additional support. This can be more challenging in instances where the individual lacks insight into their performance or capability deficit. Whilst issues such as this are more appropriate to be addressed within management supervision, the overlap between practice, management and restorative supervision requires the practice supervisor to recognise where issues may require escalation.

The circumstances under which confidentiality may be broken, and the process which will subsequently be followed, should be clearly detailed in the supervision agreement.

Challenges in accessing supervision

The benefits of accessing good quality supervision opportunities are clear and it is therefore hoped that employers recognise the importance of supporting staff to undertake supervision. Using job planning to build protected time into every role can also facilitate

[24] https://www.hcpc-uk.org/news-and-events/blog/2020/one-size-does-not-fit-all-when-it-comes-to-supervision/

effective and responsible supervision. If individuals continue to struggle to access supervision, scenarios and possible solutions are presented.

Challenge 1. My department is short staffed and so I feel that there are too many other things that come first.

If you are working for an organisation, they have a responsibility to provide the opportunity for supervision, such as scheduling this into a job plan, but this is ultimately an individual practitioner's choice. Practice supervision is an essential type of CPD that enhances service user and practitioner safety and wellbeing. As such, every effort should be made to ensure that supervision sessions are not cancelled. Job planning[25] can help, particularly where services have vacancies, as it allows you to present an accurate picture of capacity to undertake clinical activity. Job planning gives clinicians 'permission' to ensure that clinical activity is not prioritised over other essential professional activities – such as supervision and CPD. Practitioners should not feel guilty about taking time away from clinical activity. Prioritising your own wellbeing and professional development greatly improves the quality of the service you can deliver.

Challenge 2. I am the only dietitian in my service / department / organisation / clinical speciality / I am self-employed.

As supervision is an individual practitioner's responsibility, the dietitian working in isolation must agree with their employer how this will be accessed. Ideally this agreement occurs prior to commencing employment but if not, then agreement can be reached during management supervision sessions. Appropriate channels may include exploring access through an arrangement with a local organisation, through BDA specialist interest groups or appropriately trained private practitioners. For those working in services providing regulated activities – such as NHS organisations or private companies delivering NHS care - the employer has a responsibility to ensure that staff are appropriately trained and have access to supervision (see *Your employer's responsibility)*. For self-employed dietitians, the practitioner may need to self-fund supervision and this cost may need to be built into fees.

Challenge 3. I work in primary care and only get supervision from someone outside my profession.

Supervision does not need to be provided by someone from your own profession*, although the supervisor must understand the profession and/or role. They must be aware of the scope of that role and identify the limitation to the supervision they can provide (see *Training for supervisors*). This is likely to be more appropriate for experienced dietitians and

[25] https://www.england.nhs.uk/wp-content/uploads/2021/05/aps-job-planning-best-practice-guide-2019.pdf

there will still be benefit in using your professional specific networks for informal supervision opportunities should you be presented with unusual dietetic cases.

*Within mental health settings, such as eating disorders and CAMHS, the quality standards[26] recommend that supervision is delivered by someone from the same profession with appropriate clinical experience and qualifications. As such, the BDA position is that dietitians working in these environments should receive practice supervision by a suitably experienced dietitian.

Challenge 4. I don't work well with my supervisor.

It is likely to take a while to develop a strong working relationship with your supervisor, however, if after a period, the relationship isn't working then it may be time to switch supervisors. Supervision works better when the supervisee has been able to select their own supervisor. This scenario highlights the importance of having a clear supervision agreement in place which is regularly reviewed so that it is evident to both parties when the relationship isn't a success.

Challenge 5. My department doesn't have a supervision structure in place.

Discuss with your colleagues as it is likely that they have also recognised that they are missing out by not having access to practice supervision. Approach your manager to explain why practice supervision is required for yourself and the department.

Scenarios

Below are some frequent scenarios that the BDA is asked.

I work in NHS and private practice, does my NHS supervision cover both?

Accessing supervision through your NHS role to support your development as a practitioner will obviously enhance your private practice too. Regardless of what setting you work in or who your employer is, the HCPC expects registrants to meet all of the standards at all times. If you are selected for CPD audit or subject to any fitness to practise investigations, you will need to be able to demonstrate that you are able to meet the standards, which will include accessing supervision. As such, private practitioners may need to consider accessing additional supervision specific to their private role to ensure this requirement is met.

[26] https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/eating-disorders-qed/qed-community-standards---third-edition.pdf?sfvrsn=e8b3aebc_4

What should I do if I need support with a patient in my private practice?

The HCPC expects dietitians to always work within their scope of practice. This means that you should only consult with individuals where you have the relevant knowledge, skills and experience to carry out the activity safely and effectively[27]. If you decide that a particular activity is outside your scope of practice, you should either refer the individual on appropriately or consider whether you can seek training, support and supervision to enhance your scope. Working in isolation removes the opportunity for practitioners to access informal supervision that can help manage complex cases and scenarios. As such, making connections through networks and the BDA specialist groups may allow this to be established.

I am working in a dietitian role that does not include assessing patients (examples include project / catering), do I still need to access supervision?

Supervision is not just for those in clinical roles. The restorative and supportive functions of supervision will benefit all, and evidence shows this improves staff retention, confidence and wellbeing. Supervision is also an essential part of CPD that is a requirement in meeting the HCPC standards.

Within my role, I am exposed to some complex and difficult cases. How can I ensure my own wellbeing isn't impacted by this.

This is where partaking in restorative supervision on a regular basis will help as it aims to support the needs of practitioners working with clinically complex caseloads or in roles which are emotionally demanding. Restorative supervision provides a place to explore thoughts and feelings to ensure these scenarios do not impact on your wellbeing.

I deliver psychological therapy as part of my dietetic role in eating disorders. Do I have additional supervision requirements?

Dietitians working in mental health / eating disorder settings may provide some psychological therapy within their dietetic work. Whenever a dietitian is using a psychological approach to their work (e.g. Cognitive Behavioural Therapy), they should receive separate supervision for this element of their practice from a Clinical Psychologist. This may be covered within team or peer group supervision or provided on a 1:1 basis.

[27] https://www.hcpc-uk.org/standards/meeting-our-standards/scope-of-practice/what-is-your-scope-of-practice/identifying-your-current-scope-of-practice/

Abbreviations and glossary of terms

Term	Definition
CAMHS	Child and Adolescent Mental Health Services
Case Based Discussion	A structured interview designed to explore professional judgement exercised in real cases which you have managed
Clinical role	A person delivering care to people in a clinical setting, such as the NHS
Coaching	Coaching is a way of using questioning and inquiry to help leaders unlock their full potential to achieve personal and professional success.
Compassion Fatigue	Is the negative aspect of helping those who experience traumatic stress and suffering. There are two factors of Compassion Fatigue. The first concerns feelings such as exhaustion, frustration, anger and depression typical of burnout. Secondary Traumatic Stress is a negative feeling driven by fear and work-related trauma.
CPD	Continuous Professional Development: - How professionals continue to learn and develop throughout their career, to keep their skills, knowledge and ways of thinking up to date to practise safely and effectively within their current and future scope of practice.
Delegation	Giving tasks to another person to carry out on your behalf. HCPC requires that if registrants give tasks to another person to carry out on your behalf, you should make sure that they have the appropriate information to carry out the tasks safely and effectively
Extended scope	Indicates working outside or beyond the recognised elements of practice, using skills and techniques that are not included in the defined core skills and not included in the qualifying professional education curriculum.
HCPC	Health and Care Professions Council - the regulator of health and care professions in the UK which includes Dietitians
HCPC Standards	The professional standards all registrants must meet in order to become registered with HCPC, and remain on the register
Job plan	A prospective, professional agreement describing each employee's duties, responsibilities, accountabilities and objectives. It describes how an employee's working time will be used according to specific categories
Mentoring	Mentoring develops leaders through sharing of knowledge, skills and experience. It's often led by one experienced and skilled professional mentor and can lead to enhanced innovation and performance within organisations.
Moral distress	Moral distress refers to the psychological unease where professionals identify an ethically correct action to take but are constrained in their ability to take that action.
Moral injury	Moral injury can arise where sustained moral distress leads to impaired function or longer-term psychological harm. It can produce profound guilt and shame, and in some cases also a sense of betrayal, anger and profound 'moral disorientation'. It has also been linked to severe mental health issues.
Peer	Someone with the same standing as you.

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Appendix 1 – Example Supervision Agreement

Example Supervision agreement

Name of practitioner:	
Year:	
Role / level of practice:	
Named Practice Supervisor:	
Named Management Supervisor:	
Named Restorative Supervisor:	
Start date of agreement:	
Review date of agreement:	

What is the purpose of your supervision?

- e.g. management / practice /restorative supervision
- relating to a specific task or skill?
- Is it aiming to meet specific learning or development needs, how will supervision help?

What structure will your supervision take?

- e.g. 1:1, peer / groups?
- Face to face or remote?
- Is direct or indirect supervision required?

Frequency of supervision?

- e.g. weekly / monthly / quarterly?
- How long for and what time of day?
- Is there protected time in both supervisor and supervisee job plan?
- How will you ensure sufficient privacy and confidentiality?
- Who is responsible for arranging the dates / times / location / booking of room?

Location of supervision?

- How will you ensure privacy and maintain confidentiality?

Feedback, documentation, and confidentiality

- How will you evaluate and review the success and ongoing relevance of the supervision agreement?
- What type of record will be kept and where?
- How will you both access the record?
- Who will be responsible for completing the documentation?
- What are the confidentiality terms? What circumstances may require information to be shared?

Adapted from HCPC Supervision Agreement Template which can be accessed here:

https://www.hcpc-uk.org/globalassets/standards/meeting-our-standards/supervision/supervision-agreement-template-word.docx

Supervision agreement

What is the purpose of your supervision?

Name of practitioner:	
Year:	
Role / level of practice:	
Named Practice Supervisor:	
Named Management Supervisor:	
Named Restorative Supervisor:	
Start date of agreement:	
Review date of agreement:	

Feedback, documentation, and confidentiality

Other comments

Adapted from HCPC Supervision Agreement Template which can be accessed here:

https://www.hcpc-uk.org/globalassets/standards/meeting-our-standards/supervision/supervision-agreement-template-word.docx

Appendix 2 – Example Supervision log

Name of practitioner:	My name
Year:	2024
Role / level of practice:	Rotational NQP (band 5)
Named Practice Supervisor:	name
Named Management Supervisor:	name
Named Restorative Supervisor:	name

Week beginning	**Informal**	**Practice supervision (formal)**	**Restorative supervision (formal)**	**Management supervision (formal)**
1/1/24	3/1/24 – 10 min 5/1/24 – 5 min	-		-
8/1/24	8/1/24 – 20 min 10/1/24 -5 min	11/1/24 – 40 mins		-
15/1/24	15/1/24 – 5 min 16/1/24 – 5 min 17/1/24 – 5 min 18/1/24 – 5 min	-	17/1/24 – 60 mins	-
22/1/24	23/1/24 – 10 min 25/1/24 – 5 min	24/1/24 – 35 min		-
29/1/24	29/1/24 – 10 min 30/1/24 – 10 min	-		2/2/24 – 60 min

Name of practitioner:	
Year:	
Role / level of practice:	
Named Practice Supervisor:	
Named Management Supervisor:	
Named Restorative Supervisor:	

Week beginning	**Informal**	**Practice supervision (formal)**	**Restorative supervision (formal)**	**Management supervision (formal)**

Appendix 3 – Example Supervision Template

This example supervision template is available on the HCPC website here: Supervision templates | (hcpc-uk.org)

Name of supervisee:	
Name of supervisor:	
Date of meeting:	

What's the aim or purpose of your supervision session?

Supervision can have multiple objectives, such as discussions of your caseload, assistance with particular tasks or challenges; wellbeing checks; workload planning; or debriefing discussions.

It's important that your supervision has a clear focus. You should try to keep the purpose of your supervision as targeted as possible by identifying clear actions and objectives at the beginning of each session.

If this is a follow up session, it could be helpful to review notes of your last meeting to discuss previous actions identified and any progress made against these.

What goals have you achieved since your last supervision?

When discussing your achievements, you may also consider how you have put this learning into practice and how this has contributed towards your professional development.

What challenges have you faced since your last supervision?

You may want to outline any challenges that you have faced since your last supervision, and what you have done to overcome these.

If any challenges remain, you could outline what's needed to help you overcome these going forward.

What future learning objectives have you identified and what do you hope to achieve before your next supervision?

How will you achieve these objectives, and by when?
How will these contribute towards your professional development?
Will you need any additional support?

Feedback from supervisor

Feedback should be clear and focused. It should also be evidence based, which means clearly outlining the reasons for any comments provided.

Identifying clear actions and objectives will help ensure feedback is constructive, but you should also use this section to reiterate/highlight any achievements and progress made.

What actions have been agreed?

Think about what you have learnt from this supervision session, and what will you do differently.

When will your next supervision session be?

Agree a date, time and venue for your next session.

Signed: (Supervisee)	
Date:	

Signed: (Supervisor)	
Date:	