Evaluating Clinical Supervision Training

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Table of Contents

1. Background

1.1 Introduction

A 2013 inquiry into standards of care within Mid Staffordshire NHS Trust found that significant failings led to a dangerous and abusive organisational culture, which in turn impacted upon patient deaths (Department of Health, 2013). Within the recommendations to facilitate cultural change, the report proposed a need for high quality supervision for all clinicians.

Following this, regulatory bodies placed closer scrutiny upon the provision of clinical supervision within organisations. A Care Quality Commission (CQC) review of Leeds and York Partnership Foundation Trust (LYPFT) noted low uptake of supervision, poor recording practices, and notable variation across services (CQC, 2016).

A clinical supervision policy was available within the Trust, but there was no in-house training for clinical supervisors. To address this, clinical supervisor training was designed by a clinical psychologist in consultation with wider MDT colleagues. The training was rolled out systematically across the Leeds Care Group starting in 2018.

1.2 Clinical Supervision in Practice

The Francis Report described that fundamental standards of care were not being met within the Mid Staffordshire Trust, and that a focus upon targets and financial stability had fostered a culture within which concerns and complaints were disregarded (Department of Health, 2013). Recommendations from the inquiry influenced codes of conduct across disciplines and guided initiatives including the six Cs of health and social care staff: care, compassion, competence, communication, courage, and commitment (NHS England, 2015). The Francis Report also described that multiple regulators and professional bodies failed to act in response to issues. A major theme was top-down supervision throughout the workforce. The report stated that managers should be visible and accessible with a supervisory capacity in clinical settings, rather than being office bound.

This use of ‘supervision’ in its broadest term is consistent with variations in its application. Some utilise it to describe direct observation of practical skills, while many undergo management supervision focusing upon training competencies and attendance.

Clinical supervision expectations are mentioned throughout guidance and codes of conduct for individual disciplines, although definitions remain ambiguous.

Health and Care Professions Council (HCPC) Standards 4.1 and 4.2 comment upon delegation of work and the provision of appropriate supervision (2021). Although the HCPC do not set requirements in relation to the frequency or duration of supervision, clinicians should demonstrate "professional judgement" when establishing supervision practices. There are also no requirements of training to deliver supervision.

The British Psychological Society (BPS) Code of Ethics and Conduct (2018) does not specifically mention supervision, but does recommend recording decision making processes, particularly around any ethical dilemmas, allowing future review if required.

The BPS Practice Guidelines explicitly state that supervision is "an essential part of good practice as a psychologist" (BPS, 2017). The document outlines varying forms of supervision, which may be held individually or as a group, and may or may not be facilitated. However, the guidelines do not specify frequency of sessions and concede that supervision is not legally required, but assert the BPS position that supervision is required for safe and effective practice.

The Nursing and Midwifery Council's (NMC) Standards for Competence for registered nurses (2014) outlines standards expected across the fields of nursing. Supervision is cited within two of the four key areas; professional values, and leadership, management and team working. Both highlight the role of supervision in continuing professional development, and the latter standards describe the supervision of delegated care. This again highlights the varying applications of the term 'supervision'.

Beyond qualification, nurses, midwives and nursing associates must uphold the values of the NMC Code of Conduct (2018). Supervision is mentioned once within 'Practicing Effectively' in the context of supervising tasks delegated to others. Within the standards around promoting professionalism supporting other staff in their knowledge, skills, competence, and adherence to the Code is mentioned, which may be considered a function of clinical supervision. However, there is no explicit reference to expectations of clinical supervision frequency or content.

The Care Quality Commission (CQC) is one of the regulatory bodies named in the Francis report as having failed to identify the issues at Mid Staffordshire Trust. The CQC fundamental standards state that "…staff must be given the support, training and supervision they need to help them do their job" (CQC, 2021).

The CQC also outline their Key Lines of Enquiry (KLOE) during inspections, some of which are relevant to clinical supervision. When examining whether a service is effective, KLOE E3.4 explores staff skills and knowledge. This item asks about staff support to deliver effective care, including clinical supervision (CQC, 2017). The regulators also investigate whether a service is well-led, and KLOE W3 focuses on culture within the organization (CQC, 2018). Without explicitly naming clinical supervision, this item asks about staff wellbeing, support, development, learning and raising concerns. These ideas and organisational culture were a key focus in the Francis report.

It may also be pertinent to reflect upon how supervision is recorded. Supervision targets are generally in relation to session frequency, rather than any consideration of the quality of support offered. With no specific training requirements to provide supervision, and the likely variations in definitions, it is probable that there is a wide range of experiences both within and between organisations.

Further to another serious case review, the Winterbourne View enquiry, the CQC published clinical supervision guidance in 2013. It details different types of supervision and states that clinical supervision may include practice reflection, in depth discussion of clinical cases and identifying areas for development.

The document also summarised the value of clinical supervision, outlining its role in supporting the management of both personal and professional responses, identifying areas for development, and promoting a safe environment for clinical reflection and to receive feedback. It also highlighted that effective clinical supervision can ensure the provision of quality care, promote good clinical governance, foster a positive organisational culture, and support staff to avoid burnout. Building on this guidance, the definitions, purpose, and importance of clinical supervision was outlined in the training package that is the subject of the current project.

To summarise, the National Health Service is a huge organisation, and its function is dependent upon effective working relationships and positive staff wellbeing. Clinical supervision is a key part of this, however across and between services there remains variation in the definitions, quality, and frequency of supervision. Training packages such as the one evaluated in this project may go some way to promote consistency in standards of supervision. However, there is no current specification on training requirements, and evaluations such as this are required to determine whether an intervention impacts upon practice and any barriers to this.

1.3 The Training

A half day, face to face training session was offered, with participants required to book online before attending. The training was developed by clinical psychologists in conjunction with multi-professional feedback. Key aims were linked to national professional criteria, referencing policy and procedure (based on professional guidelines). Resources and literature drawn upon included models outlined within the training; Gibbs's (1988), Hawkins and Shohet (2012) and Stoltenberg, McNeill and Delworth (1998).

Aims of the training were to understand the function and purpose of supervision, increase knowledge and practical skills, to reflect on experiences and ideas, and to highlight Trust policy.

The session combined pre-reading, information on PowerPoint slides and interactive group exercises. Content covered included developmental and learning models, supervisory models (including critical evaluation), documentation, signposting to resources, and the application of content to practice.

Training was offered at several Trust sites. An initial session took place in July 2018 with all clinical leads. Further to clinician feedback the session was shaped to be more skills-based, then rolled out across the Leeds care group between October 2018 and January 2020.

The training session was initially accessible to Band 4 posts or above offering clinical supervision. This included nursing, occupational therapy, psychology, psychiatry, social care, dietetics, pharmacy and speech and language therapy staff. The package was offered to staff

within the Leeds care group, although some clinicians from specialist care groups did access the training.

During later workshops as more places became available, the opportunity to attend was extended to clinicians who were not yet supervising but had an interest in how supervision may be used more effectively.

1.4 Initial Feedback

Sessional evaluation forms suggested that the training was well-received. This feedback was used to develop the survey in this evaluation. Brief qualitative analysis of themes was conducted (guided by Braun and Clark, 2006, outlined further below) and questions were formulated seeking to explore the whether the training had impacted practice in the areas attendees hoped.

Participants' responses to the open questions within the evaluation suggested that preparing and making time for supervision sessions, supervisory process (including reflection, style, and approach) and the structure and focus of sessions (e.g., agenda setting and contracting) were key aspects of the training which they intended to develop within practice.

1.5 Aims

This evaluation was commissioned to determine whether and how the training has impacted practice 6 to 18 months after the session. The report will also highlight any barriers identified, and make further recommendations based on staff responses.

2. Method

2.1 Design

A mixed methods design was used to explore the aims outlined. A survey with both closed and open questions was created, capturing quantitative and qualitative data.

Other methods considered included individual interviews or focus groups, before an online survey was selected due to its practicality in capturing a mix of data from a large sample.

2.2 Participants

The link to the evaluation survey was sent to all attendees of the training. The total potential sample was 258 clinicians.

2.3 Procedure

2.3.1 Survey Development. Analysis of post-session evaluation forms guided the development of the survey used in the project. When asked how they hoped to implement the training content, attendees repeatedly identified areas including *preparation* (before sessions, reflection between sessions, practicing in line with policy, considering needs and expectations, prioritising sessions), *process* (a reflective space, considering approaches and styles), and *structure* (contracting, agenda setting, bringing a question, using models and implementing boundaries). Therefore, the closed questions aimed to capture whether this had occurred in the areas mentioned. A statement was offered with responses including "I did this before the training" and "I have done this since the training". The concluding questions of this section asked respondents to rate their perceived confidence, effectiveness, and skill since the training. Response options range from 'a lot more' to 'a lot less'. See full survey in Appendix 1.

After reflecting on these questions, to gather more in-depth information and allow the opportunity to expand upon their experiences, open questions were asked and free text boxes were provided. These items asked about positive experiences of supervision in practice, barriers faced, how any difficulties may be overcome, and suggestions for further personal development as a supervisor.

After development it was necessary to pilot the survey to ensure that there were no process issues and confirm that the wording was understandable. This was undertaken by a Psychologist in Clinical Training who was not involved in the training or evaluation project. Feedback detailed that they found the survey very clear.

2.3.2 Data Collection. Attendees provided their work email address when booking onto a session. These were accessible to the commissioner of the evaluation. A link was sent to the work email addresses of attendees inviting them to complete the online survey. To promote

the optimum response rate reminder emails were sent at three weeks and six weeks (Appendix 5).

The initial invitation and prompts were sent from the commissioner's NHS Trust email. The principal investigator was unknown to Trust staff, and it was hoped that receiving the information from a clinician known to attendees may encourage responses. Whilst the commissioner acts as clinical supervisor to some participants, she is not responsible for the direct management of any potential respondents, therefore this was not considered to be a conflict in roles.

The survey was open for just under eight weeks. Participants were able to proceed and submit the survey if they did not answer every question.

2.4 Ethics

2.4.1 Ethical Approval. Ethical approval was received from the School of Medicine Research Ethics Committee (SoMREC) on 17th June 2020 (Ethics Reference Number: DClinREC19-015). A copy of the ethics application feedback is appended (Appendix 3).

2.4.2 Informed Consent. The online survey sent to participants is included as Appendix 1. The first page provided information about the study including its purpose, what participation involved and an approximate duration, that participation was voluntary, there were no anticipated risks to the participant, secure storage of data and a link to the University of Leeds Privacy Notice. Consent was then implied from the participant choosing to click the link to begin the survey.

2.4.3 Right to Withdraw. The first page also explicitly highlighted the participant's right to withdraw up to the point of submitting their responses. It was explained that as data collection was anonymous it would not be possible to withdraw responses after submitting the survey. Additionally, the first page of the survey outlined the right to choose not to answer a question within the survey.

2.4.4 Confidentiality. Participants were advised that all responses would remain anonymous. The introductory page of the survey explained that any identifying information

would be removed from the data prior to analysis. Participants were advised that no identifiable data would be published.

2.4.5 Data Storage. The survey introduction also reassured participants that physical data would be kept to a minimum and input onto a database as soon as practicable. This database was then stored on a secure University drive. Electronic documents were password protected, stored on a University approved drive, and in a file only accessible to the principal investigator.

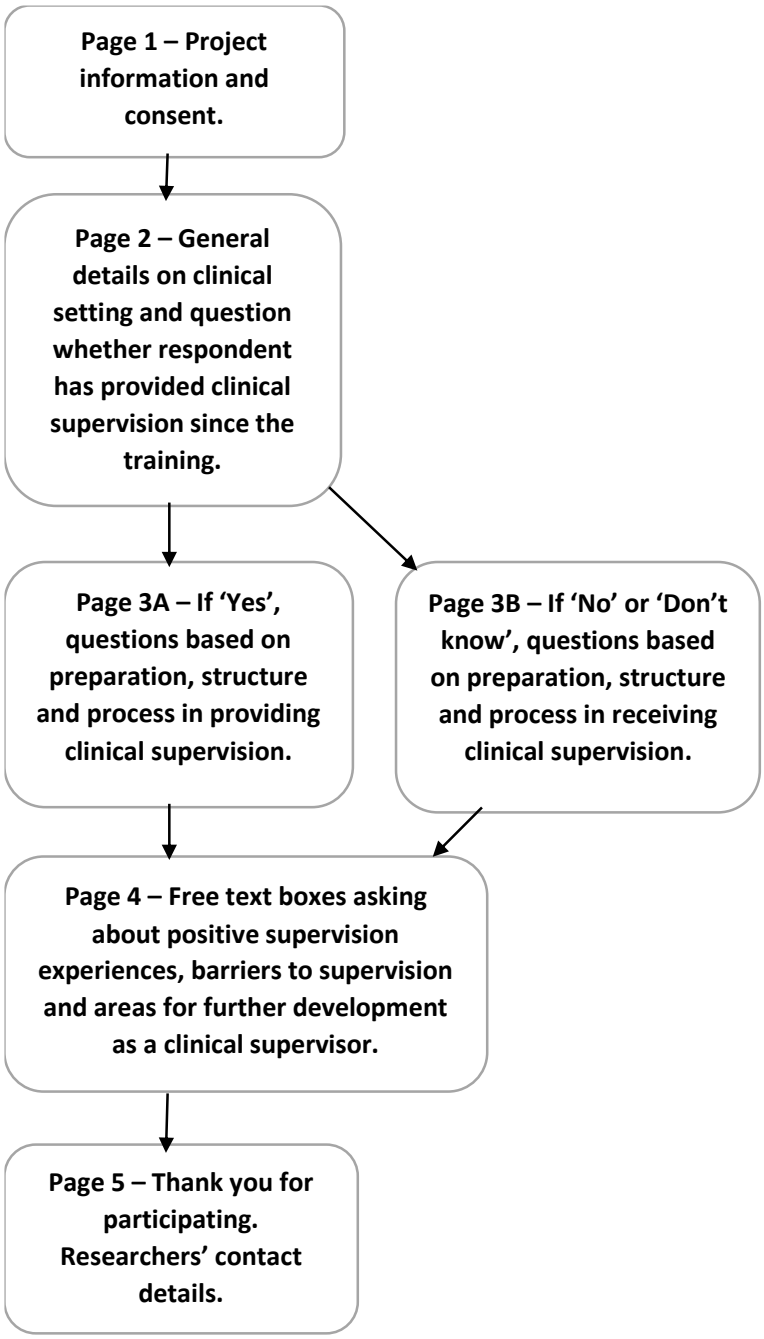
2.4.6 Potential Distress. It was not anticipated that the subject matter would be distressing for participants. Although it was considered that the questions may prompt disclosures of difficulties in relation to stress and wellbeing, particularly due to added clinical pressures of the COVID pandemic. To address this signposting of contact details for Staff Wellbeing Services was included within the consent statement.

2.5 Analysis

The survey began with general demographic questions. It then asked whether the respondent had provided clinical supervision since the training. If they had, the next section asked about their experiences of providing supervision. If the respondent didn't know or had not offered supervision, they were asked similarly focused questions about their experiences of receiving clinical supervision. Descriptive statistics were used to analyse quantitative data captured.

All participants were then asked the same free-text responses in the final section of the survey. Thematic analysis of qualitative responses was conducted (Braun and Clarke, 2006). The authors describe this flexible approach as being useful in guiding policy development, and it provided a structured method to create a descriptive summary of the data.

Figure 1. Survey Map



3 Results

3.1 Response Rate

Email invitations to complete the survey were sent to 258 clinicians who attended the training. 53 responses were received. This equates to a response rate of just under 21%.

3.2 Descriptive Statistics

Of the 53 respondents, 39 reported having provided clinical supervision since the training and 14 stated that they had not.

As the survey sought to explore changes in supervisory practice and skills learned because of the training, this part of the report will focus upon the 39 respondents who had provided clinical supervision since the training session. All quantitative data is available in tables within Appendix 2.

Key themes from the evaluation which attendees completed immediately after the training suggested that they planned to apply skills in practice including bringing questions to supervision, using models, and implementing boundaries. Interestingly, it remains unclear as to whether this has translated into their practice, with responses from those who have provided supervision suggesting a mixed picture.

Preparation as a clinical supervisor

Figure 2. Reflection upon approach by clinicians offering supervision

A total of 59% of respondents (n=23) selected that they were aware of the Trust supervision policy before the training. Of the respondents to this item 41% (n=16) selected that they had done this since the training. 5.1% responded that they don't do this (n=2)

When asked, 64.1% (n=25) responded that prior to the training they ensured supervision was in line with Trust policy. A total of 43.6% said that they had done this since the training (n=17) and 1 respondent selected that they did not know.

A total of 68.4% of respondents said that they prioritised offering supervision before the training. In response to the same question 42.1% of the respondents said that they have done this since the training; 5.3% stated that they did not prioritise supervision.

When asked, 55.3% of respondents (n=21) reported that they prepared for supervision sessions before completing the training, and the same percentage stated that they did this since the training. A further 7.9% of respondents to this question (n=3) said they did not prepare for supervision.

A total of 59% (n=23) responded that they were aware of needs/expectations within supervision before the training. This increased to 66.7% (n=26) who said that they were aware of this after the training.

Process in supervision

When asked, 64.1% (n=25) responded that they offered supervision as a reflective space prior to the training. In response to the same item, 23 (59%) stated that they had done this since the training.

Figure 3. Consideration of different styles by clinicians offering supervision

When asked, 33.3% of respondents said that prior to the training they had offered a range of approaches within supervision beyond problem solving and solution focused methods. This increased dramatically as 79.5% of respondents to this question selected that they had offered a range of approaches since completing the training.

Structure and focus within supervision

A total of 43.6% respondents selected that they agreed a supervision contract with supervisees prior to completing the training (n=17). This increased to 61.5% of respondents (n=24) who said that they had contracted with supervisees since completing the training. A further 7.7% of respondents said that they didn't do this (n=3), and one participant selected that they did not know (2.6%).

Figure 4. Agenda setting by clinicians offering supervision

A total of 57.9% responded that they implemented boundaries within supervision prior to the training (n=22). In response to the same question 44.7% selected that they had done this since the training (n=17). Two respondents said that they do not implement boundaries (5.3%) and 4 participants selected that they did not know (10.5%).

Figure 5. Clinicians asking supervisees to bring a question

Figure 6. The use of supervision models by clinicians offering supervision

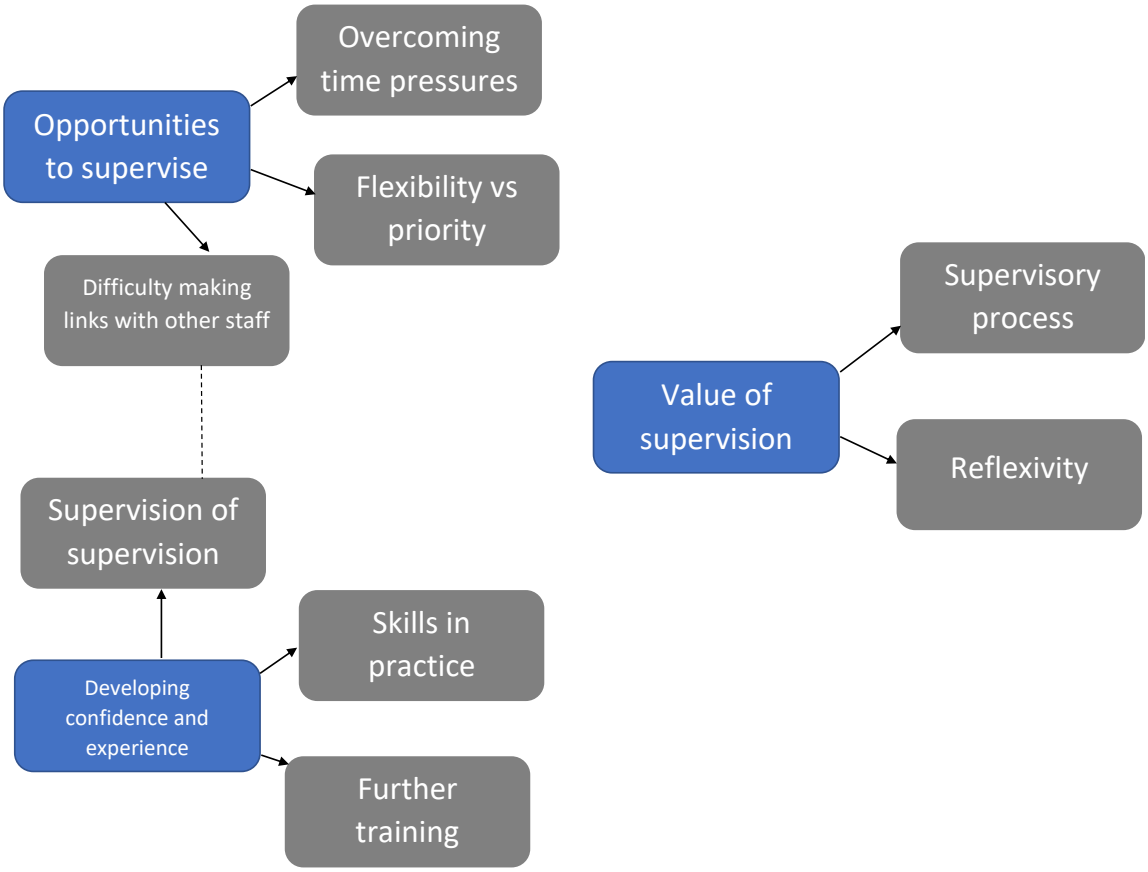
Perceived confidence, skill and effectiveness

Finally, respondents were also asked to rate their perceived confidence, skill, and effectiveness as a clinical supervisor since the training. 82.1% of participants (n=32) reported feeling more confident (23 'a bit more' and 9 'a lot more'), whilst 17.9% (n=7) selected 'neither more nor less'. 79.5% respondents (n=31) said that they felt more effective as a clinical supervisor (23 'a bit more' and 8 'a lot more'), with 20.5% (n=8) reporting that they felt 'neither more nor less' confident. And 78.9% (n=30) of participants reported feeling more skilled since the training (23 'a bit more' and 7 'a lot more'), 21.1% (n=8) of respondents selected 'neither more nor less' and it appears one participant did not respond to that question. Across the three questions there were no responses suggesting a negative impact upon these areas, and no participants responded that they 'didn't know'.

3.3 Thematic Analysis

Using Braun and Clarke's six step guide (2006), themes were identified from responses to open questions on the final page of the survey. Figure 5 displays a thematic map. Themes and illustrative quotes of subthemes are outlined in Table 1.

Figure 7. Thematic Map



Theme 1: The Value of Supervision

Most responses in relation to **supervisory process** were received in participant's descriptions of positive practical examples since the training. This was not exclusive however, with one respondent reporting that they felt colleagues struggling to engage in the interactive process was a barrier within supervision.

Reflexivity was also overwhelmingly linked to positive experiences since the training, and participants described reflection both within the session and independently after a session. One response suggested that time pressures (a further subtheme described below) could be a barrier to having the space to reflect around supervision.

Table 1. Summary of identified themes, subthemes, and illustrative quotes

Theme	Subtheme	Quotation to illustrate
The value of supervision	Supervisory process	*"In providing a reflective space I have supported my supervisee to consider different methods of engaging with SU who had previously been reluctant to meet."*
	Reflexivity	*"I keep an open mind for supervision - and whilst I take notes afterwards it is just an overview of the supervision."*
Opportunities to supervise	Making links with other staff	*"My job plan and banding means I am unable to offer this in the way that I am skilled to."*
	Flexibility versus priority	*"General barriers to clinical supervision have always been protecting the time that has been arranged especially in light of working in an unpredictable and often volatile environment."*
	Overcoming time pressures	*"Rota does not always make it easy to have regular sessions as per trust guidance."*
Developing confidence and experience	Skills in practice	*"I incorporated a reflective tool…It felt more productive and effective as a result. It also provided a visual tool for that person to take away as a reminder…"*
	Further training	*"It's been more than a year since I last did the training. I do wonder if it needs to be annual?"*
	Supervision of supervision	*"Having supervision so as to improve on my skill and use the knowledge I acquired in the training."*

Theme 2: Opportunities to Supervise

In relation to **difficulties making links with other staff** and across team, participants described a sense of struggling to pinpoint supervisees, and in some cases supervisors. Some spoke of variations in expectations of supervision across disciplines, and other responses

stated that they were unable to engage effectively in offering supervision due to their setting, team, banding or specialism.

Across responses there was a sense that clinical crises should be prioritised before supervision and a frequent need to reschedule which created a dilemma between **flexibility vs priority**. Rebooking cancelled sessions was mentioned as a response to overcome barriers. Responses also described aiming to "protect time" for supervision, but a handful described a sense of feeling uncomfortable keeping this appointment and saying 'no' to other clinical demands. Some respondents identified swapping shifts or scheduling supervision on their days off to overcome this.

Overcoming time pressures was also identified as a subtheme within responses about opportunities to supervise. This theme almost exclusively appeared in responses to the question around barriers to supervision. Though not quite strong enough to be considered independent themes, within responses about time pressures there was a sense of ambiguity around whose responsibility it was to overcome these challenges:

"*…not everyone has the understanding of their responsibilities with regard to clinical supervision. So can feel that the supervisor is responsible", "without structural change this will not be overcome", "discussed within team meeting about personal responsibility"* and *"I have spoken to my line manager about this, but a resolution has not yet been found."*

The current context of redeployment and remote working due to the COVID-19 pandemic was mentioned, but not powerfully enough to constitute an independent subtheme. Both the benefits and challenges of remote working were described:

"Covid has been difficult as I feel face to face supervision is much more productive than via technology", "It has also been a struggle to find a space in which to meet due to limited room availability and a wish to meet face to face rather than virtually".

Conversely:

"...have got used to Zoom/Teams and sharing documents via this route which has been helpful" and *"doing supervision over Zoom has helped, and then scheduling the Zoom meeting on Outlook."*

One response also mentioned that redeployment of staff during this period has been a "major issue" to providing and receiving supervision, though the impact of this would likely vary between roles and settings.

Theme 3: Developing Confidence and Experience

Positively, many participants described actively using **skills in practice** further to the training, including improving structure, contracting, following up from previous sessions, varying styles, tools, and models. More practice of these clinical skills was also repeatedly mentioned when respondents were asked how they may develop.

Within the responses seeking suggestions as to how development of supervision skills may be supported, **further training** was frequently mentioned. Most participants requested a 'refresher' of the training they had already received. One respondent suggested PowerPoint prompts be sent.

Finally, the idea of **supervision of supervision**, or an interactive support group was suggested by several respondents. Learning from others seemed to be key, and participants proposed examples including a reflective practice group.

4 Discussion

4.1 Key Findings

This project explored whether clinical supervisor training impacted upon practice and whether there were any barriers to this. Results suggested a mixed picture as to whether clinicians did apply techniques in practice.

In several areas, quantitative data suggested a change in supervisory practice since the training, with a greater percentage of respondents reporting that since the session they reflect on their approach, consider needs and expectations, use different supervisory styles and approaches, contract sessions and set agendas.

Yet in some areas within which clinicians identified plans to implement skills there seems to have been little change. There was no increase in clinicians reporting that they use a model within supervision since the training, and a large proportion of respondents stated that they do not do this, despite this being a technique many said they planned to begin using during initial evaluation of the training package.

Nonetheless, the training did appear to have a positive impact upon attendees' perceptions of their confidence, skills, and effectiveness as supervisors. Despite a minority reporting that these perceptions of themselves remained stable, a sizeable majority rated an improvement in each of these three areas. No clinicians suggested that the training had a negative impact upon their confidence, skills, or effectiveness.

Respondents also detailed positive experiences and barriers in relation to clinical supervision. Themes established highlighted the value of supervision with examples of supervisory process and reflection. Respondents identified barriers to clinical supervision including time pressures and difficulties making links with other clinicians. A dilemma around a need to reschedule flexibly around clinical demands whilst also wishing to prioritise clinical supervision was also noted.

Despite the impact of the training upon practice being unclear, respondents continued to describe the value of supervision and a wish to further develop skills. Some of the suggestions made included further training, refresher sessions, and to be supervised in practicing skills learned.

4.2 Limitations

Shortly before the survey was launched the COVID-19 pandemic struck. As a result of social distancing measures and work from home directives this had a significant impact upon the way clinicians and services worked. It is not possible to know how this may have impacted the results of the project. It may have been that remote working had a positive impact upon response rates. Conversely, clinicians' capacity to complete the survey may have been reduced. The influence of remote working upon the availability and format of supervision was mentioned throughout the free text responses but was not felt to be a key theme. Nonetheless, the impact of the pandemic continues to present challenges to the way clinicians work, and the supervisor training is part of a wider consideration as to whether the session can be delivered effectively via an online platform.

The low response rate of 21% is a further limitation of this evaluation. Most attendees did not respond to the survey, therefore it is not possible to know if they are offering supervision and whether the training has influenced their practice. The clinicians who did respond may be the most motivated and enthusiastic, leading to a responding bias in results.

A further factor not captured but which may have influenced the responses received might be the period the clinician has been in practice. Future evaluation could explore any cohort trends within supervision practice, for example if nurses who have recently completed a preceptorship period report different views or experiences to those who have been in practice for a longer period.

With the intention of promoting responses and giving participants options it was possible to select multiple answers to some survey questions, for example 'I did this before the training' and 'I have done this since the training'. However, this complicated the analysis of the data captured, and with hindsight it may be questionable as to whether the option was necessary.

Whilst increasing uptake is important, it is also crucial to consider the quality of supervision offered. This evaluation has begun to ask for subjective examples of good practice, but implementing organisational monitoring of the quality of supervision over time would be valuable. The Trust supervision policy contains an evaluation form with items asking about the quality of supervision. This form is intended to be completed by clinicians every six months and shared with their line manager, however there is no systematic follow up that this is being completed.

Finally, it is necessary to consider my own assumptions, experiences and clinical background which will have shaped my interpretation of the qualitative data. Elliot (1999) describes the importance in a researcher understanding their own perspective, but that it is not possible to fully set aside my own experiences of clinical supervision, both good and bad. Additionally, my positive working relationship with the project commissioner and a likely expectation that the training will yield encouraging results may also have been a potential bias. Due to the limited resources available to complete this evaluation credibility checks were not possible, however any future projects with greater resourcing would be able to apply such measures.

4.3 Conclusions and Recommendations

Overall, it appears that the training was well received. Responses suggest that implementation of specific skills learned within the training may have been variable, but participants have been clear in suggesting possible barriers in relation to this.

A summary of recommendations follows:

- **A supervisor register set up to support clinicians to make links.**
  The number of clinicians who have completed the training but have yet to offer supervision demonstrates either a shortage in supervisees or difficulties in establishing connections across teams. Providing a directory would assist those seeking a clinical supervisor as well as supporting those who wish to discuss practice and share skills to network with others.
- **Further training in clinical supervision.** This may include wider roll out of the current training session to the whole Trust, or refresher sessions to rehearse skills for those who have previously attended. This recommendation is currently being reviewed within the Trust to determine resources available and whether any additional training will be offered online due to ongoing restrictions because of the COVID-19 pandemic.
- **Clinical supervision training as part of the induction process.** To embed high quality supervisory practice throughout the Trust from commencing employment, this session could be incorporated within the induction training package for relevant posts.
- **Organisational monitoring of the quality of supervision.** As mentioned above, even where regular clinical supervision is being provided, there are currently no systematic measures on the quality of this. It would be pertinent for the Trust to audit supervisee feedback to encourage continuing development and professional growth for clinical supervisors.

4.4 Dissemination of Results

The results of this project have been shared with the commissioner and will be provided to the Leeds and York Partnership Trust Research and Development Department. A copy of the final report will be accessible on the Leeds Doctorate in Clinical Psychology Extranet site.

5 References

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

British Psychological Society. (2017). *Practice Guidelines: Third Edition.* Retrieved from https://www.bps.org.uk/news-and-policy/practice-guidelines

British Psychological Society. (2018). *Code of Ethics and Conduct*. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf

Care Quality Commission. (2013). *Supporting information and guidance: Supporting effective clinical supervision.* Retrieved from https://work-learn-live-blmk.co.uk/wp-content/uploads/2018/04/CQC-Supporting-information-and-guidance.pdf

Care Quality Commission. (2016). *Leeds and York Partnership NHS Foundation Trust Quality Report.* Retrieved from https://api.cqc.org.uk/public/v1/reports/fa406e86-f08b-45b4-b344-cc38d8c34c15?20210211090945

Care Quality Commission (2017). *Staff skills and knowledge (healthcare services).* Retrieved from https://www.cqc.org.uk/guidance-providers/healthcare/staff-skills-knowledge-healthcare-services

Care Quality Commission (2018). *Culture of the organisation (healthcare services).* Retrieved from https://www.cqc.org.uk/guidance-providers/healthcare/culture-organisation-healthcare-services

Care Quality Commission. (2021). *The fundamental standards*. Retrieved from https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards

Department of Health. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive summary. HC 947. London: The Stationery Office. (Chairperson R. Francis QC).

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*(3), 215–229. doi:10.1348/014466599162782

Gibbs, G. (1988). *Learning by doing: A guide to teaching and learning methods*. London: Further Education Unit

Hawkins, & Shohet, R. (2012). *Supervision in the helping professions (Fourth edition.).* Open University Press.

HCPC. (2021, March 24). *Supervision.* Retrieved from https://www.hcpc-uk.org/standards/meeting-our-standards/supervision-leadership-and-culture/supervision/

NHS England. (2015). *Introducing the 6Cs.* Retrieved from https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/03/introducing-the-6cs.pdf

Nursing and Midwifery Council. (2014). *Standards for competence for registered nurses.* Retrieved from https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-competence-for-registered-nurses.pdf

Nursing and Midwifery Council. (2018). *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.* Retrieved from https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

Stoltenberg, C. D., McNeill, B., & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counselors and therapists*. Jossey-Bass.

6 Appendices

Appendix 1 – Survey

Information and Consent

You are being invited to participate in a research study titled 'An Evaluation of Clinical Supervisor Training for Leeds and York Partnership NHS Foundation Trust.'

This study is being carried out by Meg Beadle from the University of Leeds. The purpose of this research study is to evaluate the impact of the Clinical Supervisor Training upon practice. Having attended one of the training sessions you are being invited to complete a short survey. It is estimated this will take approximately 5-10 minutes.

We are interested in your responses even if you haven't managed to put the training into practice.

Do I have to take part?

Your participation in this study is entirely voluntary and you may withdraw at any time until completing the survey and pressing 'finish'. If there are any questions you do not want to answer, just miss them out and go on to the next one.

What are the possible disadvantages and risks of taking part?

We believe there are no known risks associated with this research study.

We will minimise any risks to data protection by using a University approved survey tool, collecting only necessary data, ensuring all data is stored anonymously on secure, approved drives, and destroying all raw data upon completion of the project.

This aside, your participation in this study will remain confidential, and only anonymised data will be published.

We don't anticipate filling in this survey about your practice to be distressing, but if your work is having an impact upon your wellbeing please consider looking at the Staff Wellbeing Support within LYPFT via Staffnet. Currently Occupational Health are offering a staff support line on: 07774 335800.

What are the possible benefits of taking part?

Individual/Team: Reflecting on your supervisory practice can be helpful to professional development. You may want to keep a note of any reflections that prompt action for yourself or within your team.

Organisationally: We hope to use the results of this survey to support and guide the development of our Clinical Supervisory training and practice within the organisation.

Use, dissemination and storage of research data

All information will be securely stored in line with the University of Leeds Research Data Management guidance. Further information is available via the University of Leeds Privacy Notice (https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf).

Findings will be written up into a Service Evaluation report and presented for submission as a project forming part of a Doctoral qualification. Results will also be reported to the Trust Research and Development Department. Whilst individual quotes from responses may be used, no identifiable information in relation to any person will be published.

What will happen to my personal information?

Responses will be collected anonymously. Should your responses highlight anything which may be identifiable to you this will be removed.

Survey data will be stored on a password-protected secure University of Leeds drive. Data will not be shared with anyone outside of the research team. All data will be kept secure and destroyed 3 years after the project is completed.

The research findings may be presented and quotes used, but your personal details will not be printed.

What will happen to the results of the research project?

It is hoped that the findings of the project will help to guide clinical supervisor training in the future. A summary of our findings will be presented within a brief report for the Trust. A poster will also be presented to the Trust Research and Development department and a Service Evaluation Project conference at the University of Leeds.

Who is organising/ funding the research?
This project has been organised by Leeds and York Partnership NHS Foundation Trust, and is part of a Doctorate in Clinical Psychology qualification by the University of Leeds. Ethical approval for this project has been sought from the School of Medicine Research Ethics Committee (DClinREC19-015).

Should you have any questions or concerns please do not hesitate to contact us on the details below for further information

Meg Beadle

Trainee Clinical Psychologist

Email: m.beadle@nhs.net

Dr Gail Harrison

Principal Clinical Psychologist

Email: gailharrison@nhs.net

Dr Gary Latchford

Joint Director, University of Leeds Clinical Psychology Training Programme

Email: G.Latchford@leeds.ac.uk

After reading this information and clicking 'Next' to start the survey, you are consenting to take part in the study.

Clinical supervisor training has been offered within the Trust since 2018. You attended a classroom session provided by the Leeds Care Group psychologists. We are interested in whether you have applied this training, and what has been helpful about the training. We are also interested in whether there have been any barriers to applying the training within your clinical practice. We are collecting this information to guide us in our continued provision of clinical supervisor training.

1. Did you attend the training

- Less than 6 months ago
- 6 - 12 months ago
- Over a year ago
- Can't remember

2. Do you work in

- The Leeds care group
- A specialist care group service
- Don't know

3. Do you work on a service operating 24 hours per day?

- Yes
- No
- Don't know

4. Have you provided clinical supervision to anyone since the training?

- Yes, I have provided clinical supervision since the training
- No, I have not provided clinical supervision to anyone since the training
- Don't know

At the end of the training, attendees completed an evaluation form. They were asked how they hoped to change their practice and generated lots of ideas. We are interested in whether you have changed your practice since the training in any of these areas. Please select all that apply.

If the respondent selected that they had not provided clinical supervision or 'don't know'*

5. Preparation for my own clinical supervision
Please don't select more than 2 answer(s) per row.

	I did this before the training	I have done this since the training	I don't do this	Don't know
I reflect on my approach to supervision	☐	☐	☐	☐
I am aware of the LYPFT Trust clinical supervision policy and procedure (Policy Number C-0004)	☐	☐	☐	☐
I book and receive regular clinical supervision in line with policy i.e. for at least 1 hour, 6 times per year	☐	☐	☐	☑
I prioritise attending my clinical supervision	☐	☐	☐	☐
I prepare for supervision sessions	☐	☐	☐	☐
I am aware of needs/expectations within supervision	☐	☐	☐	☐

6. Process within supervision

Please don't select more than 2 answer(s) per row.

	I did this before the training	I have done this since the training	I don't do this	Don't know
I use supervision as a reflective space	☐	☐	☐	☐
I am open to different supervision styles	☐	☐	☐	☐
I am open to other approaches, in addition to problem solving or solution-focused styles, within supervision	☐	☐	☐	☐

7. Structure and focus in supervision
Please don't select more than 2 answer(s) per row.

	I did this before the training	I have done this since the training	I don't do this	Don't know
I have agreed a supervision contract with my supervisor	☐	☐	☐	☐
We set an agenda for each supervision session together	☐	☐	☐	☐
I bring a question to supervision	☐	☐	☐	☐
We have used a model (e.g. Gibbs, or Hawkins and Shohet) to inform the discussion	☐	☐	☐	☐
I am more aware of boundaries within supervision	☐	☐	☐	☐

8. When the opportunity arises for me to offer clinical supervision I will feel:
Please don't select more than 1 answer(s) per row.

	A lot more	A bit more	Neither more nor less	A bit less	A lot less	Don't know
Confident in offering clinical supervision	☐	☐	☐	☐	☐	☐
Effective to offer clinical supervision	☐	☐	☐	☐	☐	☐
Skilled in offering clinical supervision	☐	☐	☐	☐	☐	☐

If the respondent selected that they had provided clinical supervision*

5. Preparation as a clinical supervisor
Please don't select more than 2 answer(s) per row.

	I did this before the training	I have done this since the training	I don't do this	Don't know
I reflect on my supervisory approach	☐	☐	☐	☐
I am aware of the LYPFT Trust supervision policy and procedure (Policy Number C-0004)	☐	☐	☐	☐
I ensure supervision is regular in line with policy i.e. for at least 1 hour, 6 times per year	☐	☐	☐	☐
I prioritise offering supervision	☐	☐	☐	☐
I prepare for supervision sessions	☐	☐	☐	☐
I am aware of needs/expectations within supervision	☐	☐	☐	☐

6. Process within supervision
Please don't select more than 2 answer(s) per row.

	I did this before the training	I have done this since the training	I don't do this	Don't know
I offer supervision as a reflective space	☐	☐	☐	☐
I consider different supervision styles	☐	☐	☐	☐
I offer a range of approaches in supervision, in addition to problem solving and solution focused methods	☐	☐	☐	☐

7. Structure and focus in supervision
Please don't select more than 2 answer(s) per row.

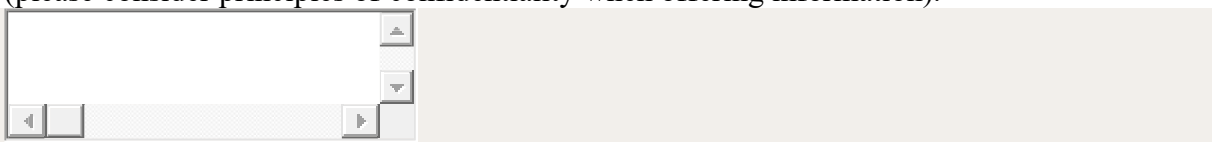
	I did this before the training	I have done this since the training	I don't do this	Don't know
I agree a supervision contract with supervisees	☐	☐	☐	☐
We set an agenda for each supervision session together	☐	☐	☐	☐
I have asked supervisees to bring a question to supervision	☐	☐	☐	☐
I have used a model (e.g. Gibbs, or Hawkins and Shohet) to inform the discussion	☐	☐	☐	☐
I implement boundaries within supervision	☐	☐	☐	☐

8. Since the training do you feel
Please don't select more than 1 answer(s) per row.

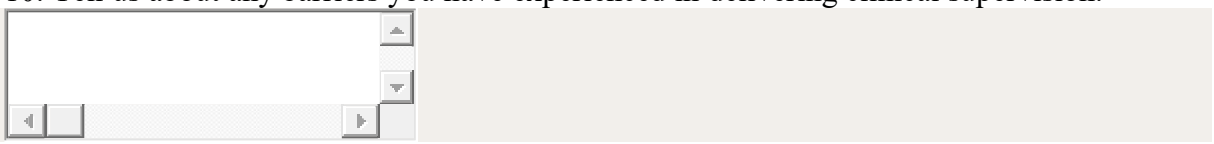
	A lot more	A bit more	Neither more nor less	A bit less	A lot less	Don't know
Confident as a clinical supervisor	☐	☐	☐	☐	☐	☐
Effective as a clinical supervisor	☐	☐	☐	☐	☐	☐
Skilled as a clinical supervisor	☐	☐	☐	☐	☐	☐

All respondents

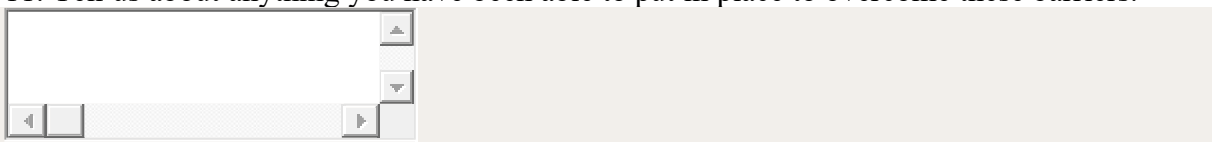
9. Please tell us about any positive practice examples of clinical supervision since the training (please consider principles of confidentiality when offering information).



10. Tell us about any barriers you have experienced in delivering clinical supervision.



11. Tell us about anything you have been able to put in place to overcome these barriers.



12. Tell us about anything you can think of which would help you to develop further as a clinical supervisor.

Thank you for taking the time to complete this survey. We hope that the findings will help us to offer clinical supervision support and training in the future.

Should you have any questions or concerns, please do not hesitate to contact us on the details below.

Meg Beadle

Trainee Clinical Psychologist

m.beadle@nhs.net

Gail Harrison

Principal Clinical Psychologist

gailharrison@nhs.net

Appendix 2 – All quantitative responses

Please note: As respondents could select more than one answer, percentages represent the percentage of respondents who selected that answer, for example 100% would represent that all respondents selected this option.

Did you attend the training

Response	**Number (percentage of respondents)**
Less than six months ago	3 (5.7%)
Six to twelve months ago	17 (32.1%)
Over a year ago	24 (45.3%)
Can't remember	9 (17%)

Do you work in

Response	**Number (percentage of respondents)**
The Leeds care group	35 (66%)
A specialist care group service	11 (20.8%)
Don't know	7 (13.2%)

Do you work in a service operating 24 hours per day?

Response	**Number (percentage of respondents)**
Yes	24 (45.3%)
No	29 (54.7%)
Don't know	0

Have you provided clinical supervision to anyone since the training?

Response	**Number (percentage of respondents)**
Yes, I have provided clinical supervision since the training	39 (73.6%)
No, I have not provided clinical supervision to anyone since the training	14 (26.4%)
Don't know	0

Responses from the 14 participants who had not provided supervision since the training.

I reflect on my approach to supervision

Response	**Number (percentage of respondents)**
I did this before the training	10 (76.9%)
I have done this since the training	4 (30.8%)
I don't do this	1 (7.7%)
Don't know	0

I am aware of the LYPFT clinical supervision policy and procedure (Policy Number C-0004)

Response	Number (percentage of respondents)
I did this before the training	8 (57.1%)
I have done this since the training	4 (28.6%)
I don't do this	2 (14.3%)
Don't know	1 (7.1%)

I book and receive regular clinical supervision in line with the policy i.e. for at least an hour, 6 times per year

Response	Number (percentage of respondents)
I did this before the training	11 (84.6%)
I have done this since the training	3 (23.1%)
I don't do this	1 (7.7%)
Don't know	0

I prioritise attending my clinical supervision

Response	Number (percentage of respondents)
I did this before the training	12 (85.7%)
I have done this since the training	4 (28.6%)
I don't do this	0
Don't know	0

I prepare for supervision sessions

Response	Number (percentage of respondents)
I did this before the training	10 (76.9%)
I have done this since the training	4 (30.8%)
I don't do this	1 (7.7%)
Don't know	0

I am aware of needs/expectations within supervision

Response	Number (percentage of respondents)
I did this before the training	9 (69.2%)
I have done this since the training	4 (30.8%)
I don't do this	0
Don't know	1 (7.7%)

I use supervision as a reflective space

Response	Number (percentage of respondents)
I did this before the training	13 (92.9%)
I have done this since the training	3 (21.4%)
I don't do this	0
Don't know	0

I am open to different supervision styles

Response	Number (percentage of respondents)
I did this before the training	9 (69.2%)
I have done this since the training	5 (38.5%)
I don't do this	0
Don't know	0

I am open to other approaches, in addition to problem solving or solution-focused styles, within supervision

Response	Number (percentage of respondents)
I did this before the training	10 (71.4%)
I have done this since the training	5 (35.7%)
I don't do this	0
Don't know	0

I have agreed a supervision contract with my supervisor

Response	Number (percentage of respondents)
I did this before the training	9 (69.2%)
I have done this since the training	2 (15.4%)
I don't do this	3 (23.1%)
Don't know	0

We set an agenda for each supervision session together

Response	Number (percentage of respondents)
I did this before the training	8 (61.5%)
I have done this since the training	2 (15.4%)
I don't do this	3 (23.1%)
Don't know	0

I bring a question to supervision

Response	Number (percentage of respondents)
I did this before the training	10 (71.4%)
I have done this since the training	4 (28.6%)
I don't do this	1 (7.1%)
Don't know	0

We have used a model (e.g. Gibbs, or Hawkins and Shohet) to inform the discussion

Response	Number (percentage of respondents)
I did this before the training	1 (7.7%)
I have done this since the training	3 (23.1%)
I don't do this	8 (61.5%)
Don't know	1 (7.7%)

I am more aware of boundaries within supervision

Response	Number (percentage of respondents)
I did this before the training	10 (71.4%)
I have done this since the training	3 (21.4%)
I don't do this	1 (7.1%)
Don't know	1 (7.1%)

When the opportunity arise for me to offer clinical supervision I will feel:

Confident in offering supervision

Response	Number (percentage of respondents)
A lot more	6 (42.9%)
A bit more	5 (35.7%)
Neither more nor less	3 (21.4%)
A bit less	0
A lot less	0
Don't know	0

Effective to offer clinical supervision

Response	Number (percentage of respondents)
A lot more	4 (30.8%)
A bit more	5 (38.5%)
Neither more nor less	3 (23.1%)
A bit less	1 (7.7%)
A lot less	0
Don't know	0

Skilled in clinical supervision

Response	Number (percentage of respondents)
A lot more	4 (30.8%)
A bit more	5 (38.5%)
Neither more nor less	3 (23.1%)
A bit less	0
A lot less	0
Don't know	1 (7.7%)

Responses from the 39 participants who had provided supervision since the training.

I reflect on my supervisory approach

Response	Number (percentage of respondents)
I did this before the training	22 (56.4%)
I have done this since the training	29 (74.4%)
I don't do this	0
Don't know	0

I am aware of the LYPFT supervision policy and procedure (Policy Number C-0004)

Response	Number (percentage of respondents)
I did this before the training	23 (59%)
I have done this since the training	16 (41%)
I don't do this	2 (5.1%)
Don't know	0

I ensure supervision is regular in line with policy i.e. for at least 1 hour, 6 times per year

Response	Number (percentage of respondents)
I did this before the training	25 (64.1%)
I have done this since the training	17 (43.6%)
I don't do this	0
Don't know	1 (2.6%)

I prioritise offering supervision

Response	Number (percentage of respondents)
I did this before the training	26 (68.4%)
I have done this since the training	16 (42.1%)
I don't do this	2 (5.3%)
Don't know	0

I prepare for supervision sessions

Response	Number (percentage of respondents)
I did this before the training	21 (55.3%)
I have done this since the training	21 (55.3%)
I don't do this	3 (7.9%)
Don't know	0

I am aware of needs/expectations within supervision

Response	Number (percentage of respondents)
I did this before the training	23 (59%)
I have done this since the training	26 (66.7%)
I don't do this	0
Don't know	0

I offer supervision as a reflective space

Response	Number (percentage of respondents)
I did this before the training	25 (64.1%)
I have done this since the training	23 (59%)
I don't do this	0
Don't know	0

I consider different supervision styles

Response	Number (percentage of respondents)
I did this before the training	12 (30.8%)
I have done this since the training	29 (74.4%)
I don't do this	2 (5.1%)
Don't know	2 (5.1%)

I offer a range of approaches in supervision, in addition to problem solving and solution focused methods

Response	Number (percentage of respondents)
I did this before the training	13 (33.3%)
I have done this since the training	31 (79.5%)
I don't do this	1 (2.6%)
Don't know	1 (2.6%)

I agree a supervision contract with supervisees

Response	Number (percentage of respondents)
I did this before the training	17 (43.6%)
I have done this since the training	24 (61.5%)
I don't do this	3 (7.7%)
Don't know	1 (2.6%)

We set an agenda for each supervision session together

Response	Number (percentage of respondents)
I did this before the training	14 (35.9%)
I have done this since the training	23 (59%)
I don't do this	8 (20.5%)
Don't know	1 (2.6%)

I have asked supervisees to bring a question to supervision

Response	Number (percentage of respondents)
I did this before the training	12 (31.6%)
I have done this since the training	15 (39.5%)
I don't do this	12 (31.6%)
Don't know	2 (5.3%)

I have used a model (e.g. Gibbs, or Hawkins and Shohet) to inform the discussion

Response	Number (percentage of respondents)
I did this before the training	12 (30.8%)
I have done this since the training	12 (30.8%)
I don't do this	15 (38.5%)
Don't know	3 (7.7%)

I implement boundaries within supervision

Response	Number (percentage of respondents)
I did this before the training	22 (57.9%)
I have done this since the training	17 (44.7%)
I don't do this	2 (5.3%)
Don't know	4 (10.5%)

Since the training do you feel
Confident as a clinical supervisor

Response	Number (percentage of respondents)
A lot more	9 (23.1%)
A bit more	23 (59%)
Neither more nor less	7 (17.9%)
A bit less	0
A lot less	0
Don't know	0

Effective as a clinical supervisor

Response	**Number (percentage of respondents)**
A lot more	8 (20.5%)
A bit more	23 (59%)
Neither more nor less	8 (20.5%)
A bit less	0
A lot less	0
Don't know	0

Skilled as a clinical supervisor

Response	**Number (percentage of respondents)**
A lot more	7 (18.4%)
A bit more	23 (60.5%)
Neither more nor less	8 (21.1%)
A bit less	0
A lot less	0
Don't know	0

Appendix 3 – Ethics Application Feedback Form

Appendix 4 - Research Participant Privacy Notice

RESEARCH PARTICIPANT PRIVACY NOTICE

Purpose of this Notice

This Notice explains how and why the University uses personal data for research; what individual rights are afforded under the Data Protection Act 2018 (DPA) and who to contact with any queries or concerns.

All research projects are different. This information is intended to supplement the specific information you will have been provided with when asked to participate in one of our research projects. The project specify information will provide details on how and why we will process your personal data, who will have access to it, any automated decision-making that affects you and for how long we will retain your personal data.

Why do we process personal data?

As a publicly funded organisation we undertake scientific research which is in the public interest. The DPA requires us to have a legal basis for this processing; we rely upon "the performance of a task carried out in the public interest" as our lawful basis for processing personal data, and on "archiving in the public interest, scientific or historical research purposes, or statistical purposes" as our additional lawful basis for processing special category personal data (that which reveals racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, genetic or biometric data, and data concerning health, sex life or sexual orientation).

How do we follow data protection principles?

- We have lawful bases for processing personal and special category data.
- Data are used fairly and transparently; we will make it clear to individuals what their data will be used for, how it will be handled and what their rights are.
- We only collect and use personal data for our research, for research in the public interest, or to support the work of our organisation.
- We only collect the minimum amount of personal data which we need for our purposes.
- We take steps to ensure that the personal data we hold is accurate.

- We keep your personal data in an identifiable format for the minimum time required.
- We take steps to ensure that your data is held securely.
- We keep a record of our processing activities.

What do we do with personal data?

Research data can be a very valuable resource for improving public services and our understanding of the societies we live in. One way we can get the most benefit from this work is to make the data available, usually when the research has finished, to other researchers. Sometimes these researchers will be based outside the European Union. We will only ever share research data with organisations that can guarantee to store it securely. We will never sell your personal data, and any data shared cannot be used to contact individuals.

The project specific information will include more detail about how your data will be used.

Your rights as a data subject

Because we use personals data to support scientific research on the public interest, individuals participating in research do not have the same rights regarding their personal data as they would in other situations. This means that the following rights are limited for individuals who participate, or have participated in, a research project:

- The right to access the data we hold about you.
- The right to rectify the data we hold about you.
- The right to have the data we hold about you erased.
- The right to restrict how we process your data.
- The right to data portability.
- The right to object to us processing the data we hold about you.

Data security

We have put in place security measures to prevent your personal data from being accidentally lost, used or accessed in an unauthorised way and will notify you and any applicable regulator of a suspected breach where we are legally required to do so.

Retention periods

We will only retain your identifiable personal information for as long as necessary to fulfil the purposes we collected it for; we may then retain your data in anonymised or pseudonymised format.

To determine the appropriate retention period for personal data we consider the amount, nature, and sensitivity of the personal data, the potential risk of harm from unauthorised use or disclosure, the purposes for which we process your personal data and whether we can achieve those purposes through other means, and the applicable legal requirements.

Additional notices and guidance/policies

The University has also published separate policies and guidance which may be applicable to you in addition to other privacy notices:
Current staff privacy notice
Current students privacy notice

The Research and Innovation Service website has other relevant policies and guidance.

Communication

In the first instance please contact the researcher who your initial contact was with. You may also contact the Data Protection Officer for further information (see contact details below).

Please see the Information Commissioner's website for further information on the law.

You have a right to complain to the Information Commissioner's Office (ICO) about the way in which we process your personal data. Please see the ICO's website.

Concerns and contact details

If you have any concerns with regard to the way your personal data is being processed or have a query with regard to this Notice, please contact our Data Protection Officer (Alice Temple: A.C.Temple@leeds.ac.uk).

Our general postal address is University of Leeds, Leeds LS2 9JT, UK.

Our postal address for data protection issues is University of Leeds Secretariat, Room 11.72 EC Stoner Building, Leeds, LS2 9JT.

Our telephone number is +44 (0)113 2431751.

Our data controller registration number provided by the Information Commissioner's Office is Z553814X.

This notice was last updated on 20 February 2019.

Appendix 5 - Emails sent to potential participants

Initial Email Invitation

Hello,

You attended one of the LYPFT in house Clinical Supervisor Training sessions between 2018 and 2020. We really appreciated the verbal and written feedback each group gave us on the day. To help us evaluate and plan further training we have designed a short survey which explores how people have found putting their knowledge and skills into practice in their workplace. We are really keen to hear from people, both about positives and barriers.

We appreciate this is a challenging time at present with Covid-19 and really appreciate your involvement. We will send out two further reminders of this survey so that we can capture as many peoples' views as possible. We estimate that the survey takes 5-10 minutes to complete, and your responses are confidential.

Megan Beadle, Psychologist in Clinical Training, has been commissioned to design and carry out this evaluation.

Please click the link below to access the survey.
https://leeds.onlinesurveys.ac.uk/evaluation-of-clinical-supervisor-training-2

If you have any further questions, please do not hesitate to contact myself, or Psychologist in Clinical Training Meg Beadle (m.beadle@nhs.net) who is undertaking this evaluation, via email.

Kind regards,
Dr Gail Harrison
Principal Clinical Psychologist

Email Prompt 1

Hello,

We emailed previously to invite you to participate in a short survey evaluating the LYPFT in house Clinical Supervisor Training session you attended between 2018 and 2020.

Huge thanks to those of you who have already completed the survey. It's really helpful to be getting this data.

The survey will remain open until Friday 21st August 2020. We estimate that it takes 5-10 minutes to complete, and your responses are confidential.

Please click the link below to access the survey.

https://leeds.onlinesurveys.ac.uk/evaluation-of-clinical-supervisor-training-2

If you have any further questions, please do not hesitate to contact myself, or Psychologist in Clinical Training Meg Beadle (m.beadle@nhs.net) who is undertaking this evaluation, via email.

Kind regards,

Dr Gail Harrison
Principal Clinical Psychologist

Email Prompt 2

Hello,

Thank you again to those of you who have already completed the short survey evaluating the LYPFT in house Clinical Supervisor Training sessions between 2018 and 2020. It's great to receive your feedback.

The survey is due to close Friday 21st August 2020, and we were wondering if anybody else would like to contribute. We estimate that the survey takes 5-10 minutes to complete, and your responses are confidential.

Please click the link below to access the survey.

https://leeds.onlinesurveys.ac.uk/evaluation-of-clinical-supervisor-training-2

If you have any further questions, please do not hesitate to contact myself, or Psychologist in Clinical Training Meg Beadle (m.beadle@nhs.net) who is undertaking this evaluation, via email.

Kind regards,

Dr Gail Harrison
Principal Clinical Psychologist