PPN SOUTH WEST Psychological Professions Network

PROMOTING EXCELLENCE IN PSYCHOLOGICAL HEALTH & WELLBEING

Rapid Review of the Psychological Supervision Requirements for Serious Mental Health Problems across the South West

April 2022

Strickland, S., Azer, S., Gallop, C., Self, P., and Spaull, S.

With acknowledgement to Ann Gledhill

PPNSW: Rapid Review Supervision Scoping Project Report

Introduction

In 2020, NHS England and NHS Improvement published implementation guidance to support the expansion of access to evidence-based Psychological Therapies for Serious Mental Health Problems (PT-SMHP). Together with dedicated funding to expand training provision in NICE recommended Psychological Therapies for Psychosis, Bipolar Disorder and Personality Disorder, increases in baseline funding for local NHS systems to expand Adult and Older Adult Mental Health services, and further transformation funding to implement new models of integrated primary and community mental health services across the country, this guidance for NHS provider organisations and Arms-Length Bodies specifically aimed to support expansion of psychological therapy capacity in line with the NHS Long-Term Plan (2019-2024). Expanding the provision of PT-SMHP was identified as one key way to transform the care offer and shift the culture of community mental health services towards more effective and accessible bio-psycho-socially balanced provision.

In February 2022, the guidance was updated and re-published to include recommended therapies for Eating Disorders (and an intension to further expand to include PTSD as well) alongside other serious mental health problems and to re-confirm the continued importance of this programme following the COVID-19 pandemic. The guidance set out clear principles for delivery of PT-SMHP as well as required therapist competencies, qualifications, accreditations, approved training and minimum amounts of dedicated time for delivery of therapy. The guidance also indicated the requirements for therapy and modality specific supervision both during training and ongoing for those practicing PT-SMHP and the required competencies, training, and experience of supervisors.

In the South West of England, a regional meeting of Chief Psychological Professions Officers (CPPOs) and other senior leads responsible for implementing this guidance within Mental Health Trusts, together with regional leads from Health Education England and NHS England and Improvement, was convened in 2021. This group has continued to meet regularly to support the most effective allocation of limited training places across the region and to work collectively to address shared difficulties and challenges implementing the national guidance. One of the common issues discussed by this group and recognised by the national programme, is the limited availability and capacity of appropriately qualified and experienced supervisors for each of the recommended therapies. Some provider leads have identified this, alongside difficulties releasing staff from other duties, as the most significant factor limiting the numbers of people who they can support to undertake training and then deliver PT-SMHP.

Project Overview

NHSE/I in the South West commissioned the PPNSW to complete a rapid review to understand the needs for supervisory capacity to support the development of a psychologically informed workforce to deliver the aspirations as described in the NHSE/I long term plan.

This review explored the impact of developments described in the community mental health framework and the psychological supervision needs that will arise as a result of this transformation. Within scope of the review were also newly developed roles (e.g. Clinical Associate Psychologists and Mental Health and Wellbeing Practitioners) alongside wider system transformation needs in primary care and Voluntary Community and Social Enterprise (VCSEs) to ensure that a psychologically informed workforce is available.

This review did not include services outside the scope of the community mental health framework i.e. inpatient, crisis liaison services etc. The scoping exercise focussed in the first instance on adult and older adult services but does include 16-25 year olds.

Recommendations from this review aim to assist the Psychological Leads in developing a strategic plan for their local mental health system which will help inform local developments and delivery in the changing mental health system which is incorporating not only NHS providers but local VCSEs.

Overarching Project Aims

The project had several key overarching aims:

- To understand the needs for supervisory capacity to support the development of a psychologically informed workforce to deliver the aspirations as described in the NHSE/I long term plan.
- To explore the impact of developments described in the community mental health framework and the psychological supervision needs that will arise as a result of this transformation.
- To provide information to help identify a strategic plan with each CPPO in each STP area across the South West to move towards a consistent approach to the delivery of psychological therapies in line with the proposed development of psychological professions.

Specific Project Aims

- To identify the supervision requirements to support the development of specialist Psychological therapies in line with the Psychological therapies for SMI development of NICE evidence based psychological therapies.
- To identify the supervision requirements to support the development of NICE evidence-based therapies that are likely to be developed in the second phase of developing the capacity of psychological therapy provision (EMDR and CAT).
- To better understand the need for psychological provision to support the development of new roles such as CAPS, Mental Health and Wellbeing Practitioners etc.
- To better understand the need for psychological supervision for the wider mental health workforce to support the delivery of psychological interventions that may not be deemed as specialist interventions but are developing evidence through practice-based delivery such as DBT lite, STEPPS etc.
- To better understand the need to work with local Partners such as the VCSE and primary care to embed psychologically informed practice into local delivery which will be underpinned by psychological thinking allied to the development of culturally competent trauma informed care which is a key aspiration in the Community Mental Health Framework.

Data collection and analysis

The rapid review consisted of three different elements:

1. Requirement Mapping: The first was an exercise to map all the supervision requirements for the identified therapies and roles. This involved examining curricula for details of what qualifications and experience are necessary for a supervisor, additional tasks a supervisor will have to complete, and how many hours of supervision are recommended, both before and after qualification. Course leads were also contacted where this information was not available.

2. Survey: The second element was a survey (See Appendix 2) to capture current supervision capacity for the different therapies and roles across the South West. Chief Psychological Professions Officers (CPPOs) and service leads were contacted and asked about numbers of supervisors, trainees and qualified staff being supervised, staff that could supervise but are not currently, and any factors that would enable their staff to start supervising or increase the number of people they supervise. Data collection took place over a month-long period, primarily via the use of a Microsoft online form.

Respondents were also offered a meeting to gather this information instead of completing the form by themselves. One Trust received an Excel spreadsheet in place of the online form, at their request. The data were then validated with Trust PT SMHP leads.

3. Focus Group: Following the survey, the final element was a focus group (See agenda / questions in Appendix 3) with the Trust PT SMHP leads where they were asked about requests made to them for the supervision of both structured psychological interventions and broader psychologically informed practice, where these requests have come from, and what meeting them would entail. The content of the transcript of the focus group was analysed and reviewed for themes which were then validated by a colleague. The time constraints of the project meant that a formal qualitative method was not used, and it was not possible to formally validate the themes with the Trust leads.

Outcome and Learning

1. Supervision Requirement Mapping Exercise:

Appendix 1 contains the table that resulted from the supervision requirements mapping exercise. It became apparent during this exercise that much of the information about supervision requirements, hours, and eligibility pre- and post-qualification was unclear or difficult to find, with training providers and others having to be contacted for information that was not publicly available. Some aspects of the requirements were not specified for some of the modalities, especially for who is eligible to supervise qualified staff and how many hours of supervision qualified staff should receive. There were also differences in the amount of hours of supervision specified in national curricula and those recommended by different training providers.

2. Survey Results - Quantitative Data (See Appendix 4 for full summary data):

A key piece of learning that became apparent early on was that information about supervision capacity is not held in one place in each Trust. While some survey respondents collected the data on the different modalities and roles and then answered for each category on the survey, others sent the survey on to different service leads throughout the Trust who each answered for the categories they were familiar with. Two of the responding Trusts in particular are large and complex organisations, so the information being sought was sitting in a lot of different places. This, in part, led to a varying response rate for the survey, with some Trusts submitting details of supervision for all therapies, and some submissions leaving gaps. It is also worth noting that not all Trusts provide all 12 of the identified therapies and roles, and not all were available to validate the data after it was collected. It also proved very difficult to clearly establish overall current or potential supervision capacity for a number of reasons. Variation in supervision format, use of additional external supervisors, the number of modalities offered in different Trusts and clarity about the extent of supervisors' time allocated to supervision as opposed to other responsibilities, revealed a very complicated picture.

Responses to the survey indicated differences between Trusts in the manner that supervision is provided. Some Trusts use group supervision for some of their modalities rather than individual one to one sessions, and some make greater use of peer supervision. Though the Trusts use internal staff for most of their supervision, some use external supervisors to meet gaps, with this being most prevalent for EMDR. Table 1 shows how many services offer each modality and role, and how many use internal and external supervision for each. While most services source at least some of their supervision for each modality and role internally, external supervision is used most commonly for EMDR and MBT, and in one case each for MANTRA, SCM, and CAPs. However, it was noted by one respondent that external supervision is more problematic for modalities/roles that involve group work or greater local team integration. Though respondents were not asked specifically about whether they make use of peer and group supervision,

some did mention it in their responses, with group supervision utilised by three of the services, and peer by two of them.

Table 1: Number of services providing modalities and roles and source of supervision

The number of services providing each modality and role, and whether they utilise internal and external supervision			
Modality/Role	**Number of services providing**	**Number using internal supervision**	**Number using external supervision**
CBT for ED	5	5	0
CBT for PD	3	3	0
CBT for P & BD	8	8	0
CAPs	7	7	1
CAT	9	9	0
DBT	8	8	0
EMDR	10	6	5
FIP	7	7	0
MANTRA	2	2	1
MHWP	1	1	0
MBT	5	3	2
SCM	4	3	1

There were also differences in the numbers of supervisees per supervisor across services for the different modalities and roles, as shown in the Table 2. This difference is most pronounced for FIP, where one Trust has 30 supervisees for each of their supervisors, and another has two supervisors for each supervisee. Some of these differences can be explained by some Trusts making use of group supervision, as well as some having staff where the majority of their role is supervision, so a single individual will supervise a large number of staff, where for others supervision is a smaller part of their work.

Table 2: Range and average of number of supervisees to supervisor allocations

Modality/Role	**Maximum supervisees per supervisor**	**Minimum supervisees per supervisor**	**Average supervisees per supervisor**
CBT for ED	9	1	4.2
CBT for PD	8	2	5
CBT for P & BD	16	1.5	4.69
CAPs	15.5	1.2	5.12
CAT	9	2	4.37
DBT	7	1	3.85
EMDR	8	0.4	5.91
FIP	30	0.5	9.21
MANTRA	*	*	*
MHWP	*	*	*
MBT	8	1	4.75
SCM	25	4	11.34

* - Insufficient data, one complete entry

3. Survey Results - Qualitative Information

There were a number of key themes in the responses to the qualitative questions in the survey:

- Capacity was mentioned as an issue across every Trust in response to questions about what would enable staff who are already supervising to take on more supervisees, and what would enable staff who are not currently supervising to do so. It was frequently reported, across organisations and modalities and roles, that staff who are already supervising are offering as much supervision as they currently can, and what would enable them to increase this included backfill for their other responsibilities to release their time for supervision, with one respondent saying that the enabling factor would be "expanding the number of trained supervisors to cope with the projected increase in trainees." One respondent also mentioned this in relation to external supervision, with the capacity of external supervisors being a limiting factor as well.

  Trainees becoming qualified and therefore requiring less supervision was mentioned as a factor that was expected to increase capacity, as was filling currently vacant posts, though one respondent highlighted that doing this is difficult. There were some mentions of Trusts having extra capacity, however, with two saying this was the case for their EMDR provision, and one having potential extra hours for CAT supervision.

- Supervision being a recognised part of a supervisor's role was seen as important in protecting their time and enabling them to provide supervision. The inclusion of supervision responsibilities in their role, and with protected time in their job plan, was mentioned across a number of Trusts. However, there was a tension noted in both the survey and conversations with leads surrounding it, that the inclusion of supervision within a job role might require a change in the staff member's Agenda for Change pay banding, leading to additional costs and inter-professional tensions within the Trust. The issue of capacity and backfill was also evident in relation to this, with one respondent saying that "these staff are largely those also responsible for offering other therapies and other aspects of psychological practice so further job-planned time for MBT supervision would need to be backfilled to avoid a loss of other aspects of service."

- Competing Demands: Our findings made it clear that supervisors across the region have a range of different responsibilities, with only 8 staff identified across the region who are only supervising one therapy or role. The vast majority of staff have multiple therapy trainings and commitments and providing supervision for more than one model, resulting in competing demands on their time, especially when they also have other clinical duties. Having a dedicated modality specific lead was highlighted as a way of addressing this issue, and one Trust reported having staff who are employed specifically to supervise their CAPs.

4. Focus Group

Following the survey, we conducted a focus group to further understand the competing demands on supervision provided by the Trusts. The group included representation from all but two Trusts in the region. Three key themes were identified from the focus group:

- Demand and capacity: Members of the group said that there is "an issue about capacity," noting both the availability of supervision and the high volume of requests for supervision generally. Leads from multiple Trusts highlighted the large number of requests, with some of them saying they expected a further increase, and that HEE training in particular put pressure on their capacity.

The variety of these requests was also mentioned, with requests from both the voluntary sector and elsewhere in Trusts for not only modality specific supervision, but also reflective practice, team and generic clinical supervision. One member said there was a reluctance to "get involved in any [service expansion] bids because we just don't have the capacity to supervise."

- The planning and governance around providing supervision was also a common theme. While some Trusts run a service in partnership with the voluntary sector or are in the process of developing that partnership with built in supervision, this was not the case everywhere. Some areas reported that voluntary sector partners expected the supervision without any formal roles being created to provide it, and that there were similar issues within Trusts as well, with new teams being created with supervision only thought about afterwards, and then being requested from the leads' departments. The importance of building in supervision at an early stage was noted, and one Trust said that they employ specific supervision and reflective practice leads to address this. Some leads have also been requested to carry out additional oversight by their Trust, to review the governance practice and models of third sector partners. This work was seen as adjacent to supervision, and another element of the structures around it that need to function for supervision to be provided effectively.

- Understanding and expectations: Several Trusts mentioned that the understanding of supervision, its provision, and its importance varied. The difference between clinical supervision and reflective practice was highlighted, with one region saying that some staff who are qualified in modality specific supervision would not necessarily be able to provide the reflective practice that the third sector often ask for. In another service there had been a lack of understanding about the type of supervision and support required by social prescribers, leading to private psychotherapists being employed to provide supervision that was not at an appropriate level for the social prescribers, resulting in them lacking basic support.

  Adding to comments about building supervision into a service, services added that not only was this necessary, but it was also important to ensure that it was perceived as such. Another service added that though they had included supervision in one of their pathways at an early stage, they then found that other parts of the system were then expecting them to supervise other staff that were out of their scope and added that being explicit about what supervision these staff offer, and to whom, is important in addressing this misunderstanding. Expectations that they would provide supervision to wider and generic teams were mentioned across multiple different services, with one participant saying that it is important that supervision is integrated into teams "rather than it being seen as somebody else's business."

Summary and Key Findings

The key learning from this rapid scoping project is presented below in relation to each of the initially identified aims of the project, followed by a collated summary of the identified barriers and potential enablers to maximising supervision capacity for the PT-SMHP programme based on the learning from this project.

1. To identify the supervision requirements to support the development of specialist Psychological therapies in line with the Psychological therapies for SMI development of NICE evidence based psychological therapies.

The information presented in appendix 1 includes a collation of the available information about supervision requirements for the existing PT-SMHP modalities. While gaps remain in the guidance, this resource will support planning to maximise the efficient use of available supervisor time.

While it was clear from the information collected from service leads that the availability of supervisors was a limiting factor in expanding access to evidence-based PT-SMHP, it was also apparent that there was additional supervisor capacity that could be drawn upon but only at the expense of other activities, including direct therapy provision, supervision of other modalities and roles, other areas of clinical practice and other types of non-therapy specific clinical supervision. These other demands on the time of practitioners able to supervise are also key to the delivery of national and local policy initiatives, resulting in competing pressures on capacity and local priority dilemmas. There was evidence of a positive expectation that general expansion in the number of psychological professionals would increase the supply of supervisors over time but that in order to train more therapists now, there was a particular pressure on supervisor capacity.

While the majority of existing supervision needs for the current PT-SMHP modalities is being met internally, additional external supervision is being bought in by at least one Trust in the region for SCM, MANTRA and MBT. This is most common for MBT (2 Trusts).

2. To identify the supervision requirements to support the development of NICE evidence-based therapies that are likely to be developed in the second phase of developing the capacity of psychological therapy provision.

EMDR and CAT are both expected to be included in the expansion of the PT-SMHP programme in the near future. Both modalities are already delivered widely across the region. No service reported requiring external supervisors for CAT and one service reported having additional supervisor capacity to their current needs. Interestingly, EMDR was the modality where the largest number of services were purchasing additional external supervisors (5 services) but also where the largest number of services reported supervisor capacity additional to their needs (2 services). Obviously, inclusion in the PT-SMHP programme may lead to further expansion in these modalities and local priorities between modalities may significantly alter demand for supervision. However, the information collected during this project suggests that there may not currently be a problem with supervisor capacity for CAT and while there does appear to be a problem for EMDR, this might be mitigated to some extent by a cross-region pooling of supervisor resources.

3. To better understand the need for psychological provision to support the development of new roles such as CAPS and Mental Health and Wellbeing Practitioners.

Both the new roles of CAPs and MHWPs are currently being implemented in the region and are significantly contributing to the general expansion in Psychological Professionals required to meet the aims of the NHS Long Term Plan and the Community Mental Health Framework. While the supervisor requirements of the two roles are slightly different, they both draw on professionals who are also likely to be supervisors for PT-SMHP modalities (CBT Therapists and Practitioner Psychologists). While some services implementing these roles have employed additional staff specifically to meet the supervision needs for these new roles, this is likely to contribute to the general vacancy rates and therefore the demands on existing supervisor time across modalities and roles. One service reported that they are using external supervision to meet their needs for these expanding new roles.

In addition, the increase in training places for some professions such as Clinical Psychologists in recent years also places an additional demand on supervisors in the region to provide placements and supervision.

4. To better understand the need for psychological supervision for the wider mental health workforce to support the delivery of psychological interventions that may not be deemed as specialist interventions but are developing evidence through practice-based delivery.

In addition to therapy-modality specific supervision and clinical/professional supervision for new roles, the service leads described a range of other clinical activities within existing services that require the provision of supervision. This included specialist assessment and bespoke interventions for complex cases, specific psychologically-informed structured interventions such as group programmes that draw on psychological evidence and therapeutic techniques but are not formal therapies or part of the PT-SMHP programme, and reflective-practice supervision to support multi-disciplinary teams or the psychological practice of colleagues from other disciplines or roles (e.g. Peer Support Workers). Many of these other activities are central to implementing broader Mental Health policy initiatives (including the People Plan which focuses on staff wellbeing and workforce retention as well as improving services) as well as meeting local service-development needs (in line with the CMHF) and the service leads reported increasing demands for various types of supervision to support them. While requiring some differences in knowledge, skill and experience, these other supervisory activities draw on similar core competencies to therapy-modality specific supervision and therefore inevitably draw on a similar pool of experienced psychological professionals. It was also highlighted by service leads, that while appropriately recognised as a need, supervision was often not factored into the funding or workforce planning of service developments. Multiple services reported that this led to unexpected additional demands on supervisor time and dilemmas over local priorities for limited supervisor capacity.

5. To better understand the need to work with local Partners such as the VCSE and primary care to embed psychologically informed practice into local delivery which will be underpinned by psychological thinking allied to the development of culturally competent trauma informed care which is a key aspiration in the Community Mental Health Framework

The Community Mental Health Framework and other NHS and Social Care policies that are currently being implemented at pace across the region, emphasise much greater collaboration and inter-agency, cross-sector working to meet diverse local population needs and support more integrated care systems. While local developments across the South West vary in detail and maturity, ICSs in the region are driving closer working relationships between traditional mental health services and other system partners such as primary care, social care and voluntary and community sector organisations. National funding initiatives to support these policies have also included requirements for systems to demonstrate improvements in areas of practice underpinned by psychological competencies, such as “trauma-informed care” and reducing health inequalities across local populations. Aligned to this, there has recently been a review of the anti-racist training and cultural competencies required by supervisors of some trainee practitioner psychologists, which is likely to be influential in shaping expectations of supervisor competence more broadly.

The service leads who contributed to this project described increasing requests for supervision from partner agencies across local systems to support these aims. In addition to requests for reflective-practice supervision, some ICSs in the region have commissioned the provision of specific psychologically-informed interventions by VCSOs and in at least one ICS an alliance of VCSOs has been commissioned to deliver some formal evidence-based psychological therapies alongside IAPT and secondary care mental health services. Service leads highlighted how similar problems of supervision requirements not being factored into to funding or workforce plans at an early stage, as experienced within organisations, are also arising across systems.

They reported that requests for supervision within the context of greater collaboration are often not clearly resourced and contribute to the demands placed on the limited supervisor resources locally. There were also reports of additional requests for psychological (including therapy) governance support across system organisations which were likely to drawn on the same experienced staff who provide supervision within services.

Identified Barriers and Potential Enablers

The key findings suggests that a simple demand and capacity analysis of supervision for the PT-SMHP programme is unlikely to be sufficient to understand the problems or identify potential solutions. The responses to this project highlight that allocating increased supervisory resources to the PT-SMHP programme, and indeed improving access to evidence-based formal psychological therapies generally, is situated within a broader policy context that involves competing demands, practical dilemmas and difficult strategic decisions for service leads. Nevertheless, during the project a number of key barriers to maximising supervisor capacity were identified, along with potential enablers. These are collated and presented below in Table 3. Some of these enablers are already available or could be implemented by local service leadership. Others require coordination across systems and regional planning or national resources and implementation.

Table 3: Key barriers and potential enablers to maximise supervision capacity

Identified Barriers	Potential Enablers
Lack of clarity over supervision requirements	Collated information in Appendix
	Reviewing/Maximising use of group and peer supervision formats (within published standards for each modality/role where these exist)
	Review /Maximise use of technology for remote supervision (within published standards for each modality/role where these exist)
Saturated local supervisor capacity given other demands on time	Funding for use of external supervisors for specific modalities The cultural shift to online working has opened up new opportunities for identifying supervisors in other regions with specialist skill sets. Online working also requires no travel time or expenses.
	Regular sharing of information between organisations regarding local supervisor demand/capacity for specific modalities
	Financial back-fill for those undertaking supervisor training
Lack of regional networks for some modalities	PPN Communities of Practice provide a model for regional networks and support for coordination
Supervision competencies and time allocation not clearly specified in Job Descriptions or Job Plans	The development of example JDs for supervisors and exemplar Job Plans for PT-SMHP therapists and supervisors
	The development of specific supervisor and modality leadership posts at appropriate A4C banding
High general vacancy rate across services	Use of 'recruit to train' models to appoint to supervisor posts and maximise impact of HEE supervisor trainings for specific modalities
	Taking advantage of high general vacancy rate to review supervision competencies, potential for 'recruit to train' roles and specified supervision expectations in Job Plans

Supervision skills required across multiple modalities, roles and activities often provided by the same individuals	Commission / Develop generic supervisor training alongside modality specific courses, mapped against core supervisor competencies and specific modality requirements
	Prioritise places on top-up and briefer practitioner training for already experienced supervisors not currently meeting specific modality requirements
Supervision requirements not factored in, funded or planned for, in service developments and workforce plans	Development of clear guidance for workforce planners on requirements of supervision and indicative resource required per therapist / wte role / activity hour
	Greater involvement of CPPOs and other Psychological Professionals in workforce planning forums at provider and ICS levels

Recommendations

For Service Leads:

1. It is recommended that service leads use the information provided in Appendix 1 to review their current supervision arrangements in order to maximise the capacity of supervisors; including:
    - the use of group and peer formats against standards for each modality
    - the use of remote technology against standards for each modality
2. Ensure that there is clear time allocation for the provision of supervision in supervisor's job plans
3. Prioritise the allocation of places on top-up and briefer practitioner training courses to already experienced supervisors not currently meeting specific modality requirements

For Workforce Planners and Service Transformation Leads:

4. Ensure that supervision requirements are clearly understood, mapped and resourced in all service developments and service transformation plans. Any assumptions that supervision needs can be met through existing resources should be routinely made explicit and negotiated across systems. Ensure that procedures for organisational approval of workforce plans have involvement of senior Psychological Professionals who can advise on requirements and resources required.
5. Take advantage of the opportunities that the general high vacancy rate and new resources offer to consider the development of specific supervisor and modality leadership posts through all recruitment activity.
6. Review all vacant roles in regard to the required supervision competencies and specified supervision expectations in job plans.
7. Consider all vacant roles for the potential to use 'recruit to train' models making use of HEE supervisor training to grow new supervisor capacity over time.

For Organisations and Local Systems (ICSs):

8. In line with recent guidance, ensure involvement of CPPOs and other Psychological Professionals able to advise on supervision and other support requirements, in all workforce planning forums at organisational and system levels.

For Regional Arms-Length Bodies:

9. Consider regional procurement of additional external supervisor time for MBT and EMDR
10. Consider providing financial back-fill for those undertaking supervisor training
11. Commission generic supervisor training alongside modality specific courses, mapped against core supervisor competencies, cultural competency and specific modality requirements

12. Commission a specific regional project to develop practical resources to support Service Leads, Workforce Planners and Transformational Leads in organisations and systems to implement workforce changes in line with the PT-SMHP programme. This should include:
    - Development of clear guidance for workforce planners on requirements of supervision and indicative resource required per therapist / wte role / activity hour
    - Development of example JDs for supervisors and modality leads (at appropriate Agenda for Change Banding)
    - Development of exemplar Job Plans for therapists, supervisors and modality leads indicating the amount of time required for each activity

Via PPN-SW:

13. Explore options to share supervisor capacity across organisations for EMDR (there may be less need for other modalities currently)
14. Regular sharing of information between organisations regarding local supervisor demand and capacity issues – using the PT-SMHP network
15. Develop and encourage Community of Practice around specific modalities

For the National Programme:

16. Clarify the training and ongoing supervision requirements for each modality as part of updates to the PT-SMHP implementation guidance. The information in appendix 1 should be used as the basis for this and gaps addressed.

PPN Psychological Professions Network
PROMOTING EXCELLENCE IN PSYCHOLOGICAL HEALTH & WELLBEING

Appendix 1

Supervision Requirements for Psychological Therapies for Serious Mental Health Problems

Psychological therapy	Course providers	Supervisor requirements during course	Hours per month during course	Additional tasks for supervisors	Supervisor requirements post qualification	Hours per month post qualification
Cognitive Behavioural Therapy for Psychosis and Bipolar Disorder CBT-p Curriculum	University of Exeter Greater Manchester MH NHS FT University College London University of Hull Oxford Health NHS FT	• AfC band 6 and above • Experienced CBT-p practitioner • BABCP accredited psychotherapist who has completed 5 day supervisor training or equivalent • Do not need to be accredited supervisors • 50% supervision from course provider and 50% from Trust	• Minimum 1 hr per month specific CBT-p supervision. University of Exeter recommend 1.5 hr Experienced CBT-p practitioner • 30-45 hrs a year. Varies according to whether it is group or 1:1 supervision. Some supervisors offer more	• 8 cases under course supervision • 1 Formative audio/ video recording of a CBT assessment/ therapy session • Open Day • 1 hr Supervisor workshop • 1 Supervisor report per year: 1 hour • Termly meetings with Clinical Leads: 1.5 hours • Termly liaison with HEI supervisor: 1.5 hours	• BABCP accreditable therapist or supervisor. Must be eligible for accreditation as CBT therapist with BABCP, but no requirement to be currently.	• University of Exeter recommend 1.5 hr • Depends on BABCP and/or service requirements, caseload, and confidence.
Cognitive Behavioural Therapy for Personality Disorder CBT-PD Curriculum	University of Exeter Greater Manchester MH NHS FT	• AfC band 6 and above • Experienced CBT-p practitioner • BABCP accredited psychotherapist who has completed 5 day supervisor training or equivalent • Do not need to be accredited supervisors	• Minimum 1 hr per month specific CBT-p supervision. University of Exeter recommend 1.5 hr Experienced CBT-p practitioner	• 8 cases under course supervision • 1 Formative audio/ video recording of a CBT assessment/ therapy session • Open Day • 1 hr Supervisor workshop	• BABCP accreditable therapist or supervisor. Must be eligible for accreditation as CBT therapist with BABCP, but	• University of Exeter recommend 1.5 hr • Depends on BABCP and/or service requirements,

	University College London University of Hull Oxford Health NHS FT	• 50% supervision from course provider and 50% from Trust	• 30-45 hrs a year. Varies according to whether it is group or 1:1 supervision. Some supervisors offer more	• 1 Supervisor report per year: 1 hour • Termly meetings with Clinical Leads: 1.5 hours Termly liaison with HEI supervisor: 1.5 hours	no requirement to be currently.	caseload, and confidence. Frequency could reduce to monthly
Cognitive Behavioural Therapy for Eating Disorders CBT-ED Curriculum	University College London University of Sheffield South London and Maudsley NHS Foundation Trust	• AfC band 6 and above • BABCP accredited, experienced and competent in delivering CBT-ED • Completed 5 day supervisor training or equivalent	• Minimum 1 hour per month of CBT-ED specific supervision • 70 hrs of clinical assessment • Clinical/ supervision hours based on a minimum of a 2-day clinical practice week but can be adjusted	• Portfolio assessed by teaching team - includes case flow charts, sample assessment reports, supervision logs, session recordings • Onsite supervisor placement reviews and final report	Not specified	Not specified
Dialectical Behaviour Therapy DBT Curriculum	British Isles DBT Training Some Trusts have internal training	• AfC band 6 and above • Accredited DBT therapists, DBT supervisors or DBT trainers with an independent accrediting body (e.g. Linehan Board of Certification, Society for DBT in the UK and Ireland) • Supervisors subject to course approval	• 2nd year a minimum of 20 hrs of individual supervision & 15 hrs of group supervision • Mix of peer supervision within the consultation team and course team	• 10 hours of live clinical material submitted to the supervisor in audio or video format • Marking written examinations, case reports, theoretical essays and literature reviews, assessing logbook	Not specified	Not specified
Mentalisation Based Treatment MBT Curriculum	Anna Freud Centre	• AfC band 6 and above • Senior clinician who has completed the MBT Certificate Course – Practitioner Level training • Have professional registration	• Minimum of twice monthly for 1 hr with a minimum of 22 supervision sessions attended • At least 4 hrs supervision for each	• Observation, discussion, and review of recordings of the trainee's MBT individual sessions. Minimum of 3x15 minute sections from different sessions over the whole treatment for each patient	Not specified	Not specified

		• Recognised by the Anna Freud National Centre for Children and Families as having specific competence to act as a supervisor in their chosen model	case with no more than 3 other supervisees (from the same team where possible)	• Discuss reflective summaries of MBT cases produced by students • MBT supervision of therapy with four individuals or two groups		
Family Interventions for psychosis and bipolar disorder FIP Curriculum	University of Exeter	• Not specified within curriculum • University of Exeter recommend supervisors are trained in FIP and based in the same place of work as the trainee • BPS guidelines require "experienced and qualified clinician with relevant training." • Minimum of one year of supervised practice in FIP by HEI	• Minimum of 1 hr per month of FIP-specific supervision from an experienced FIP practitioner (within service) • Minimum of 10 x 2 hr group supervision sessions (with a maximum of 6 people in a group), by HEI	• None for workplace. HEI complete the following: • Supervise trainees assessing and treating at least 2 families • Assess at least one formal audio/video taped family session (HEI) • Review clinical portfolio (HEI) • Assess written examinations Theoretical essays/ literature review (HEI)	• Minimum of one year of supervised practice in FIP by HEI • BPS guidance includes regular supervision from an experienced, qualified FIP clinician, does not specify who or how much time	Not specified
Clinical Associate in Psychology (CAP) No available curriculum	University of Plymouth University of Exeter Accredited by BPS	• Qualified HCPC registered Psychologists working within a clinical context	• 1 hr a week. This can be 1:1 with additional group, but cannot only be group • Additional 3 hrs contact with CAP from supervisor or other senior members of the multidisciplinary team	• Supervisors are also clinical educators and therefore are required to monitor progress and confirm CAPs are operating at the expected level • Read academic and clinical work, attend clinical tutor and tripartite (apprenticeship based) meetings • Expected reduction in supervision hours, but there is current variation as supervisors set up systems and CAPS are embedding within Trusts	• Varies by location. BPS accreditation committee decision expected shortly to standardise.	Not specified. Cornwall offers 1 hr 1:1 every other week plus 1.5 hr group supervision (often peer facilitated)
Mental Health Wellbeing Practitioner MHWP	University of Exeter	• HCPC registered Clinical Psychologist, BABCP accredited CBT Therapist, or MHWP with at least two years post-	• Minimum 80 hrs clinical contact • Minimum 40 hrs clinical supervision,	• 2 – 5 days of supervisor training, around 30 hrs • 2 hrs induction training, 3 hrs writing supervisors reports, 3	Not specified. University of Exeter based on PWP model of supervision post	Not specified

Curriculum		qualification practice experience • All supervisors should have specific training on MHWP supervision • Case management supervisor can be any suitably qualified professional. Clinical skills supervisor must have competencies in the interventions which the MHWPs will provide • Potential for a developing Senior MHWP role that would provide supervision	at least 20 in case management supervision and at least 20 in clinical skills supervision. • 15 practice-based learning days directed by education providers • University of Exeter recommend individual 4hrs case management supervision per month and fortnightly individual or group-based clinical skills supervision (2hrs per month if 1:1 or 4hrs per month if groups of 2 – 3 supervisees)	hrs observed practice, 3hrs termly meetings, and 3hrs placement meeting over a year	qualification as per IAPT Manual, with weekly caseload management supervision plus monthly clinical skills supervision	
Eye Movement Desensitization and Reprocessing EMDR EMDR website	Currently no HEE provider	• Accredited EMDR Europe Consultant with 3 years' experience of EMDR	• 3 supervised clinical cases with 10 hrs of supervision (from training provider) and consultancy • Minimum 20 hrs across 25 clients required for accreditation	Not specified	• If trainee pursuing accreditation supervisor must be an accredited EMDR consultant • If not pursuing accreditation supervisor can be an accredited EMDR practitioner or a peer group	Somerset provide monthly group supervision, approx 1.5 hrs a month with 3 - 4 in group

Cognitive Analytic Therapy CAT Curriculum in development	Association for Cognitive Analytic Therapy (ACAT) University of Exeter	• Experienced CAT therapist/ practitioner • ACAT accredited supervisor	• Weekly (15 mins per case) until completion of all clinical work for the course • 225 supervised clinical hours to fulfil UKCP requirements	• Face to face discussion in groups • Supervise 8 cases over a year	Not specified	Not specified
Maudsley Model of Anorexia Therapy for Adults MANTRA Training Programme	South London and Maudsley NHS FT Institute of Psychiatry, Psychology and Neuroscience in partnership with King's College London	• AfC band 6 and above • Experienced MANTRA practitioner • Several Trusts use same requirements as CBT-ED	• Minimum 1 hr per month	• 20 supervision sessions, fortnightly over 40 weeks	Not specified	Not specified
Structured Clinical Management SCM Curriculum	Anna Freud Centre	• AfC band 6 or above with supervisory role within the MH team, or already part of existing established SCM team • Clinical supervision- 60 minutes fortnightly with an experienced SCM supervisor.	• 22 hrs, including 12 hrs of group supervision, weekly peer supervision with the SCM team, minimum 40 peer supervision meetings over a year • 1hr fortnightly with SCM supervisor in team	• Review recordings of the trainee's SCM work • Review records of clinical practice and supervision • Review written summary of an SCM assessment and SCM group treatment and meet trainee to discuss • Supervisor must attend the SCM training alongside a group of at least 3 trainees	Not specified	Not specified

Appendix 2

Survey

This survey was hosted online using Microsoft Forms

SMI Supervision Scoping

Thank you for taking part in our survey to identify current potential supervision capacity for therapies for Serious Mental Illness across the South West, and any gaps or barriers to provision.

Please use this form to give us information about supervision for existing therapies including:

- Cognitive Behavioural Therapy for Personality Disorder
- Cognitive Behavioural Therapy for Psychosis and Bipolar Disorder
- Cognitive Behavioural Therapy for Eating Disorders
- Dialectical Behaviour Therapy
- Family Interventions for Psychosis
- Mentalisation-Based Therapy
- Structured Clinical Management
- Maudsley Model of Anorexia Nervosa Treatment for Adults

Therapies that are in development, including:

- Eye Movement Desensitization and Reprocessing
- Cognitive Analytic Therapy

New roles, including:

- Mental Health and Wellbeing Practitioner
- Clinical Associate in Psychology

If you have any difficulties with this form then please get in touch with us at ppn-sw@exeter.ac.uk

1. Email
2. Which course, intervention or profession are you giving details about? Please note, if your organisation supervises more than one we would ask you to complete the form again for each one.
   ☐Cognitive Behavioural Therapy for Personality Disorder
   ☐Cognitive Behavioural Therapy for Psychosis and Bipolar Disorder
   ☐Cognitive Behavioural Therapy for Eating Disorders
   ☐Dialectical Behaviour Therapy
   ☐Family Interventions for Psychosis
   ☐Mentalisation-Based Therapy
   ☐Eye Movement Desensitization and Reprocessing
   ☐Cognitive Analytic Therapy
   ☐Mental Health and Wellbeing Practitioner
   ☐Clinical Associate in Psychology

☐Structured Clinical Management

☐Maudsley Model of Anorexia Nervosa Treatment for Adults

Section A
Current supervisors

3. How many staff do you have that are currently supervising for this course/therapy?
4. How many trainees are they supervising between them?
5. How many qualified staff are they supervising between them?
6. What would enable staff who are already supervising to take on more hours of supervision/supervisees?

Section B
Qualified staff who are not supervising

7. How many staff do you have that are qualified to supervise this course/therapy, but are not currently?
8. How many of these staff could supervise only this course/therapy?
9. What is the reason that they are not supervising anyone at the moment?
10. What would enable these staff to supervise others?

Section C
Potential supervisors

11. How many staff do you have that could supervise for this course/therapy but do not yet meet the criteria?
12. What would be needed to enable them to take on supervisory responsibilities?

Section D
Extra information

13. Do you have any other information that it might be useful for us to know, or any other comments?

Appendix 3

Focus Group Agenda

14:00 – 14:10 Welcome, introductions, setting the scene

14:10 – 14:20 What requests have you received for the supervision of structured psychological interventions, from inside your organisation and from external voluntary sector organisations?

14:20 – 14:30 What requests have you received for the supervision of broader psychologically informed practice, from inside your organisation and from external voluntary sector organisations?

14:30 – 14:55 What would it take to meet these requests? Do you have current or developing arrangements to meet them?

14:55 – 15:00 Next steps and close

Appendix 4

Quantitative Survey Data

CBT for Eating Disorders						
Service	**Current supervisors**	**Trainee supervisees**	**Qualified supervisees**	**Qualified staff who are not supervising**	**Number of these staff who can supervise only this modality**	**Number of staff who could supervise but do not meet the criteria**
Cornwall Partnership Trust	0	0	0	1	0	0
Livewell	1	1	0	0	0	0
DPT	2 (In a peer group)	0	3	0	N/A	1
AWP - Swindon	Not available in this service					
Gloucestershire Health and Care	1	6	3	0	0	0
Somerset NHS FT	2	2	4	0	0	0
Dorset Eating Disorder Service	2	3	7	0	N/A	4

CBT for Personality Disorder						
Service	**Current supervisors**	**Trainee supervisees**	**Qualified supervisees**	**Qualified staff who are not supervising**	**Number of these staff who can supervise only this modality**	**Number of staff who could supervise but do not meet the criteria**
Cornwall Partnership Trust	1	4	4	2	1	Unsure
Livewell	0	0	0	3	0	0
DPT	Not available in this service					
AWP - Swindon	1	1	No 1-1, but some group peer supervision	1	0	0
AWP - BNSSG	0	0	0	Unsure of necessary qualifications	0	Unsure of criteria
Gloucestershire Health and Care	0	0	0	0	0	0
Somerset NHS FT	4	4	4	1	1	4

CBT for Psychosis and Bipolar Disorder						
Service	**Current supervisors**	**Trainee supervisees**	**Qualified supervisees**	**Qualified staff who are not supervising**	**Number of these staff who can supervise only this modality**	**Number of staff who could supervise but do not meet the criteria**
Cornwall Partnership Trust	1	8	8	0	0	7
Livewell	0	0	0	2	0	0
DPT	3	3	5	2	0	0
AWP - Swindon	1	1	No 1-1, but some group peer supervision	0	N/A	2
AWP - North Somerset	1	1	2	0	N/A	5
AWP - Bristol	3	1	7	1	0	0
AWP - BANES	1	3	2	0	N/A	1
Gloucestershire Health and Care	2	1	3	3	0	0
Somerset NHS FT	6	0	9	0	0	2

Clinical Associate in Psychology						
Service	**Current supervisors**	**Trainee supervisees**	**Qualified supervisees**	**Qualified staff who are not supervising**	**Number of these staff who can supervise only this modality**	**Number of staff who could supervise but do not meet the criteria**
Cornwall Partnership Trust	2	26	5	[blank]	[blank]	[blank]
Livewell	1	4	0	30 - 40	0	0
DPT	3	12	0	We have around 50 Practitioner Psychologists who could supervise	0	0
AWP - Swindon	Primary supervision is external, additional supervision from 2 staff	2	0	3	0	0
AWP - Wiltshire	0	N/A	0	12	0	0
AWP - BNSSG	1 - but she is due to start MPAC	4	0	Any of the clinical psychologists	0	N/A just needs to be qualified clinical psychologists

	training soon so we will need to find backfill			in the teams could supervise but capacity is an issue		
Gloucestershire Health and Care	2	4	0	roughly 60	Unknown	N/A
Somerset NHS FT	15	18	0	5 (within adult community team - in broader MH services could be an additional 7 if all posts filled	0	0

Cognitive Analytic Therapy						
Service	**Current supervisors**	**Trainee supervisees**	**Qualified supervisees**	**Qualified staff who are not supervising**	**Number of these staff who can supervise only this modality**	**Number of staff who could supervise but do not meet the criteria**
Cornwall Partnership Trust	5	20	4	0	0	4
Livewell	0	0	0	0	0	0
DPT	5	10	15	3	0	6
AWP - Swindon	0	0	0	0	0	0
AWP - North Somerset	2	1	10	0	N/A	2
AWP - Wiltshire	1	5	4	1	1	3
AWP - Bristol	1	1	2	0	0	0
Gloucestershire Health and Care	1	1	2	1	0	1
Somerset NHS FT	7	15	13	0	Unsure	Potentially many of the accredited CAT therapists
Dorset Pain Management Service	1	1	1	0	[blank]	0
Dorset Intensive Psychological Therapies Service	3	5	4	0	N/A	0

Dialectical Behaviour Therapy						
Service	**Current supervisors**	**Trainee supervisees**	**Qualified supervisees**	**Qualified staff who are not supervising**	**Number of these staff who can supervise only this modality**	**Number of staff who could supervise but do not meet the criteria**

Cornwall Partnership Trust	2	7	7	0	N/A	7
Livewell	1	2	3	1	0	0
DPT	3	3	11	0	0	4
AWP - Swindon	1	1	4	0	N/A	1
AWP - Bath, North East Somerset, Swindon and Wiltshire	1	2	3	0	N/A	3
AWP - BNSSG	0	0	0	0	0	Approximately 10 - maybe more
AWP - Bristol	1	1	0	7	Staff are trained in a number of models	Unknown
AWP - BANES	1	1	1	0	N/A	0
Gloucestershire Health and Care	0	0	0	0	0	0
Somerset NHS FT	0	0	0	Approx. 5 across the Trust	Uncertain	0
Dorset Intensive Psychological Therapies Service	6	1	6	0	N/A	0

Eye Movement Desensitization and Reprocessing						
Service	**Current supervisors**	**Trainee supervisees**	**Qualified supervisees**	**Qualified staff who are not supervising**	**Number of these staff who can supervise only this modality**	**Number of staff who could supervise but do not meet the criteria**
Cornwall Partnership Trust	None internally. We source Consultant EMDR therapists to deliver our supervision.	N/A there are three EMDR supervision groups, individual EMDR supervision and those who are not currently accessing EMDR supervision.	1	N/A	N/A	N/A
Livewell	5	2	0	0	N/A	2
DPT	3 (2 external and paid for, 1 internal just completing supervisor accreditation)	0	15	0	N/A	Potentially all 15 staff could become supervisors

AWP - Swindon	0 - HAVE A CONSULTANT FROM ELSEWHERE WITHIN AWP	3	2	0	N/A	0
AWP - Wiltshire	1	2	6	0	0	4
Gloucestershire Health and Care	1	1	6	1	0	0
Somerset NHS FT	2	2	14	1	0	14
Dorset Eating Disorder Service	Unspecified external, 0 internal	0	1	0	0	[blank]
Dorset Pain Management Service	1	[blank]	8	0	[blank]	0
Dorset Intensive Psychological Therapies Service	0 internal, external from other parts of Trust	[blank]	[blank]	0	N/A	5

Family Interventions for Psychosis						
Service	**Current supervisors**	**Trainee supervisees**	**Qualified supervisees**	**Qualified staff who are not supervising**	**Number of these staff who can supervise only this modality**	**Number of staff who could supervise but do not meet the criteria**
Cornwall Partnership Trust	2	2	10	0	N/A	4
Livewell	4	1	1	1	0	1
DPT	2 (Supporting peer group formats)	11	17	0	N/A	17
AWP - Swindon	1	0	5	1	0	1
AWP - North Somerset	1	2	4	N/A	N/A	2
Gloucestershire Health and Care	2	2	4	4	4	0
Somerset NHS FT	1	12	18	0	0	0

Maudsley Model of Anorexia Nervosa Treatment for Adults						
Service	**Current supervisors**	**Trainee supervisees**	**Qualified supervisees**	**Qualified staff who are not supervising**	**Number of these staff who can supervise only this modality**	**Number of staff who could supervise but do not meet the criteria**

Cornwall Partnership Trust	0	0	0	1	Unknown	Unknown
AWP - Swindon	0	0	0	0	0	0
Somerset NHS FT	Core supervision is from an external supervisor, interim supervision offered by 2 supervisors	0	4	0	0	3
Dorset Eating Disorder Service	Informal MANTRA supervision through individual case supervision	[blank]	[blank]	1	0	[blank]

Mental Health and Wellbeing Practitioner						
Service	**Current supervisors**	**Trainee supervisees**	**Qualified supervisees**	**Qualified staff who are not supervising**	**Number of these staff who can supervise only this modality**	**Number of staff who could supervise but do not meet the criteria**
Cornwall Partnership Trust	2	10	0	0	0	0
Livewell	0 - as far we know	0	0	30 - 40 in role, but not necessarily with competency in MHWP	0	N/A
AWP - Swindon	0	0	0	Roughly 10	0	0
AWP - Wiltshire	0	0	0	8	0	0
Somerset NHS FT	0	0	0	17 (12 psychology and 5 CBT)	0	4

Mentalisation-Based Therapy						
Service	**Current supervisors**	**Trainee supervisees**	**Qualified supervisees**	**Qualified staff who are not supervising**	**Number of these staff who can**	**Number of staff who could supervise but**

					supervise only this modality	do not meet the criteria
Livewell	0	0	0	0	N/A	0
DPT	0 internal, 2 external	0	8	1	1	8
AWP - Swindon	0	0	0	0	0	0
AWP - Bath, North East Somerset, Swindon and Wiltshire	2	4	8	0	n/a	2
AWP - Bristol	1	2	6	We have no staff trained in MBT supervision	All staff have a number of therapy trainings and multiple commitments	1
AWP - BANES	6	3	3	0	0	0
Gloucestershire Health and Care	0	0	0	1	0	0
Somerset NHS FT	Supervision from Anna Freud currently	4	0	0	n/a	2

Structured Clinical Management						
Service	**Current supervisors**	**Trainee supervisees**	**Qualified supervisees**	**Qualified staff who are not supervising**	**Number of these staff who can supervise only this modality**	**Number of staff who could supervise but do not meet the criteria**
Cornwall Partnership Trust	0	N/A	N/A	0	N/A	2
Cornwall Partnership Trust	External	4	0	0	0	0
AWP - Swindon	2	0	8	0	0	0
AWP - Bath, North East Somerset, Swindon and Wiltshire	8, but they are not formally trained in SCM supervision	0	40	N/A	N/A	6 staff need formal SCM supervision training- this would improve adherence and quality
AWP - BNSSG	1	5	20	0	0	5