

AHP Clinical Supervision

Policy

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AHP Clinical Supervision

Section 1 – Introduction

NHS Greater Glasgow and Clyde (NHSGGC) is committed to the personal and professional development of both registered and unregistered AHP staff and recognises clinical supervision as a vital aspect of a governance framework that enables and supports staff to deliver high quality health care. The NHS GG&C strategic plan identified the need to “support staff to develop and maintain skills and practice with effective supervision and governance arrangements” (2015-16).

Whilst the value of informal and ad hoc supervision is recognised, this policy outlines a formal, structured process of Clinical Supervision. The value of having such an organisational policy outlining: roles, responsibilities and governance procedures - is recommended by Leggat et al (2016) in their review of clinical supervision for allied health staff.

The approach outlined in this document is based upon the premise that dedicated time for shared reflection on practice within Clinical Supervision supports:

- the safe and effective delivery of health care
- service development
- a culture of openness and continuous improvement

This document should be read alongside relevant professional guidance (see appendix 1).

Section 2.1 – Rationale

This policy has been formulated to ensure that AHP staff have a clear understanding of their own and the organisation’s responsibility in relation to clinical supervision by outlining a set of underpinning processes and a framework for implementation. Although complementary, clinical supervision is separate and distinct from Line Management Supervision.

Clinical supervision in health and social care has been endorsed for decades, with an ever growing and sustained view that it is a vital component of practice among health professionals in today’s health and social care environment.

The drive towards formal appraisal within clinical structures originates from the introduction of clinical governance throughout the Health Service during the 1990s via the Department of Health consultation document, ‘*A first class service – Quality in the new NHS*’. Supervision is now recognised as an essential element of Clinical Governance.

Clinical supervision supports the principles of clinical governance. The right person (competent) doing:

- The right thing (evidence based practice)
- In the right way (skills and competence)
- At the right time (when the patients needs them)
- In the right place (location of treatment)
- With the right result (maximising health gain)

The Francis Report (2013) highlighted the importance of ensuring that staff groups are supported to deliver the best quality service to patients. Findings from this report highlighted a whole system failure and recommendations to ensure improvements were delivered.

The drive for quality, productivity and efficiency must be balanced by providing support and development opportunities for staff. The Healthcare Quality Strategy (Scottish Government 2010) makes a clear connection between staff engagement and enhanced organisational performance, linking staff experience and wellness with improved patient outcomes.

2.2 Purpose of Clinical Supervision

The Health and Care Professions Council (HCPC), the regulatory body for all Allied Health Professionals recognises the value clinical supervision has in supporting and improving registrants practice.

The HCPC understands that approaches and practice of clinical supervision vary widely across the professions they regulate and does not produce specific standards or guidance around clinical supervision.

The HCPC's requirements relate to individual registrants who are responsible for ensuring they meet the HCPC standards of practice. A number of standards relating to supervision are included in several of their key policies.

The HCPC **Standards of conduct, performance and ethics (2012)** include a number of standards relating to supervision, identified as an integral component of professional practice. These standards ensure AHPs "practice safely and effectively while maintaining high professional standards of professional conduct" (HCPC 2012).

Similarly the **Standards of Continuing Professional Development (2012)** recognises clinical supervision as an important feature of CPD – how "registrants continue to learn and develop throughout their career, keep their skills and knowledge up-dated and ensure they work safely, legally and effectively" (HCPC 2012).

The HCPC recognises that clinical supervision is an area for which all professional bodies produce guidance and look to the relevant professional bodies for specific advice for each profession they regulate (Appendix 1).

Effective clinical supervision is considered an important component of clinical governance – supporting improvements in clinical practice through reflection and support of clinicians (Dawson, Phillips and Leggat 2012).

Benefits to the individual clinician may include:-

- Regular clinical supervision can help reduce the risk of staff burnout; helping staff to deal better with work stresses (Fisher, Mitshe, Endler et al 2013).
- Ducat et al (2016) who suggest regular access to supervision, and expert assistance can help reduce professional isolation.
- Helping clinicians to cope better with work stress can increase their level of confidence in their practice - resulting in a positive impact on the quality of patient care (Kuipers, Pager, Bell, Hall & Kendall 2013).

When effectively implemented, it can be demonstrated that it enhances professional practice and improves the quality of the service offered to patients and carers. It offers the opportunity for safe, non-judgemental professional development associated with maintaining and developing the individual's excellence and independence in a particular role.

Clinical supervision will be integrated alongside other organisational and operational clinical support mechanisms already in place – see diagram below which outlines.



2.3 Clinical Supervision Definition

Clinical supervision – an accountable process which supports, assures and develops the knowledge skills and values of a clinician, clinical groups or teams. It is a formalised means of improving and monitoring practice through dialogue with another skilled, experienced practitioner, peer or senior where the content of supervision sessions is led by the supervisee – (source NHS GG&C AHP Clinical Supervision working group 2016).

The practice is supported and constructively challenged through discussion and reflection with a supervisor, enabling the supervisee to assume responsibility for their own practice and enhance patient protection, quality and safety of care. It is complementary to, but does not replace, formal systems of appraisal and performance management.

Supervisor – The person using knowledge and experience to facilitate structured reflection on practice within the context of Clinical Supervision.

Supervisee – Any registered or non-registered member of staff receiving supervision.

2.4 Differentiating AHP Clinical Supervision, AHP Professional Line Management and AHP Professional Leadership

AHP Clinical Supervision, AHP Professional Line Management and AHP Professional Leadership are separate and distinct process which it is important to differentiate.

AHP Line Management is a mandatory, hierarchical supervisory and supportive process wherein an individual staff member’s workload, clinical practice and operational performance are monitored.

AHP Professional Leadership - AHPs have access to an AHP professional of the same profession who support them with issues relating to the specific scope of their practice, e.g. professional guidelines/practice, CPD and other profession specific needs".

2.5 Clinical Supervision Model

Proctor’s Three Function Interaction Model of Supervision, (1987) is one of the most widely recognised model of clinical supervision amongst health care professions and is probably the most frequently cited supervision model in the literature.

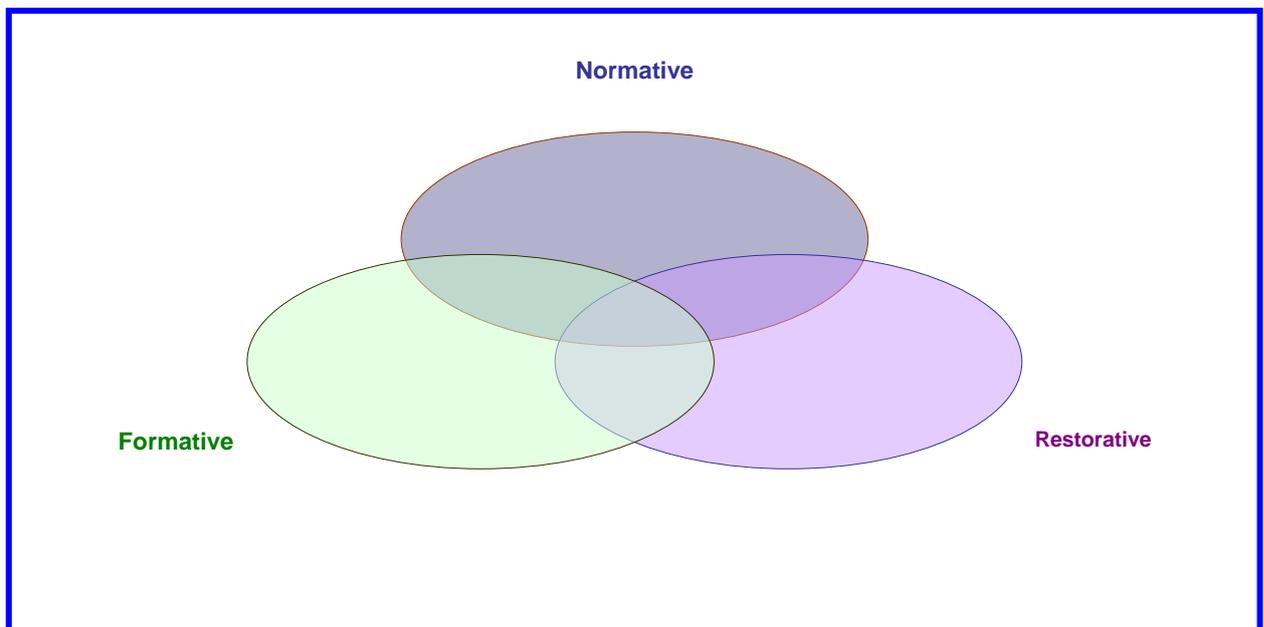


Figure 1 - Proctors 3 Function model

The focus on one or other of these functions can vary according to the needs and values of the individual Supervisee or target group. This model is not prescriptive and should guide the Supervisor and Supervisee to develop all or any of the three areas noted.

Restorative – Relates to staff support

Enabling the practitioner to sustain effective work, by supportive help for those working with stress and distress. This support is achieved by the supervisor having an unconditional positive regard for the Supervisee (this means holding a continual respect for the individual in all circumstances). In this supportive setting, positive challenges to practice can be made.

- Establish good working alliance
- Listen
- Validate good practice

- Help Supervisee to: feel safe enough to be honest, reflect on personal reaction and feelings, and identify possible need for further support.

Key words - Supportive, Building resilience, Coping strategies

Normative – Relates to quality and standards

Areas where a more directive approach required e.g. child protection, case loads gauged alongside risk management. Ensuring the practitioner maintains established standards of care by dealing with accountability aspects of practice. In the clinical supervision setting this is most powerfully achieved through reflection on practice in the supportive and challenging environment provided by the supervision relationship. It is the shared responsibility of both the Supervisor and the Supervisee.

- Provide constructive criticism
- Supporting/challenging practice when necessary
- Monitor Supervisee's adherence to their ethical code
- Provide Supervisee with honest feedback
- Regularly evaluate effectiveness of supervision

Key words – Administration, Patient safety, Quality assurance, Professional standards

Formative – Relates to skills development

Supervisor facilitates the supervisee learning through support and often guided reflective practice. This is the educational process enabling the practitioner's development of expertise and skills. This learning is achieved through guided reflection on practice in a safe, time protected setting.

- Help supervisee reflect on practice, interactions, and relationships.
- Monitor own reactions to material brought by supervisee.
- Tailor session to supervisee's level of experience and development

Key words – Education and Professional development, Skills and knowledge

2.6 Clinical Supervision Approaches

A variety of different approaches to the delivery of Clinical Supervision are available. Groups of staff may identify a preferred approach or approaches from the list below which may result in more than one approach being employed. The Supervisee is the main focus of the supervisory relationship with openness, trust and understanding being developed Lynch et al (2008).

Some Allied Health Profession groups may recommend a particular approach; it may be that an individual approach may be recommended.

One to One (1:1)

Between a Supervisor and Supervisee. The Supervisor may be equally or more experienced/knowledgeable than the Supervisee. This is the most traditional approach to clinical supervision.

Triadic approach

The 1:1 model is expanded to include 3rd person, whose job is to assist the Supervisor to help the Supervisee.

Group approach

More than one Supervisee receives supervision from one Supervisor. This may be appropriate where the group members share similar supervision needs which may have been identified in 1:1 sessions.

Peer Group approach

All participants offer mutual support through sharing, rather than receiving supervision from a single Supervisor. A chairperson or Facilitator should be clearly identified, to ensure that sessions remain constructive and do not focus exclusively on case conferences. This role would normally be rotational.

Team approach

All supervisees within a team who work together receiving group supervision from one Supervisor. This may be profession specific or a multidisciplinary team.

Network approach

Similar to peer group support but where those involved do not work together on a regular basis.

Telephone/Video conferencing

Staff working in remote areas may adapt any of the above approaches to be used by phone or video link.

Section 3 – Processes

3.1 Identifying a Clinical Supervisor

It is critically important that within the Clinical Supervision relationship, the Supervisee places his/her trust in the Clinical Supervisor and the following advice should be noted when deciding on an appropriate supervisor:

- The choice of Clinical Supervisor will be made through negotiation and mutual agreement between the individual, his/her manager and the proposed Supervisor
- The choice of Clinical Supervisor will be based more upon appropriate skills, knowledge, expertise and accessibility rather than relying on hierarchical status or clinical location
- Selection must be mutually acceptable to both the Supervisee and the proposed Clinical Supervisor – however, whilst an individual is entitled to decline *any* specific Supervisor proposed, they cannot refuse *all* supervisors (Dimond, 1998)
- In peer group supervision, there will be a suitably trained and experienced, identified Chairperson or Facilitator who fulfils the role and responsibilities of Clinical Supervisor as described in this document
- Professionals from a different discipline may provide elements of Clinical Supervision, but additional supervision arrangements for addressing issues specific to the Supervisee's own discipline may be required
- The ratio of Supervisees to Supervisor can be adjusted according to the experience and/or circumstances of the Supervisor. Faugier and Butterworth, 1993, indicate that, typically, a Supervisor would not provide support to more than:
 - 4 Supervisees for 1:1 Supervision
 - 7 Supervisees for Peer Group Supervision

3.2 Clinical Supervision Session Frequency and Venues

The frequency and duration of Supervision sessions will vary according to the Supervisee's situation. The **minimum** recommended number for AHPs is **6 sessions per year** at regular intervals, with each session lasting **no less than 1 hour**. This minimum applies to **all** AHP staff.

Snowdon, Millard and Taylor (2016) in their review on the effectiveness of clinical supervision amongst AHP's found – clinicians who have a minimum requirement for clinical supervision reported more effective clinical supervision than those who did not. Without the minimum requirement clinicians found it difficult to find time for clinical supervision despite recognising its importance and value.

It is important to recognise, however, that some staff may require more than the minimum. The required frequency and duration of Supervision sessions should be negotiated on an individual basis, regardless of the Supervisee's grade, between the Supervisee and Supervisor. This should then be agreed with the Supervisee's Line Manager and specified in the Clinical Supervision Agreement.

The Clinical Supervisor and Supervisee should arrange appropriate venues in which non-essential interruption can be avoided. The dates, times and venues for Clinical Supervision sessions should be recorded for audit purposes on the **Clinical Supervision Session Attendance Record**.

3.3 Record Keeping and Confidentiality

Required Minimum documentation

1. AHP Clinical Supervision Agreement
2. AHP Clinical Supervision Session Summary
3. AHP Clinical Supervision Session Attendance Record

A copy of each of the above will be retained by the Supervisor and Supervisee, with a third copy of (1) being filed in the Supervisee's personal file, as stated previously.

The Supervisee's copies of (1) and (3) may be used for audit purposes.

Optional documentation of content of supervision sessions

Supervisees may also wish to keep a record of their Clinical Supervision by maintaining a reflective diary or supplementing their personal portfolio or e-portfolio. The individual AHPs preferred model(s) for reflection can be used and s/he should take responsibility for such records, which are private and confidential.

Electronic records

Clinical Supervisors and Supervisees may choose to use electronic versions of any or all of the above, rather than paper documentation. Like manual records, electronic records must comply with the guidance relating to the Data Protection Act given below under "Confidentiality within Clinical Supervision".

Access to minimum documentation

Whilst the Supervisee's right to confidentiality will be respected, NHSGGC will wish to monitor the implementation and effectiveness of Clinical Supervision. Managers and auditors will require regular access to the following:

1. Clinical Supervision Agreement
2. Clinical Supervision Sessions Attendance Record

Managers do not have the right to routinely view Clinical Supervision Plans and Session Summaries and would do so only in exceptional circumstances noted e.g. in response to reports from the Supervisor relating to unsafe practise and/or patient safety which the Supervisee fails to address – see below for further information. Similarly, it is not proposed that auditors access this documentation. They do; however, require

to access evidence which confirms that Supervision sessions have taken place.

Guidance relating to access to records by patients or colleagues under the data Protection Act is given in the next section.

Confidentiality within Clinical Supervision

All discussions within Clinical Supervision are confidential and should only be disclosed to any outside party with the consent of both the Supervisor and Supervisee. **The only possible exceptions to this strict confidentiality would be if unsafe, unethical or illegal practice is revealed.**

In the event of the Supervisee/Supervisor failing to take appropriate, corrective action, the Supervisee/Supervisor would consider whether disclosure is required in the “wider public interest”. If either party believes that s/he is bound by his/her ethical duty and/or professional code of conduct to report such a situation, s/he should advise the other that they intend to do so.

Confidentiality relating to patients or clients in Supervision records must be maintained, except when the circumstances described above apply and the patient or client’s safety or well being is threatened. Patients’ or clients’ names and details from which they could be easily identified must always be anonymised in Supervision records – specific details regarding a patient or client’s care should be recorded only in that individual’s care-plan or case notes. Similar care must also be exercised regarding references to colleagues.

The Data Protection Act 1998 entitles any person to access any file (electronic or manual) which is designed to hold information in relation to him/her. However, anonymised entries such as “need to rehearse next session with patient X”, or “difficulties working alongside colleague Y” would usually fall out with the Act.

3.4 Responsibilities

NHS GG&C has a responsibility to ensure that staff is supported to engage in clinical supervision.

Supervisee Role and responsibilities are to:

- Identify issues you wish to reflect on and negotiate an agenda with your supervisor.
- To reflect on feedback received during the session.
- To discuss freely any difficulties and vulnerable feelings relating to your practice.
- Ensure the clinical supervision session relates to Proctors interaction model of clinical supervision (1987).
- Give feedback to your supervisor about his/her facilitation.
- Implement agreed actions from clinical supervision sessions.
- Ensure that clinical practice remains the focus of sessions.

Supervisor Roles and Responsibilities are to:

- Negotiate agenda with Supervisee.
- Identify and reinforce instances of good practice.
- Constructively challenge any behaviour or values.
- Recognise the limits of own competencies as Supervisor.
- Facilitate the supervisee to seek specialist help or advice when necessary.
- Act appropriately regarding any unsafe, unethical or illegal practice.
- Create a non-judgmental environment.
- Ensure that clinical practice remains the focus of sessions.
- Provide honest feedback.

3.5 Competencies For Supervisors and Supervisees

- An understanding of the purpose of supervision.
- An ability to explain the purpose of supervision.
- An understanding of the functions of supervision i.e. formative, restorative and normative.
- An ability to negotiate a mutually agreed agreement.
- Can prepare a structured approach for each session.
- Is clear about the documentation process required for supervision.
- Can set a climate that is effective and sets the boundaries of confidentiality.
- Can give and receive constructive feedback
- Can develop an effective supervisory relationship utilising appropriate interpersonal skills.
- Understands the policy approach to Clinical Supervision

Clinical Supervision Agreement

We have read and agree to our rights and responsibilities as outlined in the NHS GG&C AHP Clinical Supervision Policy.

Signature	Date
Supervisee:	
Supervisor:	
Supervisee's Manager:	
This is an agreement for: 1-1 supervision <input type="checkbox"/> Group supervision <input type="checkbox"/> Other <input type="checkbox"/>	
The choice of Clinical Supervisor has been mutually agreed: Yes <input type="checkbox"/> No <input type="checkbox"/>	

Frequency of sessions	Min 6 per year	Duration of session	No less than 60 mins
Ground Rules			
Code of Conduct	We agree to abide by the HCPC and our individual professions Code of Conduct/Ethics		
Respect	We agree to show respect to one another		
Punctuality	We agree to be punctual		
Accountability	The supervisee is accountable for their own practice and decides what to bring to supervision		
Responsibilities	Agenda is set by the supervisee unless otherwise agreed		
Note-taking	The supervisee will keep notes which can be shared with their supervisor. The supervisor will keep a record of the sessions.		
Cancellations	We agree to give notice of our non-attendance in advance, quickly re-arranging the session.		

Supervisor.....

Supervisee.....

Copy to be kept by Supervisee, Supervisor and manager.

Clinical Supervision Summary Outcome

Supervisee name: _____ Date _____

Supervisors name: _____

Possible areas for discussion:

Formative Functions – *promoting development of the supervisee’s clinical skills and knowledge*

1. Professional development
2. Professional issues

Restorative Functions – *recognises affects of work, and stresses upon the supervisee*

3. Time management
4. Personal issues which may impinge on work
5. Dealing with stress

Normative Functions – *ensuring safe working within frameworks for practice, HB organisational and professional standards*

6. Work needs and responsibilities
7. Resource / Budget management
8. Other issues

Area discussed	Outcome	Actions		Next session
		Whom	When	

Equality Impact Assessment

Do you foresee any legal risk or differential negative impact for protected characteristic groups due to the implementation of the Policy?

Please tick and provide detail in boxes below.

Protected Characteristic	Positive	Neutral	Negative	Negative: - what are the risks? Positive:-what are the benefits/opportunities?
Age	√			The policy is accessible to and for use by all NHS GG&C AHP clinical staff
Disability	√			
Gender Reassignment	√			
Pregnancy & Maternity	√			
Race	√			
Religion & Belief	√			
Sex	√			
Sexual Orientation	√			
Socio-economic status/class	√			
Other marginalised groups (travellers, people with addiction issues, literacy, offenders and ex-offenders,	√			

This policy does not require a full EQIA.

Name: - Antoinette Reilly

Position: - Facilitator AHP Clinical Supervision working group

Date:- 28th April 2017

Appendix 1

Regulatory and Professional Bodies

Health Care Professional Bodies

<http://www.hcpc-uk.org.uk/>

British Association of Art Therapists

<http://www.baat.org/>

British Association of Prosthetics and Orthotists

<http://www.bapo.com/>

British Dietetic Association

<http://www.bda.uk.com/>

British and Irish Orthoptic Association

<http://www.bda.uk.com/>

Royal College of Occupational Therapists

<https://www.rcot.co.uk/>

Chartered Society of Physiotherapy

<http://www.csp.org.uk/>

Society of Chiropodists and Podiatrists

<http://www.scpod.org>

Royal College of Speech and Language Therapists

<http://www.rcslt.org/>

Society and College of Radiographers

<http://www.sor.org/>

Additional Resources

NHS Education Scotland (NES)

<http://www.careerframework.nes.scot.nhs.uk/support-and-supervision.aspx>

<http://www.flyingstart.scot.nhs.uk/learning-programmes/safe-practice/clinical-supervision/>

Skills for Health

[Providing supervision to others outline.pdf](#)

[Make use of supervision outline.pdf](#)

NHS Greater Glasgow & Clyde

<http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/FTFT/OurCulture/Pages/HowWeWorkTogether>

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AHP Clinical Supervision working group membership

Group Chairperson - Chris Rowley (Oct 2013 – Sept 2016)
- Nikki Munro (Sept 2016 -)

Group Facilitator – Antoinette Reilly (AHP Educational Project Lead)

Group Members & area representing:

Gwen Agnew – Occupational Therapy & Art Psychotherapy

Shona Ballantyne – Occupational Therapy

Andrea Blair – Speech & Language Therapy

Murray Crichton – Radiography

Morag Donnan – Staffside representative

Jane Dudgeon – Dietetics

Jill French – Physiotherapy (MSK)

Pauline Johnston – Podiatry

Diana McCrone – Staffside representative

Gillian McDaid – Occupational Therapy

Elaine McKinlay – Dietetics (Oct 2013 – 2016)

Dr. Anne Mitchell – Public Health

David Morrison – Prosthetics

Esther O'Hara – Staffside representative

Fiona Paton – Speech & Language Therapy

Graham Pirie – Podiatry

Laura Wiggins – Physiotherapy

Emma Wilson – Physiotherapy

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