



Public – To be published on the Trust external website

Clinical Supervision

Ref CLIN-0035-v6.1

Status: Ratified

Document type: Policy

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1 Introduction

The CQC paper, 'Supporting information and guidance: Supporting effective clinical supervision', (July 2013), identifies the purpose of clinical supervision:

“The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice.”

Clinical supervision provides a structured approach to deeper reflection on clinical practice. This can lead to improvements in practice and service user care; contribute to clinical risk management as well as improving systems of accountability and responsibility. Clinical supervision is for all staff; from those at the start of their careers as well as senior and very experienced staff. Promoting good quality clinical supervision into the Trust helps to embed a supportive culture of reflection, learning and self-development.

Clinical supervision focuses on the quality of an individual's clinical practice whilst management supervision focuses on performance against role supporting appraisal and PDP processes. This policy sets out a minimum standard expected and is separate but supplemental to the Trusts Appraisal and management supervision policy and supports its implementation. More specific requirements for Clinical Supervision will be delivered in accordance with relevant professional guidelines or protocols.

2 Why we need this policy

To set the minimum standard for clinical supervision in Tees Esk and Wear Valley NHS Foundation Trust.

To provide robust monthly monitoring that supports both:-

- Annual Appraisal and Management Supervision by ensuring clinical quality and patient safety, particularly in the application of the caseload management protocol
- The relevant Professional Guidance or protocols for Clinical supervision
- The policy responds to recommendations made nationally from the Francis Report 2013 and from Skills for Care (2007) who define 'supervision' as "an accountable process which supports, assures and develops the knowledge skills and values of an individual group or team". Markey et al in 2020 also conclude that we need to adopt a "proactive approach to supporting positive working environments, and clinical supervision is a process that can assist this".
- To support Annual Appraisal and Management Supervision by ensuring clinical quality and patient safety, particularly in the application of the caseload management protocol.

2.1 Purpose

The purpose of this policy is to formalise a minimum standard of Clinical Supervision for all staff delivering direct service user. This will be in addition to, and not a replacement for, professionally mandated standards or protocols.

2.2 Objectives

The policy objectives are to:

- Clarify the Trust’s position on meeting professional and clinical supervision requirements of practitioners employed by the Trust.
- Reinforce the educational requirements for those supervising (mentoring) pre and post graduate students.
- Provide opportunity for individuals to:
 - Review standards of practice in relation to caseload and workload management.
 - Keep up to date with developments.
 - Identify developmental needs and be clear that they are working within professional boundaries.
- Ensure care standards are met to deliver safe and effective care.

3 Scope

The scope of the policy and associated professional protocols is to provide guidance on a minimum standard for clinical supervision expected by the Trust.

3.1 Who this policy applies to

This policy applies to staff delivering direct service user care.

- Registered nurses and Social Workers employed by the Trust on the basis of their professional qualification.
- Allied Health Professionals
- All staff employed by the Trust in a nursing or clinical support role of any grade, including support workers, STR workers, associate practitioners and health care assistants.
- Medical Staff, and psychological professions staff by reference to separate professional guidelines

This policy and all procedures and training relating to it will adhere to the Trust Equality Diversity and Human Rights Strategy

3.2 Roles and Responsibilities

Role	Responsibility
Executive Director of Nursing and Governance	The development, monitoring and support of this policy.
Operational Directors	Implementation and monitoring of this policy in their areas of responsibility, ensuring the implementation systems and processes are in place and monitored to ensure compliance with this policy.
Operational Line	Ensuring their staff have access to, and are participating in

Managers	<p>appropriate supervision for their role.</p> <p>They will do this through Appraisal and Management Supervision process.</p> <p>All Managers have a responsibility to ensure staff are aware of this policy and its implications.</p>
Clinical Directors and Professional Leads (Including Heads of Nursing)	<p>The maintenance and monitoring of compliance with this policy within their area of responsibility.</p> <p>Will ensure that all clinical lead staff are delivering clinical supervision as a key part of their roles and that they develop and maintain clinical supervision networks and practice.</p>
Supervisors & Supervisees	<p>Complying with this policy and establishing a clinical supervisory relationship and/or forum(s) appropriate to their role.</p> <p>They will do with in collaboration with, and under the guidance of, their line manager and appropriate clinical lead</p>

4 Policy

The Trust views Clinical Supervision as a mandatory practice and clinically necessary for all staff delivering direct service user care.

All staff that this policy applies to, will seek and actively engage in clinical supervision and will meet the minimum standard of eight (8) hours of clinical supervision each year, equating to 1 hour formal and 1 hour informal / other supervision each quarter. The requirements for medical staff including physician associates can be found in Appendix 1.

A contract (Appendix(N.B not for use by medical staff) should be completed prior to any formal supervision going ahead this will define the frequency of supervision, record keeping and confidentiality

Once a supervision session has been completed it will be responsibility of the supervisees to upload or write up their supervision notes on the SARD electronic supervision system, though medical staff will record within their portfolio / training / appraisal https://tevw-foundry.sardjv.co.uk/users/sign_in

Guidance on how to use this system can be found in Appendix 3

This may be achieved in a variety of forms such as:-

Supervision Types:

Formal clinical 1:1 supervision	Professional supervision
Group/Team supervision	PBS supervision
Live supervision (with formalised reflection)	AHP Clinical / Professional supervision
Reflective receive of taped/video sessions	IPS supervision
Peer supervision	ASYE Supervision
Other e.g. Formulation meeting, case discussion etc.	Child Safeguarding supervision
Non Medical Prescriber 1:1 Supervision	Think ahead supervision

Non Medical Prescriber Group Supervision	Governed psychological therapy/ modality specific supervision
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4.1 What is Clinical Supervision

Clinical Supervision is a planned formal process of professional support and learning.

It is used to enable individual practitioners to develop knowledge and skills through self-assessment and reflection.

This process aims to support and enhance service user care and clinical practice.

Clinical supervision applies to all staff undertaking direct service user care or clinical work and should be provided in addition to management supervision.

The most senior clinical staff should also ensure they access clinical supervision. This should not be seen as a hierarchical activity but an essential aspect of their role.

Definitions of supervision can be found at **Appendix 4**

4.2 Benefits

- To inform and improve Clinical Practice
- Creating a safe environment to discuss concerns regarding an individual's practice
- To support an individual's health and well being
- To support continued learning through reflection
- An opportunity to acknowledge good practice and positive outcomes

4.3 What is Not Clinical Supervision

- It is not a forum for raising concerns in regard to management processes
- It is not an informal discussion regarding workplace concerns.
- It is not a tool to address training needs.
- It is not a forum to discuss roster requirements or issues

(Examples of good supervision can be found in Appendix 4.

There is a clear distinction between clinical supervision and management supervision, for further guidance about management supervision please refer to the management supervision policy.

Where relevant to the role, caseload management issues should be covered as part of the 1:1 formal supervision session to support the quarterly Management supervision sessions which will entail formal caseload management reviews.

Supervision required above the minimum standard to meet professional requirements (e.g. Nurse Revalidation or Generic Professional Practice Guidelines for Psychology, or Health Care Professions Council HCPC), should be delivered in accordance with relevant professional guidance or protocol. Assistant psychologists (band 4 or 5) are graduate psychologists with no clinical qualification and therefore a qualified applied psychologist or

psychological therapist must take clinical responsibility for their practice. They will need a minimum of fortnightly formal supervision and access to informal supervision at other times. (A psychological therapist may provide the regular formal clinical supervision for the assistant psychologists however, to comply with BPS guidelines, a qualified applied psychologist must provide their professional management).

In partnership with their line managers and professional leads, supervisees will identify supervisors and negotiate appropriate supervision arrangements taking account of:-

- The supervisee's development needs and the needs of the service.
- Availability of supervisors who meet those needs.
- The skills and experience of supervisors.
- The requirements of the supervisee's role.
- Any employee experiencing barriers to meeting the minimum standard for supervision must inform their line manager.

Newly appointed staff will be allocated a supervisor by their manager and/or clinical lead for the first 6 months of their appointment.

It is the responsibility of both the supervisor and the supervisee to keep clear, accurate and up-to-date records.

Supervisees must make entries into individual service user case notes of any action plans discussed pertaining to that individual. All records of supervision outwith the clinical record must ensure that only initials of individuals discussed are used for identification.

All supervision records will be written on to the electronic SARD system in accordance with all relevant legislation and organisational policy, and be made available to the organisation for auditing purposes if requested.

4.4 Supervision in Extended Roles

Where clinicians have extended roles and clinical qualifications, such as Non-Medical Prescribing (NMP) and Psychological therapies; (CAT; DBT; etc.), they have a responsibility to access clinical supervision in accordance with the standards of the relevant regulatory bodies.

The Trust has developed assurance standards for the Psychological Therapies. These are outlined in the TEWV Governed Psychological Therapies (GPT) document. Each of the GPTs approved for delivery within the Trust are included in this document. The requirements for training within the GPT, the supervision and CPD requirements for staff delivering the GPT and for the supervisors are also included.

In particular Registered Non-Medical Prescribers will adhere to their relevant professional and organisational additional guidance such as the NMC Code of Practice, NMP Procedure to Practise (Accessible within the Trust Medicines Overarching Framework) and national legislation. AHP's in non AHP specific roles will follow the main supervision policy and follow AHP professional clinical supervision protocols for any AHP therapy delivery within these roles.

4.5 Supervision and Safeguarding Children and Vulnerable Adults

If a safeguarding concern becomes apparent during clinical supervision and is unable to be addressed within the supervision session due to complexity/knowledge, the supervisee must contact the safeguarding team for advice in regard to the need for further actions.

If the case is very complex, the practitioner may request specialist safeguarding supervision or safeguarding nurse may request for the case to be brought into safeguarding supervision with the safeguarding team.

If a case goes to child protection conference then safeguarding supervision from the trusts safeguarding team or within CAMHS a CNS who has undertaken the specialist safeguarding supervision training.

Trust requirements is for children on a child protection plan to have mandatory specialist safeguarding supervision 3 monthly.

Additionally it is a quality requirement that practitioners working with a looked after child, child in need, child involved in early help services and working with MAPPA cases, also bring these to clinical supervision on a 3 monthly basis.

4.6 Equality, Diversity and Human Rights

In order to deliver the best healthcare and to be a provider and employer of choice we must have a good understanding of our communities and our workforce. We must cultivate an inclusive and diverse workforce culture in order to fully achieve our vision of being a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations. Clinical supervision is a safe space for staff to discuss the Equality, diversity and human rights (EDHR) needs of service users and a space to reflect and review staffs understanding of EDHR to ensure the needs of service users with protected characteristics are being met and that staff have an understanding of human rights. Clinical supervision also allows the opportunity to talk about the EDHR needs of staff too.

4.7 Definitions

Definitions of supervision and reflection are detailed in **Appendix 3**.

5 Related Documents

Generic Professional Practice Guidelines (The British Psychological Society)

http://www.bps.org.uk/sites/default/files/documents/generic_professional_practice_guidelines.pdf

Skills for Care (2007). Providing effective supervision. A workforce development tool, including a unit of competence and supporting guidance.

CLIN/0036/v3 Allied Health Professionals Professional Clinical Supervision Protocols

Nurses, Social Workers and Non-Regulated Practitioners Professional Clinical Supervision Protocol

Clinical and managerial Supervision for Medical Staff within TEWV

Appraisal procedure

[Clinical supervision: A panacea for missed care - Markey - 2020 - Journal of Nursing Management - Wiley Online Library](#)

TEWV Governed Psychological Therapies (July, 2020)

6 How this policy will be implemented

<ul style="list-style-type: none"> This policy will be published on the Trust's intranet and external website.
<ul style="list-style-type: none"> Line managers will disseminate this policy to all Trust employees through a line management briefing.
<ul style="list-style-type: none"> Professional and clinical leads will engage in training and skills analysis for their relevant areas of responsibility, undertake baseline audits and develop action plans to deliver the minimum standards outlined in this policy.
<ul style="list-style-type: none"> A range of training and support structures will be mapped and developed in response to baseline and continuous audit of the minimum standard.
<ul style="list-style-type: none"> All staff recruited into posts that deliver direct service user care will be made aware of the clinical supervision policy at Trust and local induction.
<ul style="list-style-type: none"> The trust will make commit to making clinical supervision available to all staff to whom this policy applies.

6.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All staff requiring clinical supervision	e-learning Face to Face	2 days	One time only

7 How the implementation of this policy will be monitored

<ul style="list-style-type: none"> The policy will be published, i.e. intranet, Trust website
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- Line managers will disseminate this policy to all Trust employees through a line management briefing.
- Supervision will be recorded on the SARD software tool. Compliance monitoring will be made available via an IIC dashboard for all staff to review as per IIC access processes.
- Reports are also currently made available to Senior Management via a monthly visual control board; this process will continue.
- Clinical and professional supervision will be audited annually within the Trust to ensure compliance with NHS litigation authority standards and Standards for Better Health.
- Audits will focus on compliance with the minimum standard and also an audit of the quality of clinical supervision.
- Educational supervision will occur as a part of the educational audit process.
- This policy will be reviewed and amended as a part of the audit and evaluation cycle every three years.

Implementation Action Plan				
Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
The policy will be published, i.e. intranet, Trust website	Accessible to staff on intranet and external interested parties on Trust website	On publication	Policy Co-Ordinator	Visible to policy lead to on both intranet and Trust website
Supervision will be recorded on the SARD software tool.	Compliance monitoring will be made available via an IIC dashboard for all staff to review as per IIC access processes	Reviewed monthly within localities	Operational Managers	IIC reporting

8 Document control

To be recorded on the policy register by Policy Coordinator

External

Date of approval:	07 July 2021	
Next review date:	24 February 2024	
This document replaces:	Clinical Supervision Policy CLIN-0035-v6	
This document was approved by:	Name of committee/group	Date
	Senior Leadership Group	07 July 2021
This document was ratified by:	Name of committee/group	Date
	Senior Leadership Group	07 July 2021
An equality analysis was completed on this document on:	22 January 2021 (reviewed 16 June 2021)	
Document type	Public	
FOI Clause (Private documents only)	N/A	

Change record

Version	Date	Amendment details	Status
5.1	07 Jul 2017	Para. added to 4.6 re safeguarding children and vulnerable adults	Withdrawn
5.1	25 Nov 2019	Review date extended from 31 Dec 2019 to 01 April 2020	Withdrawn
5.1	09 Apr 2020	Extended to 01 Oct 2020	Withdrawn
5.1	Oct 2020	Review date extended to 31 December 2020	Withdrawn
5.1	24 Dec 2020	Review date extended to 28 February 2021	Withdrawn

6	24 Feb 2021	Full review and updates throughout reflecting 'good' supervision and its importance. Also more emphasis on the different supervisions available to staff. Transferred in to new policy template.	Ratified
6	30 Apr 2021	Annotation error [how long should these be kept for?] removed from page 7	Published
6.1	07 July 2021	Request from medical staffing to amend medical staff process	Published

9 Appendices

Appendix 1 – Guidelines for clinical and managerial supervision for medical staff including physician associates

Appendix 2 – Supervision Contract (Excluding medical staff)

Appendix 3 – Guidance on the use of SARD, Foundry system (Excluding medical staff)

Appendix 4 – Definitions

Appendix 5 – Example of a good supervision

Appendix 6 – Supervision log (Excluding medical staff)

Appendix 6A – Supervision log (Medical staff)

Appendix 7 – Policy Inter-relationships diagram

Appendix 8 – Equality Analysis Screening Form

Appendix 9 – Approval Checklist

Appendix 1: Guideline for clinical and managerial supervision for medical staff, including physician associates

Clinical practice for doctors and physician associates working in TEWV is governed by standards set by the General Medical Council and by the Royal College of Psychiatrists. Relevant guidance for career grade medical staff is set out in Good Medical Practice (GMC, 2013) and by a series of reports from the Royal College of Psychiatrists (RCPsych, 2009, 2010, 2013, 2014, 2015, 2017).

Standards for supervision of psychiatrists in training is set out in the core psychiatric training curriculum and copied into each of the higher specialist training curricula (RCPsych, 2020). Definitions of supervision are described in the Appendix. New curricula are expected to be approved by the GMC in 2021, but no changes to the standards for supervision are anticipated. Overarching standards for supervision of postgraduate medical trainees, which include those for foundation doctors, are described in the Gold Guide (COPMED, 2020).

With respect to physician associates, supervision standards have been set by the Faculty of Physician Associates in the Royal College of Physicians (FPARCP, 2020), and these standards have been incorporated in the guidance provided by the Royal College of Psychiatrists for PAs working in mental health settings (RCPsych, 2020).

This guideline should be read in conjunction with the TEWV clinical supervision policy. Trust policy states that all staff will actively engage in clinical supervision and will meet the minimum standard of 8 hours of clinical supervision each year, equating to 1 hour of formal and 1 hour of informal / other supervision each quarter. Management supervision will meet the minimum standard of 4 hours each year, equating to 1 hour each quarter.

This guideline relates to the routine clinical work provided by TEWV doctors. Where doctors undertake more specialized work, for example, governed psychological therapy or ECT, they should engage in the recommended supervision for that activity.

Standards for consultant psychiatrists

Clinical supervision will be provided across a range of settings but most commonly at the consultant's peer supervision group and by the annual individual appraisal meeting. Consultants should be attending their peer supervision group at least quarterly. Peer supervision meeting minutes should be recorded and the minutes attached to the consultant's SARD appraisal portfolio.

Examples of activities which could be incorporated into clinical supervision include case-based discussions, direct observations of practice, and critical appraisal of clinical evidence. The content of clinical supervision will be led by the supervisee (RCPsych, 2010).

Managerial supervision will be provided by the annual job plan review meeting with the consultant's line manager and by directorate senior clinical staff meetings attended by the line manager. The content of management supervision will be led by the supervisor (RCPsych, 2010).

A record of clinical and management supervision undertaken should be maintained and attached to the SARD job plan review document (template document in appendix).

Standards for specialty doctors

Clinical and managerial supervision will normally be provided by the specialty doctor's line manager who will be a consultant psychiatrist. In some circumstances the clinical

supervision might be delegated to another consultant psychiatrist working in the same directorate.

Frequency of supervision will depend on the experience of the specialty doctor. Those with significant experience and working at the level of an associate specialist would access clinical supervision similar to consultant psychiatrists. Whereas newly appointed specialty doctors would need clinical supervision in a model more akin to that of doctors in training (e.g. one hour per week or fortnight). This would be determined by the line manager.

Specialty doctors will also receive clinical supervision through attendance at peer supervision group meetings and at their annual individual appraisal meeting.

A record of supervision undertaken should be maintained and attached to the SARD job plan review document.

Standards for doctors in training grades

All training grade doctors will have one hour of timetabled protected time weekly for clinical and managerial supervision from their psychiatric supervisor. The psychiatric supervisor is the consultant psychiatrist (and accredited GMC trainer) who is the doctor's line manager. This would normally add up to 40 hours per year for full time doctors in training (pro rata for LTFT trainees and those on shorter placements). Supervision will be recorded by the trainee in their training portfolio and reviewed at the Annual Review of Competency Progression (ARCP). The psychiatric supervisor will complete the clinical supervisor report for the ARCP process.

Standards for Trust doctors

The nominated supervisor for Trust grade doctors may not be formally approved as a supervisor but the Trust will ensure they are competent to undertake this role. Supervision will be recorded in the doctors' training portfolio and reviewed at their annual appraisal meeting.

On-call doctors

When working out-of-hours first on-call or resident doctors will access immediate clinical supervision from the second on-call doctor. The second on-call doctor in some cases will be a senior registrar or specialty doctor; in other cases it will be a consultant psychiatrist. Where the second on-call doctor is a senior registrar or specialty doctor, they will access supervision from the third on-call doctor, who will be a consultant psychiatrist. Doctors are encouraged to seek supervision in a timely way – so for example to seek immediate advice for any situation they have not encountered before.

Standards for physician associates

Physician associates (PAs) are included in this guideline as they function in a similar way to doctors in training grades: they are responsible for their own actions and decisions, but the overall clinical responsibility for their patients rests with their psychiatrist supervisor. As with training grade doctors, the psychiatric supervisor is the consultant psychiatrist who is the PA's line manager. Intensity and frequency of supervision will depend on the experience of the PA, but would be expected to be at least one hour weekly for the first 12 months, with a gradual reduction so that it becomes monthly after 3 years' experience. Supervision sessions will incorporate both clinical and management supervision.

Each PA will also have educational supervision from the lead educational tutor. This will occur monthly in the first year, quarterly in the second year and then biannually thereafter. The educational tutor will conduct the annual appraisal.

References

- Conference of Postgraduate Medical Deans of the UK. *The Gold Guide 8th edition*. COPMED, 2020.
- Faculty of Physician Associates. *The supervisor and physician associate relationship*. FPARCP, 2020.
- General Medical Council. *Good Medical Practice*. GMC, 2013.
- Royal College of Psychiatrists. *Good psychiatric practice (CR154)*. RCPsych, 2009.
- Royal College of Psychiatrists. *Supervision for career-grade psychiatrists in managed settings. PS2/2010*. RCPsych, 2010.
- Royal College of Psychiatrists. *Valuing expertise and experience: specialty doctors and associate specialists in psychiatry (CR179)*. RCPsych, 2013.
- Royal College of Psychiatrists. *Supporting information for appraisal and revalidation: guidance for psychiatrists (CR194)*. RCPsych, 2014.
- Royal College of Psychiatrists. *Continuing professional development: guidance for psychiatrists (OP98)*. RCPsych, 2015.
- Royal College of Psychiatrists. *Safe patients and high quality services: a guide to job descriptions and job plans for consultant psychiatrists (CR207)*. RCPsych, 2017.
- Royal College of Psychiatrists. *A competency based curriculum for core specialist training in psychiatry*. RCPsych, 2020.
- Royal College of Psychiatrists. *Employing physician associates*. RCPsych, 2020.

Definitions of supervision for doctors in training grades

Psychiatric supervision

This is the one hour per week of protected time for clinical and managerial supervision provided by the consultant psychiatrist line manager.

Clinical supervision

This is the support provided to doctors on the day to day assessment and management of clinical work. All doctors in training should be aware of who is available for clinical supervision at all times. This would usually be the consultant providing psychiatric supervision but at times it would routinely be delegated to others (e.g. the covering consultant during periods of leave; the on-call consultant during out-of-hours work). At times, clinical supervision can also be delegated to a senior registrar or specialty doctor with an appropriate level of experience.

Educational supervision

This is support provided to doctors in training over the course of a training programme (2 years for foundation doctors, 3 years for core and GP registrars) to manage progress through the programme. For senior registrars, the psychiatric supervisor also acts as the educational supervisor for the one year placement. Supervision meetings are usually scheduled 2-3 times per placement. The annual educational supervisor report covers the domains for medical appraisal and revalidation.

Appendix 2: Clinical supervision contract

This supervision contract should be used as a basis for individual discussion, agreement and negotiation. However, any negotiation must meet the requirements of trust policy. (Excluding medical staff)

Supervisee.....	Line manager.....
Role and work base	

Supervisor.....	Line manager.....
Role and work base	

Date of contract Contract review date

Frequency and length of sessions.....

Arrangements for booking/cancelling/rescheduling sessions.....

.....

.....

Type/model of supervision.....

.....

Aims of supervision

As clinical supervisor and supervisee we agree to:

1. Work together to facilitate in-depth reflection on issues affecting practice, so developing both personally and professionally to develop a high level of clinical expertise and facilitate the application of effective practice to the clinical workload

2. Create a safe space to deal with the emotions generated by clinical work and address support needs to deliver effective care

-
3. Maintain effective oversight – working together to ensure that clinical work (of the individual and the practice they see around them) is conforming to quality assurance expectations and practiced in a safe manner

 4. **For Registered nurses** reflective accounts with a peer will support requirements of NMC revalidation

 5.

 6.

As supervisee I will:

- Be willing to honestly share my clinical experiences. Be willing to learn, develop and be open to receiving feedback

- Meet all of my responsibilities relating to clinical supervision as laid out in trust policy and the nursing protocol

- Take responsibility for

-

- Prepare for sessions by.....

-

-

-

-

-

As supervisor I will:

- Offer you advice, support and challenge to enable us to meet our aims for clinical supervision
- Be committed to developing myself as a practicing professional, using my own clinical supervision to support and develop my abilities as a clinician and as a clinical supervisor
- Meet all of my responsibilities relating to clinical supervision as laid out in trust policy and the nursing protocol
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-
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Confidentiality and Record Keeping:

Confidentiality between supervisor and supervisee cannot be absolute within clinical supervision. Trust and respect are an important part of the supervisory relationship but it is important to recognise that this has boundaries. Information may need to be shared for a variety of reasons such as:

- A public safety issue being recognised in the supervisees work
- A breach of codes of conduct, policy or protocol
- Criminal activity being revealed by the supervisee
- Safeguarding concerns
- Audit or evaluation of clinical supervision

Clinical supervision frequently covers aspects of work with service users and supervisory responsibilities. General and informed consent should be sought for those occasions where identifiable information may be discussed

Appendix 3: Recording Supervision

Guidance on how to add an episode of Clinical or Management Supervision (Excluding medical staff) within the SARD system can be accessed via the [staff intranet](#).

Appendix 4: Definitions

Term	Definition	Scope
Clinical supervision	<p>A formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations. It is central to the process of learning and to the scope of the expansion of practice and should be seen as a means of encouraging self-assessment and analytical and reflective skills.</p> <p style="text-align: right;">Department of Health, 1993</p> <p>Clinical supervision is focused on the practice of an individual's clinical work and should be provided in addition to management supervision arrangements for every staff member involved in clinical practice and may not be applicable to other supervision.</p>	Applies to all staff undertaking direct service user care or clinical work
Professional supervision	<p>Different clinical and non-clinical professional groups will have specific requirements for supervision. It is important that needs for professional supervision are met to provide assurance on governance standards. Professional supervision provides the opportunity for employees to review their professional standards, keep up to date with developments of their particular profession, identify professional development needs and be clear that they are working within professional boundaries. This may be provided alongside clinical supervision in some cases.</p>	Applies to all professionally governed groups of staff, both clinical and non-clinical (such as accountants)
Managerial supervision	<p>Managerial supervision is a requirement for all staff. Managerial supervision involves issues related to:</p> <ol style="list-style-type: none"> 1)An employee's job purpose and function 2)Progress towards objectives set within personal development plans. 3)Supporting employees 4)Health and wellbeing of employees 5)Developmental review 6)Their workplace 7)Performance management 8)Review of capability and competence 	Applies to all staff
Formal supervision	<p>Planned processes of managerial, clinical, professional or educational/training supervision.</p>	
Live or Informal supervision	<p>Live or Informal supervision is a term used to describe supervision that is not part of a formal structure and occurs as a part of day to day work/operations.</p> <p>In the context of Clinical Supervision this would be timely feedback on any planned or unplanned observation of clinical practice.</p> <p>Informal supervision can provide opportunities for reflection, debate, challenge and validation but there are essential elements</p>	

	in the support, development and oversight processes of employees' work that require formal and planned supervision processes.	
Personal Reflection	Where a person self reflects on their practice or an event. Personal reflection uses a reflective model to guide the person through analysis of their practice or event. Personal reflection can be largely self-confirming so requires the individual to hold a level of skill in self objectivity.	
Guided Reflection	<p>Guided reflection is most commonly used in clinical supervision. It is facilitated by a skilled supervisor and presents challenge to the supervisee and cultivates broader thinking and multiple options around learning and practice. It is a dynamic process that ensures follow up and review on how an individuals practice has changed or improved.</p> <p>The skill of the supervisor can vary which is dependent on experience and training.</p>	

Appendix 5: Example of a good record of Clinical Supervision Social Workers, Associate Practitioners and HCA's

Date	Time	Venue	Supervisee	Supervisor
Date of next Appraisal			Date for Review of Contract	Length of Session
Type of supervision (Individual/Group etc.)		<p>OUTSTANDING – The environment is private, free from distractions for the entire duration of the supervision.</p> <p>Safe Supervision relationships based on openness, honesty and trust</p> <p>Protected time and arranged in advance.</p>		

Agenda
<p>Health Wellbeing “How Are You?” (Includes: - Relationships at work; Personal concerns; Health issues including work related stress, anxiety, etc.)</p> <p>Agnes reports she is feeling Ok; on further discussion she identifies that overall she is well and balancing work/ childcare arrangements after a period of flexible working.</p> <p>Agnes reports that she gets on well with most of the team but has some challenges with XXX. Spent some time talking about the difficulties and explored ways to manage / improve situation. Reminded Agnes that it is important so that she feels a sense of wellbeing when at work.</p> <p>Used models such as Coveys circle of influence /control to help Agnes understand how we can get “bogged” down and she identified she liked the explanation and the visual aspects of this.</p>
<p>Review and update on previous session actions and progress</p> <p>Agnes identified in last session that she was having difficulties with one particular service user. In particular she was finding it hard to develop a relationship with him and we had explored reasons for this – we had identified that he was experiencing the world / ward / staff / others in threat mode.</p> <p>Today we discussed this – Agnes stated that she had not considered that previously but had used this information in the last month and her relationship with the service user has improved so that she feels she has a therapeutic relationship with him.</p>

Topics for this session (Agenda)

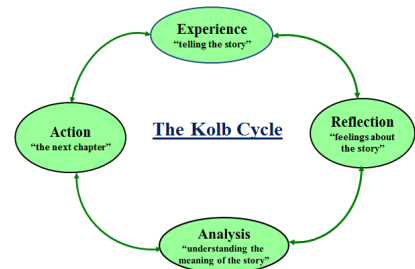
Staff Dynamics – discussed as above (See Wellbeing)

Documentation issues – Agnes is feeling frustrated due to various documentation being used for diet / fluid charts & inconsistent completion. Agnes offered some solutions for this and we have agreed that she will check which form should be used and delete all others from the shared drive.

We have agreed to take the solutions offered to the next staff meeting for further team discussion.

Incident 02/02/18; Used KOLB reflective cycle

Guided Reflection As part of their Continuous Practice Development (CPD) The Supervisee should bring an example of a situation that they have reflected on and present their conclusions. The supervisor should guide the supervisee through their reflective account, issue challenge and help supervisee to consider any changes to their as a result of this situation; which may include training or education needs.



The Experience “telling the story”?

What was your aim, what were you planning to do, who was there, what did you observe/hear/say/do. What surprised you, what did you expect to happen, what reactions did you notice to what you said /did, what didn’t you notice or observe, what words, non-verbal communication, images, smells, sounds struck you, what would others observe about you.

Agnes was on night duty doing the checks when she found a service user in her bedroom who had self-harmed. She was quite shocked about it and she thought the service user seemed in quite bad distress. She called for a colleague to support her and expected that this would be helpful or supportive for the service user. However when the colleague arrived the service user seemed to change in her mood and became agitated and verbally aggressive towards staff. She wasn’t able to notice any triggers, words or non-verbal communication that contributed to the situation.

The Incident then escalated and the colleague was assaulted with no warning. The service user had to be physically restrained for 5 minutes.

Reflection “feelings about the story”?

How did this make you feel, what contributed to the feeling, what feelings did you take to the visit, Did your feelings reflect anything you saw or heard, what did you think the user was feeling, did what happen remind you of anything else, If the users race or gender was different would it have changed how you feel, what did you tell yourself about what was happening or about your feelings.

Agnes felt vulnerable, a bit shocked about seeing the cuts as was feeling a sense of empathy given that the service user seemed in considerable distress, she was surprised at the rapid change in mood and did not expect her to lash out at a staff member and so felt guilty and upset about staff member having been assaulted because up until that time both staff member had developed a good relationship with the service user.

Felt angry that there was no extra support until the assault happened.

Analysis – “understanding the meaning of the story”?

Think about any assumptions you held about the service user, what are the current strengths, needs, risks for the service user , What is not known, what behaviours are acceptable to you, what behaviours are acceptable to the person, how would you explain or understand what happened, what is the nature of the power relationship between you and the service user,

Agnes did not think she held any assumptions about the service user before the incident, on discussion she did acknowledge that the service user may have noticed her shock on discovering the self-harm and that this might have affected her mood. Agnes didn't fully know the service users story and so this might have affected them both – her own reaction may have been different if she understood more about the trauma the service user had experienced. Agnes talked about how the self-harm was shocking to her personally and how she couldn't understand how anyone could cut themselves so badly, in discussion she acknowledged that self-harm is a valid coping strategy for others.

Agnes stated that perhaps the service user felt intimidated by the 2 staff being there and maybe felt threatened by their presence.

Action – “the next chapter”...

What is your overall summary of where things are and what needs to happen next, can you identify what you are/are not responsible for in managing this situation, who else needs to be involved, does the action plan reflect the urgency identified in the *analysis* section, is it practical/realistic, how will you know if changes have happened, will it be acceptable to the service user, how do you measure success plans for the service user, are there any safety measures for you to consider, when will it be reviewed?

As a result of this situation Agnes states she feels a bit nervous about the patient – almost wary of her and what she will do. Overall Agnes feels that she needs to talk to the service user a bit more, get to know her personally and begin to re-build the relationship by making sure the service user knows she is there for her.

We discussed some DBT skills that can be used to help manage distress and talked through these.

Agnes accepts that she can't be responsible for the assault on her colleague but that such feelings are usual and valid.

Agnes identified that she would need further training on managing & understanding these situations. She

says she will spend some time with the psychologist in the first instance and we will look for some more formal training to help her develop her skills.

We have agreed to re-visit this situation next time to explore how using skills has impacted.

Overall Actions from this session – (Consider development/education opportunities or other development or support needs identified)

1. Agnes will approach the psychologist and arrange some informal training.
2. Manager will look for some more formal training.
3. Agnes will spend time with service user x and attempt to use some of the skills that we have discussed.
4. Agnes will check which fluid / diet form should be used and delete all others from the shared drive.
5. Manager will take the solutions for compliance of form keeping discussed to the next staff meeting for further team discussion.

How did you find the session?

Signed:

Supervisee _____ Date _____

Supervisor _____ Date _____

Date and Time of next Supervision:-

Notes completed by? Supervisee Supervisor

Appendix 6: Supervision Log (Excluding medical staff)

Name _____ Role _____ Team/Service _____

Date	Type/Form of Supervision or Clinical Learning Experience (1:1, Group, Live etc.)	Brief summary of key issues /Learning/Reflection (All instances of clinical learning experience or supervision should be confirmed by an appropriate clinician or your Clinical Supervisor)	Duration	Signature	Confirmer / Supervisor Signature

Appendix 6a: Supervision Log (Medical staff)

APPENDIX 6A: SUPERVISION LOG FOR DOCTORS (please upload to your SARD appraisal section 1 Maintaining Professional Performance, sub section CPD Peer Group or for junior doctors please upload to your portfolios).

NAME:		ROLE:		SPECIALITY & LOCALITY:	
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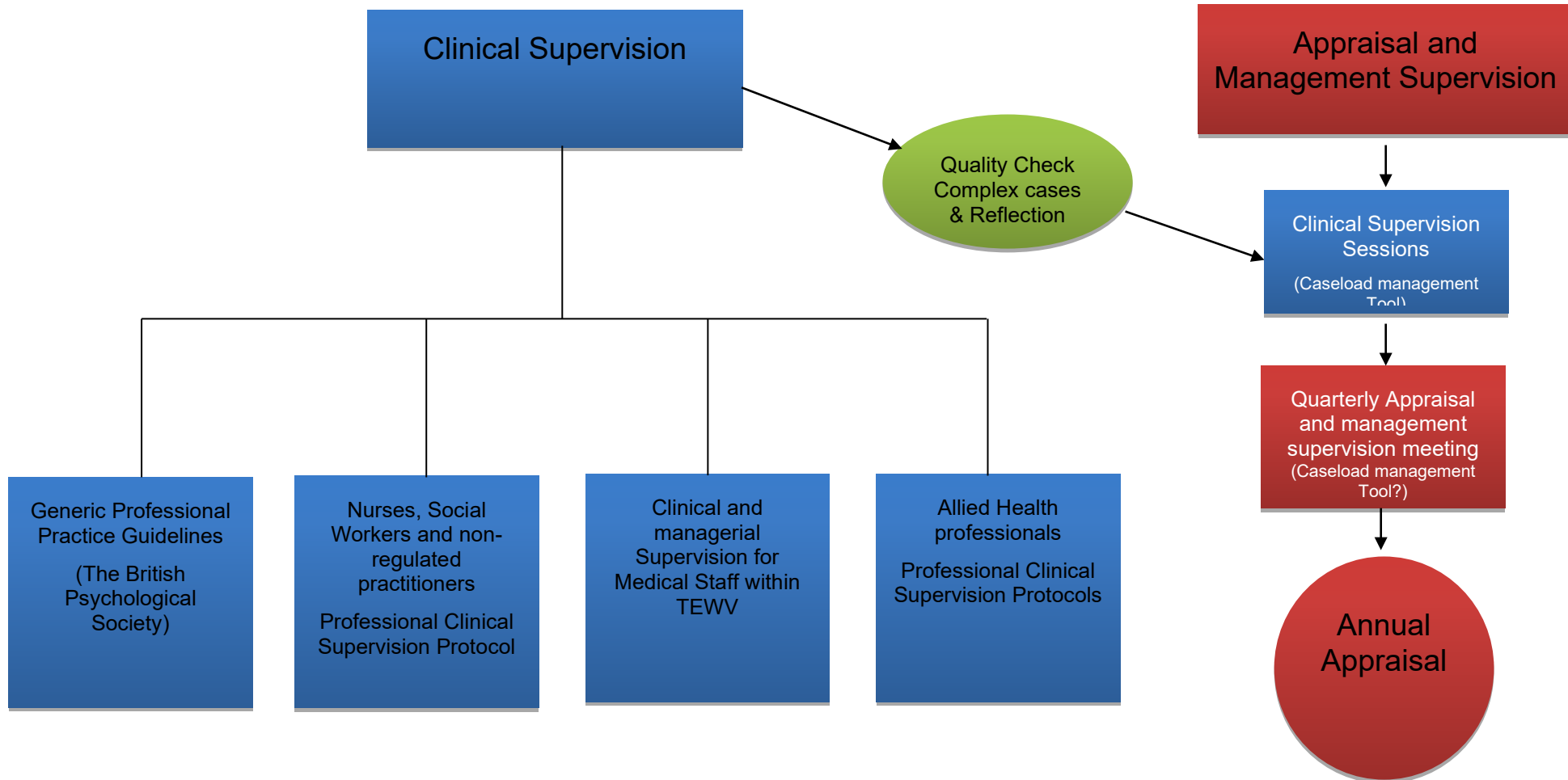
DEFINITIONS:	
Clinical Supervision	Meeting with clinical colleague(s) involving discussion of your clinical practice
Management Supervision	Meeting with line manager to discuss matters relating to your employment

ACTIVITIES:		
	CLINICAL SUPERVISION : 8 HOURS	MANAGEMENT SUPERVISION : 4 HOURS
	<p>Case-based discussion</p> <p>CPD Peer group meeting</p> <p>Critical Incident review meeting</p> <p>Case Presentation</p> <p>Appraisal meeting</p>	<p>Job Plan meeting</p> <p>Job Plan review</p> <p>1:1 meeting with line manager</p> <p>Consultants meeting with CD</p>

DATE	CLINICAL SUPERVISION HOURS	MANAGEMENT SUPERVISION HOURS	DESCRIPTION OF MEETING/EVENT	NAME OF SUPERVISOR	1:1/GROUP

TOTAL HOURS:

Appendix 7: Policy Inter-relationship diagram



Appendix 8: Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Directorate of Nursing and Governance			
Title	Supervision Policy			
Is the area being assessed a	Policy/Strategy		Service/Business plan	Project
	Policy	x		
	Procedure/Guidance			Code of practice
	Other – Please state			
Geographical area	Trust Wide			
Aims and objectives	<p>To set the minimum standard for clinical supervision in Tees Esk and Wear Valley NHS Foundation Trust.</p> <p>To provide robust monthly monitoring that supports both:-</p> <ul style="list-style-type: none"> • Annual Appraisal and Management Supervision by ensuring clinical quality and patient safety, particularly in the application of the caseload management protocol • The relevant Professional Guidance or protocols for Clinical supervision 			

Start date of Equality Analysis Screening	22 nd January 2021 / Reviewed 16 th June 2021
End date of Equality Analysis Screening	22 nd January 2021 / Reviewed 16 th June 2021

Please read the Equality Analysis Procedure for further information

You must contact the E&D team if you identify a negative impact. If you require further advice and support please ring Sarah Jay or Tracey Loynes on 0191 3336267/3542

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?					
All Staff					
2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?					
Race (including Gypsy and Traveller)	No	Disability (includes physical, learning, mental health, sensory)	No	Sex (Men, women and gender neutral etc.)	No

		and medical disabilities)			
Gender reassignment (Transgender and gender identity)	No	Sexual Orientation (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	Age (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and some other non-religious beliefs)	No	Pregnancy and Maternity (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	Marriage and Civil Partnership (includes opposite and same sex couples who are married or civil partners)	No
<p>Yes – Please describe the anticipated negative impact</p> <p>No – Please describe any positive outcomes</p> <p>Opportunity for reflection on practice</p> <p>Support and guidance for staff</p> <p>Checks on health and well being</p> <p>Risk Management</p> <p>Development of Good Practice</p>					
<p>3. Have you considered any codes of practice, guidance, project or business plan benefit?</p> <p>If 'No', why not?</p>				Yes	No
				x	

Sources of Information :

- Feedback from equality bodies Care Quality Commission,
- Investigation findings including external review of group of incidents
- Trust Strategic Direction
- Data collection/Analysis – Audit results
- Internal Consultation
- Other – Professional Groups

**4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?:
Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership**

Yes – Please describe the engagement and involvement that has taken place

No

No – Please describe future plans that you may have to engage and involve people from different groups

Future audit will include equality and diversity questions.

5. As part of this equality analysis have any training needs/service needs been identified?

Yes	Please describe the identified training needs/service needs below; Supervision awareness – for all staff Supervisor preparation training				
A training need has been identified for					
Trust staff	Yes	Service users	No	Contractors or other outside agencies	No
Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so					
Please forward this form by email to: tewv.policies@nhs.net Please Telephone: 0191 3336267/6542 for further advice and information on equality analysis					

Appendix 9: Approval Checklist

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	Title		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2.	Rationale		
	Are reasons for development of the document stated?	Y	
3.	Development Process		
	Are people involved in the development identified?	Y	
	Has relevant expertise has been sought/used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	
	Have any related documents or documents that are impacted by this change been identified and updated?	Y	
4.	Content		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
5.	Evidence Base		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are supporting documents referenced?	Y	
6.	Training		
	Have training needs been considered?	Y	

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
	Are training needs included in the document?	Y	
7.	Implementation and monitoring		
	Does the document identify how it will be implemented and monitored?	Y	
8.	Equality analysis		
	Has an equality analysis been completed for the document?	Y	
	Have Equality and Diversity reviewed and approved the equality analysis?	Y	
9.	Approval		
	Does the document identify which committee/group will approve it?	Y	
10.	Publication		
	Has the policy been reviewed for harm?	Y	
	Does the document identify whether it is private or public?	Y	Public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	