Clinical Supervision Policy

During the COVID19 crisis, please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Assurance Group.

Document Author	Authorised
Written By: Consultant Nurse **Date:** December 2019	**Authorised By:** Chief Executive **Date:** 19th March 2020
Lead Director: Director of Nursing	
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DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification/ Approval
29 Mar 12	1.0	29 Mar 12	Executive Director of Nursing	Logo and wording updated for new organisation	
2 Jan 11	1.1		Executive Director of Nursing	Updated to reflect changes in NHSLA standards	
	1.2-1.9		Executive Director of Nursing	Consultation and amendments agreed at various committees and 1:1 meetings	
25 Sep 12	1.10	Originally approved in 2009	Executive Director of Nursing	Amendments to the policy are to ensure that it reflects current good practice, and that all parts of the organisation are working to this policy as the only policy in use. The amendments are needed to reflect the diversity of approaches to clinical and management supervision	
25 Oct 12	1.10	4 Oct 12 Subject to amendment	Executive Director of Nursing	Amendment as requested at	Quality and Patient Safety committee
28 Nov 12	1.11	28 Nov 12	Executive Director of Nursing	Agreed at	Policy Management Committee with amendments
3 Dec 12	2.0	03 Dec 12	Executive Director of Nursing	Approved at	Executive Board
20 Oct 15	2.0	20 Oct 15	Executive Director of Nursing	Extension agreed at	Policy Management Group
19 Jan 16	2.0	19 Jan 16	Executive Director of Nursing	Extension agreed at	Policy Management Group
12 Apr 16	2.0	12 Apr 16	Executive Director of Nursing	Extension agreed at	Policy Management Group
28 Jun 16	2.0	05 Jul 16	Executive Director of Nursing	Three month extension agreed by voting buttons by	Corporate Governance & Risk Sub-Committee
13 Sep 16	2.0	13 Sep 16	Executive Director of Nursing	Extension agreed until the end of Oct 2016	Corporate Governance & Risk Sub-Committee
11 Oct 16	2.0	11 Oct 16	Executive Director of Nursing	Extension agreed for 2m until the end of Dec at	Corporate Governance & Risk Sub-Committee
28 Oct 16	2.1		Executive Director of Nursing	For ratification	Clinical Standards Group
13 Dec 16	3.0	13 Dec 2016	Executive Director of Nursing	For Approval	Corporate Governance & risk Sub-Committee
12 Dec 19	3.1		Director of Nursing	Review	
31 Jan 2020	3.1		Director of Nursing	Agreed at	Clinical Standards Group
19 March 2020	4.0	19th March 2020	Director of Nursing	Approved via voting and Chairs Action at	Policy Management Sub-Committee

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

Contents

1. Executive Summary

1.1. Clinical supervision is the term used to describe a formal process of professional support which should be seen as a means of encouraging self-assessment, analytical and reflective skills.

1.2. The term 'clinical supervision' can be confusing, largely because its definition, rationale and objectives, as well as frameworks and models of practice are used differently across practice settings and professional groups (White & Winstanley 2011). However, there are a number of common features:

- It is a formal alliance between practitioners in which the roles of the supervisor and supervisee(s) are defined.
- The focus is on providing professional support and enhancing professional functioning, through facilitated reflection and by increasing self- and therapeutic awareness.
- It addresses issues such as ethical, professional and best practice standards, which impact on quality of care.
- It aims to enhance practice and improve or optimise outcomes for patients.

1.3. It is also important to understand what clinical supervision is not. It is not a component of performance appraisal or a job for a line manager; and it is not the same as or interchangeable with mentoring, coaching or preceptorship.

Clinical supervision is not:

- An informal or ad hoc interaction or arrangement
- A whinge session or opportunity to complain about colleagues
- Therapy for the supervisee
- An opportunity for the supervisor to practice counselling
- An opportunity to identify and get rid of ‘bad’ or 'unsuitable' practitioners
- An imposed arrangement controlled and delivered by management
- An opportunity for an intimate relationship to develop
- A way to shift accountability and responsibility on to the supervisor

(Lynch et al, 2008)

1.4. The Isle of Wight NHS Trust places clinical supervision at the heart of its operations to support the achievement of its objectives, including improving the patient experience and patient safety, working with staff and making best use of resources. It is a requirement of the Care Quality Commission Fundamental Standards

regulation 18 (staffing) (CQC 2014) requires that the Trust sets out a clinical supervision policy covering all clinical staff.

1.5. This policy sets out the requirements of clinical supervision within the Trust providing a framework for supervision, and the supporting education and monitoring processes.

1.6. Supervision operates as a process for maintaining and improving the quality of services. Clinical supervision is also a professional regulatory requirement for many healthcare professionals. It operates alongside performance appraisal and the NHS Knowledge and Skills Framework as part of continued professional development.

1.7. For different professional groups within the Trust there are different requirements. These are explained – **See Appendix A**

2 Introduction

2.1. There are many forms of supervision, including professional, management, clinical, case and peer supervision. This policy covers clinical supervision.

2.2. This policy aims to provide a comprehensive and satisfactory framework appropriate for staff supervision that ensures the delivery of a competent, safe and high quality service.

2.3. The document is part of the Care Quality Commission (CQC) requirements and contributes to the Trust framework of safe practice and other clinical guidance.

3 Definitions

3.1 Reflective practice is central to the continuing development of many professionals (Taylor, 2010) and a requirement for maintaining registration for doctors, nurses and professional allied to medicine (PAM) (Muir, 2010; Nicol and Dossier, 2016; NMC, 2018).

3.2 A contemporary definition emphasises the reflective nature of clinical supervision as: “a designated interaction between two or more practitioners within a safe and supportive environment that enables a continuum of reflective critical analysis of care to ensure quality patient services and the wellbeing of the practitioner” (Bishop, 2007).

3.3 Professional bodies have advised that clinical supervision is practice focused and includes a professional relationship that enables reflection on practice with the support of a skilled clinical supervisor.

3.4 Reflection contributes to the development of professional knowledge and skills. It is an integral part of continuing professional development (CPD) and of lifelong

learning. It should be available throughout a career, enabling constant evaluation and improvement of service user, patient and client care. Formal reflective practice aims to bring practitioners and skilled supervisors together to reflect on practice, to identify solutions to problems, to increase understanding of professional issues and to work together to continuously improve standards of care.

4 Scope

4.1 The aim of clinical supervision is to promote patient safety, improve patient care and develop clinical practice through confidential professional guidance and support.

4.2 This policy applies to all substantive registered clinical staff with patient contact, and caring or therapeutic responsibilities, in adult, child, mental health and learning disability healthcare.

4.3 Non-registered professionals, including but not limited to, chaplains, health care support workers and associate practitioners are also included within this policy.

5 Purpose

5.1 The purpose of this policy is to provide the detailed organisational requirements of clinical supervision which will contribute to patient safety and high quality care.

5.2 This document contributes to the maximisation of the benefits of clinical supervision, to patients, staff, and the organisation. These are:

Patient benefits:

- Positive care experience.
- Safe and effective care and services which are responsive to patient need.
- Professionalism of staff demonstrated in every contact
- The delivery of contemporary evidence-based care.

Staff benefits:

- Motivation and empowerment.
- Support and encouragement.
- Development of reflective clinical practice and evaluation skills.
- Development of self-awareness.
- Identification and understanding of own development needs and how to address them.
- Development of strategies for change.

- Regular contact and opportunity for discussion with a supervisor.
- Learning and developing improved working practices, skills, knowledge and values.
- Learning from errors and successes.

Organisational benefits:

- Achievement of Trust strategic priorities.
- Assurance of high quality safe and continually improving services for patients.
- Meeting Adult and Child Safeguarding standards.
- Supporting innovation, experimentation and positive risk taking.
- Developing positive relationships between staff.
- Encouraging evidence based practice and responsiveness to relevant national/professional agendas.
- Validating decision making processes.
- Improving working lives.
- Practicing and developing empowering behaviours positively influencing the organisational culture.

6 Roles and Responsibilities

6.1 The Executive Medical Director, Executive Director of Nursing and Director of Human Resources and Organisational Development are responsible for:

- Ensuring appropriate systems of clinical supervision are in place for all clinical staff.
- Linking systems of clinical supervision to clinical governance and continuing professional development.

6.2 The Assistant Director Organisational Development is responsible for:

- Providing training and development for key staff able to act in a supervisory capacity for clinical supervision.

6.3 Line Managers are responsible for:

- Identifying any gaps in the availability of clinical supervision and taking appropriate action to resolve gaps.
- Ensuring appropriate records are kept relating to delivery of clinical supervision.
- Ensuring clinical supervision is supported and that all staff are provided with appropriate protected time to enable them to access clinical supervision according to clinical need. Some groups will require a specified amount of

protected time (**See appendix A**: Professional Perspectives on Clinical Supervision).

- Monitor that appropriate protected time that has been available for clinical supervision, at appraisal.

6.4 All staff are responsible for considering their own developmental needs and using the opportunity to access clinical supervision. They are responsible for discussing with their line manager any professional, personal and organisational requirements, appropriate protected time and will evidence time spent on clinical supervision at appraisal.

6.5 The recommended frequency of clinical supervision is a minimum of once a year but this may be more and in some professions professional body requirements will be very much greater and as specified by each professional body.

7 Policy Detail/Course of Action

7.1 All clinical staff have the right to discuss, reflect and develop their work using confidential formal reflective practice in the form of clinical supervision.

All clinical staff will participate in clinical supervision as part of professional practice. Frequency will be determined by individual practitioners in conjunction with their professional lead and line manager to ensure it can occur, unless professional guidelines and requirements or individual clinical business units (CBU) specify the amount that is required **(See Appendix A).**

7.2 The line manager also has a responsibility to ensure that staff who are involved in patient care undertake clinical supervision. Meeting this expectation will be monitored by the line manager as part of the annual appraisal process and in communication with the professional clinical lead where appropriate.

7.3 The line manager will support and facilitate the supervisee and supervisor to have protected time to undertake clinical supervision.

7.4 It is recommended that a supervision contract, including ground rules, will be agreed by the supervisor and supervisee at the outset of the supervision sessions.

7.5 It is the responsibility of the supervisee to ensure clinical supervision takes place.

7.6 The nature and frequency of clinical supervision will be determined by the supervisee and their supervisor, and agreed with the line manager to ensure this can occur. There must be protected time for this at least once a year and this will be separate from appraisal. It is acknowledged that for certain professions the frequency and duration of supervision will be considerably more and in keeping with professional practice guidance.

7.7 Protected time for supervision will depend on particular circumstances, but as a guide, one to one and a half hour session would be appropriate, as the maximum and minimum suggested time for formal sessions. Informal sessions may be less.

7.8 It is suggested that individuals supervise no more than three supervisees. This will depend on departmental demand, professional practice guidance and service requirements.

7.9 The agenda for clinical supervision is set by the supervisor and the supervisee who will bring relevant and pertinent issues to the clinical supervision session. Clinical supervision does not take the place of seeking immediate management or practice advice, or from accessing informal reflection and discussion as required. For staff providing clinical supervision it is a mandatory requirement that they have completed a clinical supervision course or equivalent. These are available as a management and clinical supervision e-learning programme and as taught programmes from a local university delivered on site. (More detail of opportunities in paragraph section 9.2).

7.10 The supervisor will not disclose content unless any issue contravenes a relevant professional Code of Conduct or practice guideline and such disclosure should only be made following discussion with the supervisee.

8 Consultation

8.1 This document has been circulated to all key stakeholders within the Trust.

9 Training

9.1 An e-learning package is available to support staff and managers in developing the necessary skills and knowledge to undertake clinical and management supervision.

9.2 The training and development of clinical supervisors can be undertaken in a number of ways, all of which are acceptable:

- Formal educational modules from Institutes of Higher Education
- Work-based learning modules
- Study days
- On the job training and supervised practice of delivering clinical supervision within the chosen model.
- Shadowing of an experienced supervisor.

9.3 All clinical supervisors will undertake refresher training every 3 years to promote maintenance of skills in clinical supervision via one of the above mentioned methods. This will be monitored as part of the appraisal process.

10 Monitoring Compliance and Effectiveness

10.1 Compliance with the Clinical Supervision Policy will be monitored via the completion of annual appraisals, which requires all registered professionals to provide evidence of having received clinical supervision at least once within the year.

11 Links to other Organisational Documents

- Appraisal policy
- Clinical and Educational supervision policy
- Emotional Wellbeing policy
- Capability policy and procedure
- Safeguarding Children and Young People policy
- Safeguarding Adults multi-agency policy, guidance and toolkit
- Disciplinary and Dismissal policy and procedure
- Information Governance Risk policy
- National Whistleblowing policy
- Incident Management policy
- Countering Fraud and Corruption policy and reporting procedure

12 References

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Nicol JS and Dosser I (2016) Understanding reflective practice. *Nursing Standard.* **30:** 36, 34-40

Nursing and Midwifery Council (NMC) Revalidation. *Your step by step guide through the process* [ON LINE]
URL: http://revalidation.nmc.org.uk/ [last accessed 12th December 2019]

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Taylor BJ (2010) *Reflective Practice for Healthcare Professionals,* 3rd ed. Maidenhead: Open University Press

White, E. & Winstanley, J. (2011). Clinical Supervision for mental health professionals: the evidence base. Commissioned for Special Edition 'Current Trends in Mental Health Services'. *Social Work and Social Sciences Review, 14:3*, pp73-90.

13 Appendices

Appendix A Professional Perspectives on Supervision
Appendix B Financial and Resourcing Impact Assessment on Policy Implementation
Appendix C Equality Impact Assessment (EIA) Screening Tool

Appendix A

PROFESSIONAL PERSPECTIVES ON SUPERVISION

Nursing and Midwifery

- Under the Nursing and Midwifery Council (NMC) professional standards of practice and behaviour for nurses, midwives and nursing associates (2018) nurses are required to continually improve their practice, promote and use evidenced based care and develop effective working relationships with patients, relatives and other healthcare professionals.

- Within the Trust this is promoted and supported actively in nursing using a number of different models of supervision and include – clinical supervision, preceptorship, action learning sets, case supervision, peer review, and coaching.

Mental Health and Learning Disabilities

For Mental Health and Learning Disabilities clinical staff, including non-professionally qualified staff.

- MH practitioners in the community who are professionally registered nurses, Occupational Therapist or Social Worker, are required to observe the local clinical supervision guidance for mental health staff designed to ensure staff remain safe, effective practitioners whilst providing care for very complex, often high risk patients.

- Supervision is provided in a number of ways, 1-1, group supervision and reflective practice.

- Monthly clinical supervision unless a longer timescale is agreed for specific reasons.

- Management supervision (two weekly)

- Supervision contracts should be held within personnel folders.

- Supervision contact details i.e. dates and times should be recorded and accessible to the management team.

- Notes from clinical supervision are confidential and are not held within personnel files. Often held by the supervisee.

- Reflective practice and peer supervision sessions are recorded with date, attendees and theme. This record should also be held centrally for manager's access.

Allied Health professionals

- Allied Health professionals are governed by the relevant professional body. Where guidance and standards for clinical supervision are set, this should be evident in local procedures for supervision.

- Allied Health professionals should understand and participate in the supervision arrangements in their local area.

- In all cases the Trust seeks to support staff to obtain appropriate supervision to enable them to continually improve. Supervision can include individual clinical supervision, case supervision, peer review, and coaching.

Clinical Psychology (and including Counselling and Health psychology)*

- Clinical Psychologists supervision arrangements comply with national guidance published by the British Psychological Society – Practice Guidelines 3rd edition (2017).

- The organisation's minimum standard for supervision of psychologists is 60-90 minutes for every 10 sessions worked. (1 session equals ½ a day). In practice most psychologists are expected to receive more than this minimum standard. It is recognised that clinical supervision is an essential supportive mechanism that ensures the highest level of professionalism, professional support, reflective practice and best quality outcomes for patients. All psychologists are statutorily required by their professional body to ensure that access to such supervision is in place at all times. Where specialist clinical supervision is unavailable within the NHS Isle of Wight, it will be necessary for such supervision to be acquired from outside the organisation. Where an individual psychologist carries out private practice outside of their NHS contracted hours it is accepted that the cost for their clinical supervision in relation to this work are met from their own funds and not funded by the NHS.

  More detailed guidance on clinical supervision for psychologists can be found at:

  https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Practice%20Guidelines%20%28Third%20Edition%29.pdf

* Please note: the principles outlined above will also apply to psychological therapists, although it is recognised that the frequency and duration of supervision may vary depending on the therapeutic discipline involved.

Medical Staff

All new junior doctors should have undertaken a clinical competency assessment prior to taking up post. The assessments are grade and specialty specific, areas of weakness in critical areas become the subject of urgent training to allow the junior doctors to undertake their job safely. All junior doctors work under the direct supervision of the clinical supervisor who is responsible for the quality of the work they do and the necessary training to allow them to develop the practical skills. Any doctor introducing a new procedure to the Trust must pass this through the new procedures committee. This process is supported via the clinical and educational supervision policy.

Ambulance professionals

There is no registration statutory requirement for paramedics to undertake clinical supervision. However, the Health and Care Professions Council (HCPC) standards of

proficiency for paramedics require continuous professional development and reflection on and review of practice, which would be encompassed in clinical supervision.

The Isle of Wight NHS Ambulance Service has committed to giving all registered paramedics a bi-annual review which is separate to line management, and incorporates aspects of both clinical and management supervision as described in this policy. Procedures relating to clinical supervision can be obtained from local Ambulance HQ and via line managers.

Appendix B

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	**Clinical Supervision Policy**

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs	**0**	**0**	**0**
Training Staff	**0**	**0**	**0**
Equipment & Provision of resources	**0**	**0**	**0**

Summary of Impact:

Risk Management Issues:

Benefits / Savings to the organisation:

Equality Impact Assessment

- Has this been appropriately carried out? YES
- Are there any reported equality issues? NO

If "YES" please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**
Operational running costs			

Totals:			

Staff Training Impact	**Recurring £**	**Non-Recurring £**
Totals:		

Equipment and Provision of Resources	**Recurring £ ***	**Non-Recurring £ ***
Accommodation / facilities needed		
Building alterations (extensions/new)		
IT Hardware / software / licences		
Medical equipment		
Stationery / publicity		
Travel costs		
Utilities e.g. telephones		
Process change		
Rolling replacement of equipment		
Equipment maintenance		
Marketing – booklets/posters/handouts, etc.		
Totals:		

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

Appendix C

Document Title:	Clinical Supervision Policy
Purpose of document	To provide a framework for Clinical supervision for non-medical healthcare staff
Target Audience	Non medical Healthcare staff
Person or Committee undertaken the Equality Impact Assessment	Consultant Nurses

Equality Impact Assessment (EIA) Screening Tool

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men			
	Women			
Race	Asian or Asian British People			

	Black or Black British People			
	Chinese people			
	People of Mixed Race			
	White people (including Irish people)			
	People with Physical Disabilities, Learning Disabilities or Mental Health Issues			
Sexual Orientation	Transgender			
	Lesbian, Gay men and bisexual			
Age	Children			
	Older People (60+)			
	Younger People (17 to 25 yrs.)			
Faith Group				
Pregnancy & Maternity				
Equal Opportunities and/or improved relations				

Notes:
Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact: N/A			
		YES	**NO**
Legal (it is not discriminatory under anti-discriminatory law)			
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:	
NONE	
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:	
NONE	
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?	
NONE	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	