journey to change

NHS
Tees, Esk and Wear Valleys
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Clinical and Professional Supervision Policy

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Contents

1 Introduction

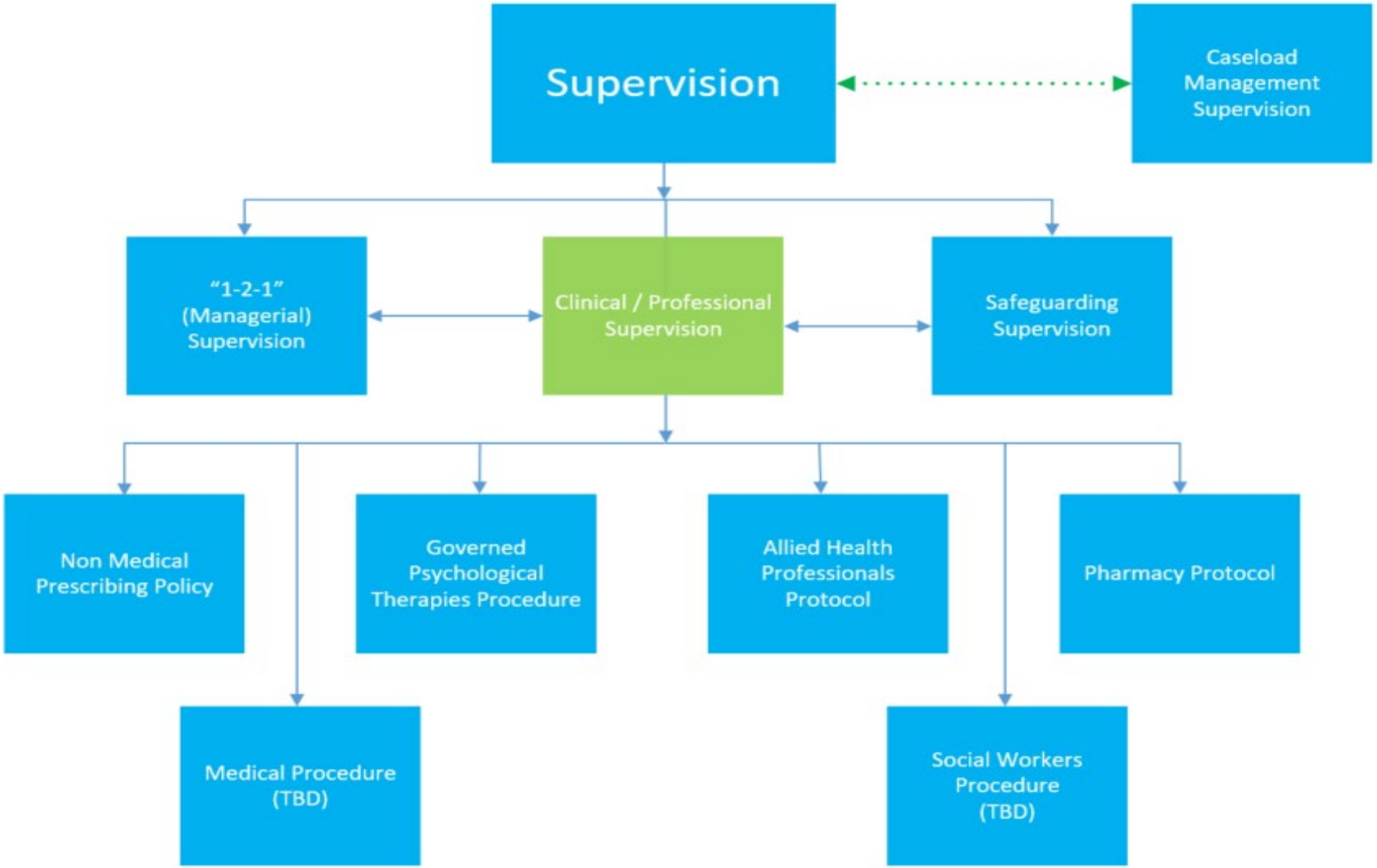
1.1 Supporting professional standards

This policy has been developed to support clinical staff meeting the professional standards of the Nursing and Midwifery Council (NMC, 2018), the Health Care Professions Council (HCPC, 2022), and the General Medical Council (GMC, 2021). The policy also considers the guidelines set out in the Care Quality Commission (CQC) document "Supporting effective clinical supervision" (CQC, 2013) towards meeting CQC Regulation 18 (CQC, 2023).

1.2 Types of supervision

The policy describes how there are several types of supervision – the three most referred to are clinical, managerial, and professional supervision. The terms used in this area may sometimes overlap and in practical terms, it may sometimes be difficult to separate them from each other.

This is the overarching clinical / professional supervision policy for the organisation which is further supported by detailed information about the application of supervision according to profession in the relevant guidance documentation (see section 4.4).


Supervision
Caseload Management Supervision
"1-2-1" (Managerial) Supervision
Clinical / Professional Supervision
Safeguarding Supervision
Non Medical Prescribing Policy
Governed Psychological Therapies Procedure
Allied Health Professionals Protocol
Pharmacy Protocol
Medical Procedure (TBD)
Social Workers Procedure (TBD)

1.3 Importance of informal supervision

Nothing contained within this policy is intended to diminish or replace the importance of, or the need for, informal supervision which is expected to happen in a variety of settings.

All staff should have access to, and take responsibility to access, appropriate support as the need arises, whether relating to urgent matters or routine clinical work.

Informal supervision should be central to the culture of the team, with the leadership team providing encouragement, support, and enabling the facilitation of informal supervision, and ensuring that it is recording appropriately.

1.4 Managerial (Management) supervision

“1-2-1” (Managerial) supervision is not discussed further within this policy, please refer to the staff development policy for further information.

1.5 Clinical supervision

Clinical supervision provides an opportunity for staff to:

- reflect on and review their practice.
- discuss individual cases in depth.
- change or modify their practice and identify training and continuing development needs.

1.6 Professional supervision

The term **professional supervision** is sometimes used where supervision is carried out by another member of the same profession or group.

This can provide staff with the opportunity to:

- Review professional standards.

- Keep up to date with developments in their profession.
- Identify professional training and continuing development needs.
- Ensure that they are working within professional codes of conduct and boundaries.

Professional supervision is often interchangeable with clinical supervision and so, for the purpose of this document, when using the term clinical supervision this will also include professional supervision unless specifically stated otherwise. Similarly, some professions and occupations may use alternative titles such as 'peer supervision', 'developmental supervision', 'reflective supervision' or just 'supervision', and these will also be encompassed in the term "clinical supervision" providing it remains complementary to, but separate from, one to one / managerial supervision.

1.7 Caseload management supervision

- For all staff employed by the Trust who hold responsibility for a caseload of patients (care coordinators or lead professionals) associated with a community team, caseload management supervision supports these staff members with the progression of their patients towards recovery and flags those areas that require discussion or actions. Please refer to the Community Caseload Supervision Policy for further detail.

Caseload management supervision **is not** a replacement for clinical, professional or safeguarding supervision.

1.8 Our Journey to Change

Promoting good quality clinical supervision into the Trust helps to embed a supportive culture of reflection, learning and self-development. 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. This supports the Trust's vision and "Our Journey To Change".

"Our Journey To Change" sets out why we do what we do, the kind of organisation we want to become and the way we will get there by living our values, all the time. To achieve this, the Trust has committed to three goals. This policy supports the three goals of "Our Journey To Change".

Strategic goal 1: To co-create a great experience for patients, carers, and families.

This policy will support the delivery of outstanding and compassionate care at all times by ensuring that there are clear definitions and requirements to enable high quality clinical supervision for clinical staff that also includes its monitoring, recording and oversight.

Strategic goal 2: To co-create a great experience for our colleagues.

The policy will ensure that colleagues understand their roles and responsibilities, and any follow up actions. When staff understand their roles and their duties, and are confident and supported in their practice, they can be confident in their involvement and that the actions that they take are appropriate and consistent with best practice and professional requirements.

Strategic goal 3: To be a great partner.

The policy will support our understanding of the needs and the strengths of our communities; the service users and carers, and the multidisciplinary services available within it that will ensure that we will be better able to meet the needs of all within it.

Having a clear definition for clinical supervision will help to ensure we live our values of respect, compassion, and responsibility.

This policy and all procedures and training relating to it will adhere to the Trust's Human Rights, Equality Diversity and Inclusion Policy.

2 Why we need this policy.

The policy responds to recommendations made from the Francis Report (2013) and CQC Regulation 18 which states:

> "**Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities.**"

This policy highlights that clinical staff **must** have an opportunity to reflect on their clinical interactions to practice safely, to maintain and improve the quality of their practice, and to address their own needs for support and well-being.

Each profession may have additional and specific requirements for clinical supervision and the relevant professional guideline procedures and protocols are available within this overarching policy.

2.1 Purpose

The overall purpose of supervision in the Trust is to support and continually improve the quality and safety of the services we deliver and the professionalism of staff in line with shared Trust values, and to provide an opportunity to support the health and wellbeing of the staff.

This policy will identify, for all staff working clinically, the expected values and standards that individual supervision arrangements must meet and the processes for recording, reporting, and monitoring these standards.

2.2 Objectives

The policy objectives are to:

- Clarify the Trust's position on meeting the minimum professional and clinical supervision requirements of practitioners and all clinical staff employed by the Trust.
- Outline the requirements and process by which the organisation provides supervision to staff and to monitor compliance arrangements.
- Provide access to specific supervision procedures and protocols that identify any mandated standards required for each profession or skill set.
- Provide a framework for individuals to:
- 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.
- Clarify individual responsibilities / duties in relation to supervision.
- Provide clear definitions and terminology of the types of supervision to be provided.
- Highlight the method and importance of recording all supervision contacts.
- Reinforce the importance of reflective learning in improving the quality of services on an on-going basis.

3 Scope

3.1 Who this policy applies to

This policy applies to all staff that either have a clinical role or are practising social workers. This includes staff that are permanent (full and part time), temporary (fixed term), and bank staff.

3.1.1 Who this policy does not apply to

Excluded from this policy are agency staff, however, they remain able to seek clinical supervision from their respective work areas within the Trust as appropriate or required should they wish to do so. If a serious incident takes place the Temporary Staffing Service would assist in ensuring that supervision is arranged and completed. However, requirements towards revalidation will be supported by their contracting Agency.

3.2 Roles and responsibilities

All staff must have access to and take personal responsibility to access appropriate support as the need arises, whether relating to urgent matters or routine clinical work.

Role	Responsibility
Chief Executive,	• On behalf of the Trust Board has overall responsibility for ensuring that the organisation complies with its statutory obligations.
Chief Nurse, Medical Director, Director of Therapies, and Chief Pharmacist	• To ensure that the principles within this policy are embedded in practice.
Clinical Directors, Associate Directors, and Professional Leads	• The maintenance and monitoring of compliance with this policy within their area of responsibility. • 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. • Ensuring action plans to address areas of non-compliance with this policy are fully implemented. They are responsible for

	dealing with areas that consistently non-comply with the requirements of this policy. • Leading a supervision approach within services that focuses on quality conversations that are supportive of both supervisor and supervisee.
Operational Directors and General Managers	• 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. • Ensuring all staff within their directorates / professional areas comply with the policy and that professional standards are maintained. They must make certain that all staff are supported and released to undertake and record supervision.
Line Managers and Team leaders	• Ensuring that all staff have access to this policy – especially those without access to the Trust intranet, and that the policy has been read and understood by staff. • Ensuring all staff (including themselves) access supervision, in accordance with the agreed guidance of their regulatory body and this policy. • Ensuring all recommendations are addressed where issues of concern are identified via quality monitoring processes. • Leadership support to ensure a supervision approach within services that focuses on quality conversations that are supportive of both supervisor and supervisee. • Escalating issues where appropriate • Ensuring that all services have local agreed procedures for supervision in their work area and all staff are aware of this. • Ensuring that each new employee understands the value, reasons, and benefits of regular supervision during their induction period.

Supervisor	Has a joint responsibility with the supervisee for ensuring supervision occurs, formulating a supervision contract, identifying boundaries, and confirming record keeping arrangements.
	• The supervisor has a responsibility to ensure all supervision activity is recorded and reported monthly for performance compliance purposes.
	• The supervisor should:
	  ○ Ensure that they operate within their sphere of competence.
	  ○ Undertake mandatory supervision training via e-learning or face-to-face.
	  ○ Ensure the supervisee is working within their sphere of competence.
	  ○ Ensure maintenance of supervision standards.

Supervisee	Has a joint responsibility with the supervisor for ensuring supervision occurs, formulating a supervision contract, identifying boundaries, and confirming record keeping arrangements.

	The supervisee should: • Be honest, open, and constructive and committed to the process. • Ensure that they operate within their sphere of competence. • Jointly contribute to the supervision agenda. • Prepare for the supervision session. • Avoid personal relationships with the supervisor that might compromise objectivity and effectiveness. • Accept constructive criticism and challenge and act on any outcomes / actions from the supervision session in a timely manner. Supervisees should ensure their supervision session is recorded within 2 working days of completing supervision. **When it is not the member of staff who records the supervision** - i**t remains the individual member of staff's responsibility to ensure their supervision records are accurate**.

4 Policy

4.1 Overview

4.1.1 Clinical Supervision Overview

Clinical Supervision is a practice focused professional relationship, involving a practitioner reflecting on practice guided by a skilled supervisor. Enabling practitioners to access preceptorship and clinical supervision recognises that support and learning does not end with registration but continues throughout their career. Through maintaining and improving their knowledge and competence staff will be ensuring that they are providing an accountable and safe standard of practice to the patients in their care.

The purpose of clinical supervision is to:

- Have time to engage in supportive self-examination, to facilitate reflection and learning with regards to clinical skills and practice
- Drive and maintain care standards.
- Identify practice issues and to consider evidence-based approaches.
- Consider the client / family members / carer and their journey through the service inclusive of risk, safeguarding, assessment, analysis / formulation, and intervention (care / action plan), and the promotion of anti-discriminatory practice.
- Be professionally open to question about clinical work in a safe environment.
- Have the opportunity to consider future training and development needs to inform Personal Development Plans.
- Promote innovations in practice.
- Ensure staff are up to date with any national clinical developments which impact on practice e.g., NICE guidance.
- Have the opportunity to discuss home life / personal issues as appropriate if these have an impact on practice.
- Have the opportunity to talk about their health and well-being as appropriate if these have an impact on practice and consider any potential reasonable adjustments.
- Develop clinical skills and expand knowledge through discussion and review.
- Be supportive and encouraging of new skills learnt through training courses, e.g., assisting the supervisee in implementing a new process / way of working.
- Review assessments, formulations, care planning and outcomes.
- Review patient safety issues or safeguarding issues.

- Review any engagement or interpersonal issues with service users or carers.
- Review any ethical issues.

4.1.2 Professional supervision overview

Professional supervision is necessary in instances where the supervisee is a practitioner and is not clinically or managerially supervised by someone of their own profession.

The supervisor must be of the same professional background as the supervisee. It provides the opportunity for staff to:

- Maintain professional identity.
- Identify professional development needs and career progression.
- Keep up to date with developments of their profession.
- Be clear that they are working within professional boundaries.
- Review clinical work with specific reference to their professional speciality.
- Discuss the supervision of students.
- Review professional standards and codes of conduct.
- Ensure that they are working within professional codes of conduct and ethics.

Professional supervision can be provided by a senior or peer of the same profession as the supervisee. For some professions this is required for revalidation in profession and or / additional accreditation with bodies. Professional supervision addresses core professional standards, competency issues, development of skills and career development, and as such should be used by the supervisee for the purposes of revalidation and appraisal.

It is expected that wherever possible professional supervision should be integrated into either or both clinical and managerial supervision.

Staff can negotiate with available colleagues to identify a supervisor for other areas of supervision or can use their manager for managerial, professional, and clinical if felt appropriate. The functions of these areas can overlap but when all areas are addressed it ensures safe, supported, and effective practice.

4.2 Minimum standards and best practice

Supervisees need to have as much supervision as they need to fulfil their role. It depends on experience and position / type of role and should be negotiated accordingly. Self-assessment can help the professional think about their supervision needs (appendix 3).

The focus of all conversations around supervision needs to be the value of it from the perception of the supervisee, for all the reasons described in this policy. Frequency of supervision might increase or decrease in line with changes in the work environment, the person's home life, or their health and wellbeing. As such, the standards below are seen as the **minimum** required to support a colleague in the workplace, not the target to aim for.

4.2.1 Minimum requirements

To provide assurance as to agreement of the experience of supervision, supervisees will receive an email whenever supervision is recorded as being provided to them.

- All clinical staff must actively participate in a mandatory minimum of **EIGHT hours of clinical supervision per year** (pro rata). There is a minimum requirement to have 2 hours every 3 months.
- 4 of these 8 hours **must** be formal 1:1 clinical supervision, i.e., one hour every 3 months (pro rata).
- The remaining 4 hours may consist of: formal 1:1 clinical supervision, informal / group supervision, i.e., one hour every 3 months (pro rata).
- **Safeguarding supervision** for relevant staff - please refer to section 4.3 below when:
- Safeguarding or safety of clients or public or where practice / standards / clinical concerns are raised.
- Specialist safeguarding supervision is accessed.
- **Non-medical prescribing** supervision – 6 hours per year, spread across each quarter in addition to the above with their medical supervisor, and specific to their prescribing role.
- 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), must be delivered in accordance with relevant professional guidance or protocol – see section 4.4.
- A contract is required to be completed prior to any formal supervision going ahead this will define the frequency of supervision, record keeping and confidentiality.
- A record of the content of the supervision must be kept by both the supervisor and the supervisee.

- All formal supervision records must be signed by both supervisor and supervisee (this can be an email confirmation of agreement with content). See section 4.6 for further detail.
- All clinical / professional supervision must be logged electronically on the Trust's electronic recording system to capture a log of the supervision sessions and be made available to the organisation for auditing purposes as required and in accordance with all relevant legislation and policy.
- Where relevant to care, an appropriate summary must be made by the supervisee into the relevant Electronic Patient Care Record (EPCR) when it changes the plan of care or decision previously made pertaining to the patient(s). All records of supervision outwith the clinical record must ensure that patient confidentiality is maintained.
- For group supervision all participants must keep a copy of the record of the content of the session, if a client is discussed any decisions and action must be recorded in the EPCR.
- Feedback from supervisors is required to be incorporated into the staff members annual appraisal.
- The provision of supervision for bank staff will be considered and proportionate to the number of hours worked in the Trust averaged over the previous year.
- Any employee experiencing barriers to meeting the minimum standard for supervision **must** inform their line manager.

4.2.2 Further best practice considerations

- It is the responsibility of each practitioner to come to the session prepared with cases and completed documentation for discussion and reflection on actions.
- It is advisable to undertake one to one and / or clinical supervision upon commencement into role, or following return from significant periods of leave (e.g., maternity, long term sickness absence).
- Newly appointed staff will be allocated a supervisor by their manager and / or clinical lead for the first 6 months of their appointment. Where required and appropriate, staff are to be given opportunity to seek out specific professional supervision in addition to supervision provided by their team.
- Clinical supervision can occur between individuals from the same or different professional backgrounds and / or pay scale (i.e., peer supervision), provided the supervisor is appropriately experienced either in relation to professional training or clinical expertise.
- The format of recording is not prescriptive but should reflect the content and outcome of supervision.

- For **group supervision**, depending on the size of the group and the experience of the different individuals present, it can be difficult to state how much of that group supervision time can be allocated to the individual attendee's personal supervision record. Therefore, the group members need to decide how much of the time spent in any session should be recorded against their individual supervision records.

4.2.3 Key characteristics of effective supervision

An evidence review (Rothwell et al, 2019) identified that effective clinical and peer supervision is based on the following ten characteristics:

- When supervision is based on mutual trust and respect.
- When supervisees are offered a choice of supervisor with regard to personal match, individual needs, and expertise.
- When both supervisors and supervisees have a shared understanding of the purpose of the supervisory sessions, which are based on an agreed contract.
- When supervision focuses on providing staff support the sharing / enhancing of knowledge and skills to support professional development and improving service delivery.
- When supervision is regular and based on the needs of the individual (ideally weekly, minimum fortnightly). Ad-hoc supervision should be provided in cases of need.
- When supervisory models are based on the needs of the individual. This may include one to one, group, internal or external, distance (including the use of technology) or a mix.
- When the employer creates protected time, supervisor training and private space to facilitate the supervisory session.
- When training and feedback is provided for supervisors.
- When supervision is delivered using a flexible timetable, to ensure all staff have access to the sessions, regardless of working patterns.
- When it is delivered by several supervisors, or by those who are trained to manage the overlapping responsibility as both line manager and supervisor.

4.2.4 Models of Clinical Supervision

Clinical supervision can take on many different models depending on the supervisor's theoretical orientation and the supervisee's practice area. No one model is necessarily better than another; it is essential to find a model that fits both the supervisor and supervisee well. NHS Employers (2022) highlight a sample of clinical supervision models for registered professionals, however it is advised to pursue further readings in supervision models to enhance knowledge of supervisory competence.

4.2.5 Frequency of supervision

As discussed above, the agreed frequency of clinical supervision will vary dependent upon the supervisee's role, the amount of time they are engaged in practice and on recommendations in relevant clinical and professional guidelines. However, in general terms it is recommended that a member of staff engaged in clinical practice should receive clinical supervision at least monthly.

However, this minimum standard for many clinicians will not be sufficient to meet professional standards. It is recognised that these supervision sessions may need to take place more frequently if the supervisee is dealing with a very complex or challenging issue, is undertaking a specific activity such as psychological therapy, is undertaking further training in a specific area of practice, or they are a newly qualified or inexperienced member of staff. It is the line manager's responsibility to ensure that individual supervision arrangements are appropriate to support high quality and safe practice in all aspects of an individual's role.

Skills for Care (2007), highlights that the optimum frequency for supervision for an individual will depend on several factors which specifically include:

- The experience of the worker.
- The length of time in the job.
- The complexity of their work.
- The individual's support needs.

4.2.6 Supervision arrangements

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.

How the supervision conversations take place can vary and need to be responsive to staff's way of working e.g., agile, flexible, or home working. Therefore, alternatives to face to face meetings such as phone calls or internet based (e.g., videoconferencing) may be appropriate. However, for the interaction to be considered as supervision, all parties involved must approve it as such.

When establishing supervision arrangements, the supervisee and supervisor should consider their relative availability and accessibility, both in relation to their existing workload and to minimise any travel incurred. Supervision arrangements will frequently exceed the Trust minimum standard of one per month to meet the professional and other requirements of the role, and the impact of the total required supervision time of any individual regarding clinical capacity of the service also needs to be considered. However, it noted that relevant professional and accreditation standards for the required duties performed must be maintained.

It is the responsibility of the line manager to agree arrangements that balance the required clinical capacity of an operational service with the quality and safety standards that include appropriate supervision arrangements. Advice and support can be obtained from the Heads of Professions

4.2.7 Supervision contracts

For "one to one" clinical supervision, a supervision contract must be drawn up between the clinical supervisor and the supervisee, shared with the line manager and kept on the supervisee's personal file. The Trust supervision contract can be used, or an alternative locally agreed contract to cover additional details. However, this agreement must contain information regarding:

- The name(s) of the supervisor(s) for each area of supervision and identification of who will provide professional sign off and who will co-ordinate yearly supervision review for appraisal.
- The frequency, timing, and venue of meetings.
- The type or types of clinical / practice and safeguarding supervision to be undertaken.
- With areas of focus based on supervisees specific needs / strengths, assets, and areas for improvement.
- Responsibilities for record keeping and documentation.
- Confidentiality, including disclosure of unsafe and unprofessional practice.
- The duration of the supervisory contract.

- The review and / or termination of the supervisory contract.
- Method for giving feedback as part of the annual appraisal.

Appendix 4 provides the Trust template for clinical supervision contract – also please refer to appendix 5, and appendix 6 for further thoughts regarding the supervision agenda, and boundaries of supervision respectively.

The supervision contract may require to be reviewed, for example due to a change in role or a change in relationship between supervisor and supervisee. In which case the revised version will undergo the same process.

4.2.8 Supervision Contracts for different settings

For group supervision delivered across multiple operational teams, supervision contracts must be in place between each member and the supervisor, and a copy held on the supervisee's personal file.

Where supervision is delivered to a whole operational team (e.g., reflective practice supervision or safeguarding supervision), one contract can be put in place between the supervisor and the team manager and held by both.

Where appropriate, clinical teams may provide regular team supervision with an appropriately skilled and experienced supervisor. It is the responsibility of the line manager and supervisee(s) together to identify that such an arrangement is sufficient to meet the needs of the individual and their role (including meeting professional and accreditation requirements).

Where clinical supervision is offered in a peer format, a supervision contract must still be in place, detailing the arrangements for all parties and the mechanisms for all parties to raise any professional or practice concerns with each supervisee's line manager. This contract must be shared with each person's line manager and uploaded to the personal file for each supervisee.

The group-based supervision scenarios should have agreed terms of reference which should include:

- Responsibilities for facilitation.
- Agenda setting and prioritisation of discussion.
- Aims of supervision – percentage of agenda supportive and percentage clinical case work.
- Responsibilities of attendees.
- Expected participation of members in agenda and discussion.

Where group supervision is amongst peers, the supervision records must be overseen by a named member of the group.

Informal / ad hoc supervision or case discussion is an opportunistic time to reflect on a clinical case, formulate care and plan interventions and can be at a point of crisis or after a difficult interaction at work. It does not require a contract but requires a reflective log entry to be made if used as supervision hours for professional accreditation or revalidation purposes.

In all cases both supervisor and supervisee must agree that their interaction / conversation was of a supervisory nature and relevant to clinical practice.

4.2.9 Non-attendance to supervision

Non-attendance at supervision should be managed in the first instance by the individual's supervisor. Where supervision is persistently cancelled through sickness or team / ward issues, the supervisee / or supervisor must give details of this to their Line Manager who will make all reasonable adjustments to the supervisee's / supervisor's workload to ensure supervision occurs.

If supervision still does not happen the supervisee / supervisor is obliged to report this to the Line Manager – who must resolve the situation, through initially an informal process of managerial support and guidance, then if deemed ultimately necessary through trust performance / disciplinary procedures.

4.3 Supervision and safeguarding children and vulnerable adults

Safeguarding concerns that become apparent during clinical supervision **must** follow the guidance within the Safeguarding Children Policy and Safeguarding Adult Policy.

Specialist safeguarding supervision is **mandatory for practitioners who are directly working with a child, or parents or carers caring for a child, who is subject to a child protection plan on a 3 monthly basis**. This supervision is facilitated by the Trust Safeguarding & Public Protection team or Clinical Nurses Specialists (within CAMHS). Additionally, it is a quality requirement that practitioners bring cases to clinical / management supervision when working with a looked after child, child in need, child involved in early help services and children discussed within the Multi Agency Public Protection Arrangements (MAPPA) and Multi Agency Risk Assessment Conference (MARAC) forums.

If adult safeguarding concerns become apparent during clinical supervision, then this must be discussed within this forum as to how the safeguarding concern will be managed. If required, this may mean further discussion with the wider multi-disciplinary

team or the Trust Safeguarding & Public Protection team for further support. If the case is complex, specialist safeguarding supervision from the Trust Safeguarding & Public Protection team should be requested. A guide for what constitutes a complex case can be found in the Safeguarding Adult Policy in addition to what is identified through clinical supervision on professional judgement.

4.4 Professional groups

Professional groups within the Trust may have additional standards or requirements to:

- Maintain accreditation and revalidation of registration and right to practice.
- Provide further support and guidance.

Please access below where applicable for further specific detail:

- Allied Health Professional Staff
- Nursing Staff
- Professional Nurse Advocacy (currently in development)
- Medical Staff (please note a revised process is currently in development)
- Non-Medical Prescribers
- Peer Worker Staff (currently in development)
- Pharmacy Staff
- Psychology
    - Governed Psychological Therapies (GPT) : (Psychological Therapies, Low Intensity Interventions and Psychological Well-Being Interventions) procedure
- Social Worker Staff (currently in development)

4.5 Other supervision experiences

4.5.1 Supervision in extended roles

Where clinicians have extended roles and clinical qualifications, such as Non-Medical Prescribing (NMP), Practice Educators, ASYE mentors, 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.

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.

Details of these additional requirements can be found in section 4.4

4.5.2 External supervision

External supervision is provided by experts in their field (either by qualification or experience). This is provided where there is an identified need and no-one with the required skill set is available within the Trust. It is also appropriate to use external sources when feedback on clinical practice is required to allow services to reflect and benchmark their practice, or where we are addressing service improvements in relation to practice.

It can be formal or informal, but formal supervision of this nature will require a contract whereas informal supervision can be recorded in a reflective summary. The supervisee's line manager must be aware and have agreed to the input from the external supervisor, and clear lines of communication and escalation must be established between the line manager and the external supervisor.

4.5.3 Supervision for supervisors

Supervision for supervisors ensures standards of supervision are consistent and any issues arising from supervision of others can be reflected upon. All supervisors should identify a process by which they can seek support, advice, and reflective space. This can be planned or organised in response to need. Training in supervision for supervisors will also need to be considered.

4.5.4 Restorative supervision

Restorative supervision contains elements of psychological support including listening, and through polite and professional challenge support the supervisee to develop further their ability / capacity to cope, especially in managing difficult situations. When faced with complex workloads and decision making, professionals need to process feelings of anxiety, fear, and stress to liberate their minds, so they can focus on learning and development needs and move towards a more creative, solution-focused approach.

The Professional Nurse Advocacy policy provides further detail for nursing staff (see section 4.4).

4.6 Record keeping and confidentiality.

A log of all clinical supervision that is attended must be maintained by the supervisee, unless otherwise for the supervisor to update, through the appropriate Trust recording system. Clinical supervisions sessions (including individual, group, team, reflective practice, and safeguarding supervision) must also be recorded on the patient care record system (PCRS) where appropriate. The exception to this is in Talking Therapies service where clinical supervision is recorded within the IAPTus electronic patent record system.

Once a supervision session has been completed, the supervisor and supervisee will co-produce the supervision notes, agreeing who will write these up with differing opinions acknowledged. It will be responsibility of the supervisees to write up their supervision notes, example templates are shown in appendix 8 together with a fictitious illustration as a “good example”. Medical staff will record within their portfolio / training (see section 4.4).

The content of discussions within clinical supervision will generally remain confidential. However, where notes are made by the supervisor these must be kept locally and securely while supervision is on-going. These notes must also not include any identifiable clinical or personal information. At the end of a clinical supervision relationship, it must be agreed between the supervisor and supervisee whether these notes are shredded or retained by the supervisee.

If the supervisor has any concerns about the practice or welfare of the supervisee, they have a professional duty to break confidentiality and raise these with the line manager. Any such concerns raised must be documented by the line manager within the personal file of the supervisee and appropriate action taken to ensure the safety of all concerned and that quality of practice is maintained.

Any clinically relevant information or decisions made during clinical supervision must also be recorded within the clinical notes for the individual concerned by the supervisee.

4.7 Training

Training provided by the Trust will support the standards outlined within this policy.

Line managers of staff who offer supervision of any type must ensure that they have the appropriate competencies, skills, and experience to offer this and that their own supervision arrangements support high quality and safety in supervisory practice.

Training requirements associated with this Policy:

- All staff should receive advice, guidance, and training on how to participate in and engage with meaningful supervision.
- All clinical staff should complete the supervisee training and / or supervisor training as appropriate.
- All supervisors should have appropriate training to fulfil their role in a competent way.
- All Safeguarding Supervisors should complete specific face to face training offered by the Children's Safeguarding Team.

4.8 Supervision compliance and reporting

The Trust places a high level of importance on the health and wellbeing of its employees. "Our Journey To Change" and embedding of our values and behaviours in everything we do equally apply to staff and patients / clients / service users. Therefore, support for further study and training, including funding may be withheld if evidence of supervision is not available within the requirements of quarterly compliance reporting.

The recording of supervision on the Trust electronic system is evidence that a supervision session occurred. It is the responsibility of the supervisee to ensure their individual supervision recorded accurately reflects the supervision details.

Different combinations of recording supervision are possible on the Trust clinical supervision recording tool:

- Formal 1:1 / Individual Supervision
- Group Supervision
- Peer Supervision
- Peer Group Supervision
- External supervision
- Professional supervision

4.8.1 Monitoring

Monitoring of the Trust compliance can be achieved via the Trust clinical supervision recording tool and may also be monitored corporately through the clinical supervision dashboard which will be available to all staff and managers via the Trust systems (IIC). These reports will show the percentage of staff in any given team or service that have received clinical supervision in the current and previous quarter which has been recorded on the clinical supervision recording tool.

4.8.2 Compliance

Compliance will be monitored quarterly via our systems; with reports being disseminated via operational meetings.

To meet commissioner expectations, the Trust must demonstrate that the KPI of 85% of its clinical facing staff are undertaking supervision in line with policy. Bank staff data will not be reported within the Trust's compliance KPI.

4.8.3 Professional requirements

Clinical supervision standards and criteria for the purpose of accreditation and revalidation of the supervisees professional registration must follow the specific requirements as detailed by their professional body. It is the responsibility of the professional leads to monitor and oversee the supervision training provided by or on behalf of the Trust and to ensure that it supports the standards and values outlined in this policy. Periodic audits on the quality of supervision and compliance with this policy will also be conducted and overseen by the professional leads.

4.8.4 Manager assurance

On request managers will be expected to provide an overview of the clinical / practice and safeguarding supervision arrangements for the team to feed into other quality assurance processes.

5 Definitions

Term	Definition	Scope
Clinical supervision	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 is a means of encouraging self-assessment and analytical and reflective skills. Clinical supervision is focused on the practice of an individual's clinical work and must be provided in addition to one to one (managerial) supervision arrangements for every staff member involved in clinical practice and may not be applicable to other supervision.	Applies to all staff undertaking direct service user care or clinical work
Professional supervision	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 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.	Applies to all professionally governed groups of staff
One to One (Managerial) supervision	Managerial supervision is a requirement for all staff. Managerial supervision involves issues related to: 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, clinical and non-clinical
Caseload Management Supervision	Caseload management supervision supports staff with the progression of their patients towards recovery and flags those areas that require discussion or actions.	

	Caseload management supervision is not a replacement for clinical or safeguarding supervision.	
External supervision	**External supervision** is provided by experts in their field (either by qualification or experience). This is provided where there is an identified need and no-one with the required skill set is available within the Trust. It is also appropriate to use external sources when feedback on clinical practice is required to allow services to reflect and benchmark their practice, or where we are addressing service improvements in relation to practice. It can be formal or informal. Formal supervision of this nature will require a contract whereas informal supervision can be recorded in a reflective summary. The supervisee's line manager must be aware and have agreed to the input from the external supervisor, and clear lines of communication and escalation must be established between the line manager and the external supervisor.	
Formal supervision	Planned processes of managerial, clinical, professional, or educational / training supervision.	
Live or Informal supervision	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. In the context of Clinical Supervision this would be timely feedback on any planned or unplanned observation of clinical practice. Informal supervision can provide opportunities for reflection, debate, challenge, and validation but there are essential elements 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	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. The skill of the supervisor can vary which is dependent on experience and training.	
Supervision Interaction	An overview of the interaction of the types of supervision can viewed in appendix 9.	

6 Related documents

- Allied Health Professionals Professional and Clinical supervision Protocol
- Appraisal Policy for Doctors
- Appraisal Procedure for Medical Staff
- Community Caseload Supervision Policy
- Governed Psychological Therapies (GPT) : (Psychological Therapies, Low Intensity Interventions and Psychological Well-Being Interventions) procedure
- Human Rights Equality Diversity and Inclusion Policy
- Non Medical Prescribing Policy to Practice
- Peer Worker Staff (currently in development)
- Pharmacy Clinical Supervision Protocol
- Safeguarding Adults Policy
- Safeguarding Children Policy
- Social Worker Protocol / Procedure (currently in development)
- Staff Development Policy

7 How this policy will be implemented

• This policy will be published on the Trust's intranet and external website.
• Line managers will disseminate this policy to all Trust employees through a line management briefing.
• 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.

- The Trust will make commit to making clinical supervision available to all staff to whom this policy applies.

7.1 Implementation action plan

Activity	Expected outcome	Timescale	Responsibility	Means of verification / measurement
Supervision will be recorded on the Trust approved Supervision Recording Tool. Personal details are not held here and will be kept separately by the supervisee.	Compliance monitoring is available via an IIC dashboard for all staff to review as per IIC access processes	Reviewed monthly within localities	Operational Managers	IIC reporting

7.2 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

8 How the implementation of this policy will be monitored

Number	Auditable Standard / Key Performance Indicators	Frequency / Method / Person Responsible	Where results and any Associate Action Plan will be reported to, implemented, and monitored; (this will usually be via the relevant Governance Group).
1	Compliance against Trust policy minimum standards for all staff eligible for clinical supervision to meet the required minimum 8 hours of clinical supervision.	F = Quarterly / Annually M = IIC and in data collection tool R = clinical staff	• People, Culture and Diversity Exec group. • Care Group Boards and sub-groups • Quality Assurance and Improvement Groups
	Compliance against Trust policy minimum standards for all clinical teams to meet the required 85% of its clinical facing staff are undertaking supervision.	F = Quarterly / Annually M = IIC and in data collection tool R = team / ward manager	• People, Culture and Diversity Exec group. • Care Group Boards and sub-groups • Quality Assurance and Improvement Groups
2	Audits will also focus on the quality of clinical supervision for staff via the QA2 audit.	F = Monthly M = QA2 audit R = By all staff overseen by the Modern Matron	• Quality Assurance and Improvement Groups
3	Compliance with NHS litigation authority standards and “Standards for Better Health”.	Annually	• People, Culture and Diversity Exec group. • Care Group Boards and sub-groups • Quality Assurance and Improvement Groups

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10 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	16 April 2024
Next review date	16 April 2027
This document replaces	CLIN-0035-v6.1
This document was approved by	ECLS
This document was approved	17 March 2024 (subject to required amendments - authorised 15 April 2024 by the Chief Nurse)
This document was ratified by	Management Group
This document was ratified	16 April 2024
An equality analysis was completed on this policy on	28 September 2023
Document type	Public
FOI Clause (Private documents only)	n/a

Change record.

Version	Date	Amendment details	Status
7	16 Apr 2024	• Updated to align with OJTC base template and format. • Updated references and associated hyperlinks for recording tool. • Restructured document content. • Updated appendices. • Removed direct detail to management supervision and appraisal policy which is now referenced only. • Updated associated and supporting documents and their references / links. • Safeguarding updated text • E&D screening reviewed. • Broad and general update, adjusted to accommodate different structure and content. • Reviewed for harm and amended as appropriate.	Ratified

Appendix 1: Equality analysis screening form

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

Section 1	Scope
Name of service area / directorate / department	Directorate of Nursing and Governance
Title	Clinical Supervision Policy
Type	Policy
Geographical area covered	Trust Wide
Aims and objectives	To set the minimum standard for clinical supervision in Tees Esk and Wear Valley NHS Foundation Trust. To provide robust monthly monitoring that supports: - • the caseload management policy • the annual appraisal and management supervision processes by ensuring clinical quality and patient safety • The relevant Professional Guidance or protocols for clinical supervision
Start date of Equality Analysis Screening	01 July 2023
End date of Equality Analysis Screening	20 September 2023

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	All clinical staff
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women, and gender neutral etc.) **NO** • **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 philosophical 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** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans, and their families **NO**
Describe any negative impacts	None
Describe any positive impacts	Opportunity for reflection on practice Support and guidance for staff Checks on health and well being Supports potential for reasonable adjustments for staff with a LTHC / Disability Risk management Development of good practice

	A safe and confidential space for staff to discuss their needs that they may have in relation to their protected characteristics.

Section 3	**Research and involvement**
What sources of information have you considered? (e.g., legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	• 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
Have you engaged or consulted with service users, carers, staff, and other stakeholders including people from the protected groups?	Due for formal consultation following initial review.
If you answered Yes above, describe the engagement and involvement that has taken place	N/A
If you answered No above, describe future plans that you may have to engage and involve people from different groups	Future plans to include equality and diversity questions.

Section 4	**Training needs**
As part of this equality analysis have any training needs / service needs been identified?	Yes
Describe any training needs for Trust staff	Supervision awareness – for all staff Supervisor preparation training
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2: Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee / group for consideration and approval.

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

	Title of document being reviewed:	Yes / No / Not applicable	Comments
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes	28 September 2023 AH
9.	**Approval**		
	Does the document identify which committee / group will approve it?	Yes	
10.	**Publication**		
	Has the policy been reviewed for harm?	Yes	No harm
	Does the document identify whether it is private or public?	Yes	PUBLIC
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/a	

Appendix 3: Self-assessment

It is recommended that supervisees consider what they want from supervision and discuss this with their supervisor to ensure that there is a common understanding in the relationship.

Things to consider will include:

- What you have felt helpful / unhelpful in previous supervision
- What do you expect to gain from supervision and how will this be managed if expectations can't be met.
- What are your strengths and what areas do you want to develop with your supervisors help.
- What should your supervisor know about you – either professionally or personally which may impact on your supervision.
- How would you want difficulties that arise from supervision to be managed.
- How do you respond to constructive and critical feedback in supervision.
- Would you want the opportunity for shadowing, e.g., to observe your supervisor in the working environment.
- How will you handle disagreements in supervision.
- How do you feel about your supervisor observing your practice - live or recorded.
- Are there any areas of your role that you find difficult / uncomfortable which you want to address in supervision.
- How would you raise having too much / too little to do, not having the skills to do what is expected, not having your skill set recognised or utilised.
- Do you have a reasonable idea of how your work is going to be evaluated and how will you clarify this with your supervisor.

(Scaife, 2001)

Appendix 4: 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 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 my responsibilities relating to clinical supervision as laid out in trust policy and the nursing protocol.

- ……

……

- ……

……

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 must be sought for those occasions where identifiable information may be discussed.

We will keep the following records…….

……..

……..

These records will be stored……..……...

……..

If these records need to be accessed, we will……..

……..

……..

Other areas of agreement

……

……

Contract Agreement:

Supervisee: Date:

Supervisor: Date:

Copy to:

Supervisee – Date:

Supervisor – Date:

Supervisees line manager –

Appendix 5: Clinical supervision agendas and preparation

Think about

- Management of client sessions – engagement, endings, boundaries, timing, and frequency.
- Relationship factors – how the client makes you feel and how you manage this, responses to psychological disturbance and substance misuse, managing dependency in the relationship.
- Data gathering – history taking, use of verbal and non-verbal communication, assessment skills, use of diaries, questionnaires, self-monitoring by the client. Inclusion of relatives and significant others.
- Thinking formulation and planning – applying theory to the information available to understand the client to determine the most appropriate care pathway and thinking about how progress is reviewed.
- Interventions – knowledge and skills of interventions, applying theory to practice, gauging whether interventions are consistently applied and relevant to the problem. Recognising appropriateness to the therapeutic model and evidence-based care. Reviewing progress.
- Professional issues – working within codes of conduct, awareness of power issues, prioritising workload, and self-care, taking advantage of learning opportunities, professional relationships, working within levels of competence, maintaining appropriate documentation, awareness of legal obligations.
- Supervision issues – supervision contracts, expectations of supervision, use of role play, recordings, live supervision, dealing with feedback, setting the supervision agenda, keeping records of supervision.
- The service context – awareness of the services available for the client group, knowledge of issues influencing the client group, developing knowledge and skills base appropriate to role, recognition of the roles of other agencies, awareness of the politics and organisational agenda.

(Scaife, 2001)

Appendix 6: Boundaries of clinical supervision.

Things to consider include:

- Confidentiality and its limitations.
- Responsibilities.
- Awareness of supervisees support networks and not straying over personal and professional boundaries of the supervision agreement.
- Dual relationships – friends and supervisee / supervisor / manager – must have an independent supervisor in another area… potential for collusion.
- Choice of supervisor – should ideally be internal – if external rationale must be given – can't be about choice needs to be skill / service rationale.
- Some flexibility for training in supervision – skill enhancement / teaching / directed learning – to be logged to acknowledge the developmental side of supervision and liaised via management to be encompassed in the performance appraisal and development review and aims of supervision contract.

(Scaife, 2001)

Appendix 7: Guideline for medical staff and physician associates.

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 required minimum standard as detailed in the Appraisal Policy for Doctors and the Staff Development Policy.

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 doctor's peer supervision group and at the annual individual appraisal meeting. Doctors should be attending their peer supervision group at least quarterly. Evidence for attendance (i.e., minutes of meetings) should be attached to the annual appraisal portfolio.

(Peer supervision group meetings, along with any other supervision meetings, should be recorded and attached to the consultant's SARD Job Plan Section 4 'Review of the Job Plan').

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).

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. Circumstances may require the clinical supervision to 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 level of 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 may 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 similarly 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 as 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

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iv. Royal College of Psychiatrists. *Good psychiatric practice (CR154).* RCPsych, 2009.

v. Royal College of Psychiatrists. *Supervision for career-grade psychiatrists in managed settings. PS2 / 2010.* RCPsych, 2010.
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vii. Royal College of Psychiatrists. *Supporting information for appraisal and revalidation: guidance for psychiatrists (CR194).* RCPsych, 2014.
viii. Royal College of Psychiatrists. *Continuing professional development: guidance for psychiatrists (OP98).* RCPsych, 2015.
ix. Royal College of Psychiatrists. *Safe patients and high-quality services: a guide to job descriptions and job plans for consultant psychiatrists (CR207).* RCPsych, 2017.
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xi. 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.

SUPERVISION LOG FOR DOCTORS (please upload to your SARD Job Planning Section 4 – Review of the Job Plan or for postgraduate doctors please upload to your portfolios).

NAME:		**ROLE:**		**SPECIALITY & LOCALITY:**	

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**
	Case-based discussion **CPD Peer group meeting** **Critical Incident review meeting** **Case Presentation** **Appraisal meeting**	**Job Plan meeting** **Job Plan review** **1:1 meeting with line manager** **Consultants meeting with CD**

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

TOTAL HOURS:

Appendix 8: Supervision log (excl. medical staff) examples

Example Template 1

Name_____ Role_____ Team / Service_____

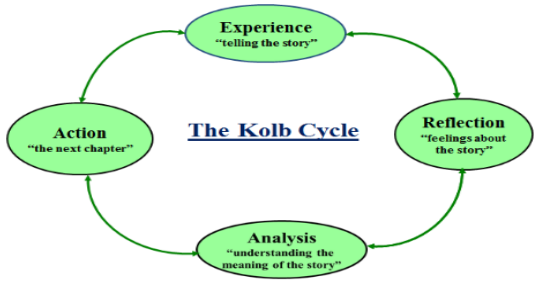
Date	Type / Form of Supervision or Clinical Learning Experience (1:1, Group, Live etc.)	Brief summary of key issues / Learning / Reflection (All instances of clinical learning experience or supervision must be confirmed by an appropriate clinician or your Clinical Supervisor)	Duration	Signature	Confirmer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

Example Template 2

Date	Time	Venue	Supervisee	Supervisor

Date of next Appraisal		**Date for Review of Contract**		**Length of Session**	
Type of supervision (Individual / Group etc.)					

Agenda
Health Wellbeing "How Are You?" *(Includes: - Relationships at work; Personal concerns; Health issues including work related stress, anxiety, physical and mental health, sleep, feelings, stress, work life balance, self-care. The discussion should also include any impact and barriers around protected factors e.g., race / disability discrimination etc., and matters relating to workplace adjustments, impacts of a socio-political context)*
Review and update on previous session actions and progress
Topics for this session (Agenda Items) Subject of agenda item 1 Subject of agenda item 2 Subject of agenda item 3 Subject of agenda item 4 Subject of agenda item 5 (related to reflection)

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 practice because of this situation, which may include training or education needs. The rationale of choice of model should be highlighted.* (*Kolb used as an example here*)	

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.)*

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.)*

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,)*

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?)

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

1.
2.
3.
4.
5.

How did you find the session?

Signed:

Supervisee_____ Date_____

Supervisor _____ Date_____

Date and Time of next Supervision: -

Notes completed by. Supervisee ☐ Supervisor ☐

Populated example of a Clinical Supervision Record

Date	Time	Venue	Supervisee	Supervisor

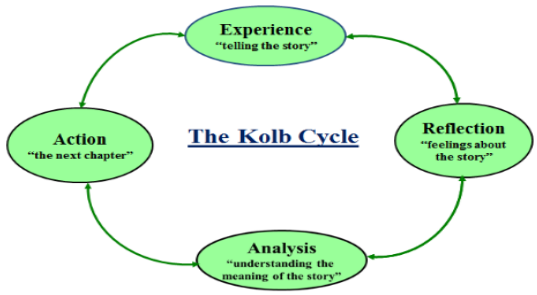
Date of next Appraisal		**Date for Review of Contract**		**Length of Session**	

Type of supervision (Individual / Group etc.)	OUTSTANDING – The environment is private, free from distractions for the entire duration of the supervision. Safe Supervision relationships based on openness, honesty, and trust. Protected time and arranged in advance.

Agenda
Health Wellbeing "How Are You?" *(Includes: - Relationships at work; Personal concerns; Health issues including work related stress, anxiety, physical and mental health, sleep, feelings, stress, work life balance, self-care. The discussion should also include any impact and barriers around protected factors e.g., race / disability discrimination etc., and matters relating to workplace adjustments, impacts of a socio-political context)* 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. 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. Used models such as Covey's 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.
Review and update on previous session actions and progress Agnes identified in last session that she was having difficulties with one service user. 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. 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.
Topics for this session (Agenda) Ensure that colleagues with protected characteristics are supported with their wellbeing. matters relating to peoples protected characteristics (and to include Armed Forces too) Then maybe provide examples relating to workplace adjustments or discrimination etc. 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 (NB Kolb issued as an example ONLY)

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 practice because of this situation, which may include training or education needs. The rationale of choice of model should be highlighted.



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 was not 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 an incident 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 issues that were shocking to her personally and how she couldn't understand the individual's approach, although in discussion she acknowledged various coping strategies.

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 9: Supervision interaction

Interaction between the areas of management, clinical and professional supervision, and its relationship with appraisal process.