Lincolnshire Community Health Services NHS Trust

Clinical Supervision Policy

Reference No:	P_CS_29
Version:	3.1
Ratified by:	LCHS Trust Board
Date ratified:	11th April 2017
Name of originator/author:	Lisa Green / Kim Todd
Name of approving committee/responsible individual:	Quality Scrutiny Group
Date issued:	June 2017
Review date:	March 2019
Target audience:	Clinical staff across all clinical professions within LCHST
Distributed via:	Website / Intranet

Lincolnshire Community Health Services NHS Trust
Clinical Supervision Policy
Version Control Sheet

Version	Section/Para/ Appendix	Version/Description of Amendments	Date	Author/Amended by
1	Whole document	New policy to align to Trust developments	February 2014	Lisa Green Annie Burks
2	1, 1:2, 3:3, 3:4, 4:4, 5:2, 6	Policy refreshed to reflect introduction of SAS and Qlikview and training elements	March 2015	Kim Todd
3	Page 1 Page 4 Page 5 Section 1 Pages 6 &9 Sections 3.2 & 4.3 Section 3.3 Page 7,9&10 Section 3.4 , 4.4 &6 Page 10 Sections 4.6 and 4.7 NHSLA Monitoring	Full policy refresh Change of author Replace vision and values with behavioural framework. Training to be identified at appraisal to inform the TNA. Add intranet to dissemination. Specialist course- via TNA process Replace elearning module with Clinical Supervision Workbook Update policy list Add Director of Operations Change from Professional Development Unit to Education and Workforce Development Team Replace Supervision and Appraisal System with computerised recording system Remove Supervision agreement and register of attendance sections Removed PPAG, replaced with Q&R or QSG	January 2017	Kim Todd
3.1	Page 11	Minor amendments	June 17	Kim Todd
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Lincolnshire Community Health Services NHS Trust

Clinical Supervision Policy

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Lincolnshire Community Health Services NHS Trust

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Policy Statement

Background	Lincolnshire Community Health Services NHS Trust (LCHST) aims to provide the highest standards of quality and safe patient care. Every employee has a personal responsibility to achieve and sustain high standards of performance, behaviour and conduct that reflects the Trusts behavioural framework at all times. LCHST recognise that, in order to deliver their roles and statutory duties, and to support the organisation to meet its objectives, all employed professional and clinical support staff have the right to regular supervision that enables a mechanism for providing professional advice, support and guidance, underpinned by reflective practice that empowers employees to be effective in and accountable in the conduct of their duties. LCHST is committed to ensuring that there is an environment that promotes equality, embraces diversity and respects human rights both within our workforce and in service delivery. The Trust is also committed to ensuring that there is a systematic process in place for implementing, monitoring and evaluating Clinical Supervision in line with best practice guidance as a minimum and is committed to ensuring that time and facilities are available to ensure that Clinical Supervision takes place, that it is recorded, monitored and audited. This policy outlines the types and process of Clinical Supervision and requires that all professional and clinical support staff access and participate in appropriately agreed levels of Clinical Supervision.
Statement	This policy applies to all professional and clinical support staff whether employed within full time, part-time, bank or fixed term contracts irrespective of their length of service.
Responsibilities	The roles of LCHST, managers, supervisors, supervisees and employees are identified within the policy.
Training	All staff will receive training appropriate to their role within the supervision process. Further training will be identified at appraisal and inform the training needs analysis All new members of staff will be introduced to the policy standards and expectations during the organisations Induction Programme
Dissemination	Website and Intranet
Resource implications	It is expected that all staff will receive appropriate training from the organisation unless a specialised course is requested via the training needs analysis process

1. Introduction

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 and analytical and reflective skill Clinical Supervision can both empower and support those in practice, but only if it is developed by clinical staff and implemented through them, as the process relies on those who are actively working in practice and have current experience.
Clinical Supervision involves a tripartite partnership between the Supervisor, Supervisee and LCHST. If any one of these fails to participate in Clinical Supervision, the supervisory process cannot be fully effective or demonstrably beneficial.

There are many benefits in Clinical Supervision to both the individual practitioner and the organisation.The process facilitates the evaluation of the practitioner's interaction with patients and the rest of the team to ensure that the best quality of care is provided.

This policy has been developed to provide a framework around which the practice of Clinical Supervision can be enhanced within LCHST. The aim of the framework is that it will support a variety of models of clinical supervision that can be developed in accordance with local circumstances and staff development needs.

This policy includes the basic principles of Clinical Supervision but is not intended to prepare an individual to take on either the role of Supervisor or Supervisee. A Clinical Supervision : Guided Study Workbook is accessible to all staff(until an elearning package becomes available), and can be accessed via the staff intranet, patient safety,practitioner performance section-Training to prepare and refresh clinical supervisors specific to their roles require identification at appraisal to inform a training needs analysis.
This policy should be read in conjunction with the following policies and documents:

- Safeguarding Children Policy
- Safeguarding Adults Policy
- Safeguarding Children Supervision Policy
- Your Performance Matters Appraisal Policy
- Multi-Professional Preceptorship Policy
- Clinical/Professional Supervision Toolkit

1.1 Objectives Clinical Supervision aims to provide all clinicians with support enabling them to maintain and develop their individual competencies. Quality and safety of care will also be addressed by the following key aims:

- To protect the patient/client
- To decrease feelings of isolation and distress. Increase feelings of responsibility and commitment to improve client / patient care.
- To safely appraise practice
- To develop professional skill
- To question established practice
- To seek or develop new approaches using evidence based practice. To review and reflect on clinical issues.
- To reflect on critical incidents.
- To keep a perspective on professional boundaries and to ensure that the boundaries in the practitioner / patient relationship are understood.
- To ensure legal and ethical standards are maintained.

Grant (2000) states that Clinical Supervision can support clinicians to explore their feelings in relation to their duty of care and to ensure that they practice within professional and ethical guidelines. In relation to consumer need, clinicians need to be able to engage in evidence based

practice and be able to demonstrate professional accountability by embracing clinical supervision.

1.2 Scope

Clinical Supervision is mandatory and applies to all registered clinical staff and unregistered staff who have a clinical role or who work in a clinical area.

The minimum requirements for the participation in clinical supervision by clinicians will be agreed during the appraisal process and participants will be expected to demonstrate compliance of the requirements at subsequent appraisals. The minimum standard for LCHS staff is participation and recording of Clinical Supervision 4 times per year as a minimum

Clinical staff will be expected to identify and participate within a range of clinical supervision opportunities within their normal working practices, for example, in depth patient focused discussions, RCA's complaints responses, preparing statements for coroners.

2. Definitions

Clinical Supervision has been described as "*an exchange between practicing professionals to enable the development of professional skills";* it is described as having a vital part to play in sustaining and developing professional practice through self-assessment and application of analytical and reflective skills. (Butterworth and Faugier 1992)

The NHS Management Executive defined Clinical Supervision in 1993 as: - *"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 situations."*

3. Roles and Responsibilities

3.1 Chief Executive

The Chief Executive has overall accountability for the strategic and operational management of LCHST.

3.2 Director of Nursing and Operations

The Director of Nursing and Operations will have overall responsibility for ensuring that there is an effective training programme in place within LCHST to support the implementation and maintenance of the Clinical Supervision Policy. They will provide the Chief Executive and Trust Board with an annual report of Clinical Supervision including an overview of themes and changes that have been implemented as a result of supervision.

All staff requiring clinical supervision will be identified via the Qlikview dashboard utilizing information from ESR

3.3 Education and Workforce Development

On induction, new starters will be advised of the Trusts minimum standard for supervision participation and how to access the Clinical Supervision: Guided Study Workbook

At Mandatory Training, staff will be reminded of the requirements for supervision and where to access the Clinical Supervision: Guided Study Workbook

3.4 Service Leads

Service Leads at all levels are fully responsible for ensuring that effective systems are in place to provide assurances that all aspects of this policy are being applied to all clinical staff within their service.

They must ensure that all clinical staff are aware of the clinical supervision policy and are actively engaging and recording their participation via the Trusts current computerised recording system. .All new starters require to be linked into clinical supervision and preceptorship requirements.

To allow for the implementation of clinical supervision, service leads will commit to offering protected time to clinicians to engage meaningfully in their supervision sessions. The requirement of a quiet area free from interruption is essential.
Service Leads will investigate non-compliance with individual members of staff and formulate action plans for completion within agreed timescales.

3.5 Clinical Staff

All professional and clinical support staff have a duty to read and work within the policy, and must keep themselves up to date with all procedural documentation issued by LCHST. Staff must ensure that they are aware of the location of procedural documents and how to access them.

Clinical staff will agree with their manager protected time away from the workplace to access clinical supervision within the agreed model for their profession, through their annual appraisal process.

Clinical staff who undertake the role of a Clinical Supervisor will receive clinical supervision themselves, this may be either one to one or in a small group.

The Trust acknowledges that Supervisors need a willingness and commitment to fulfil the role.
3.6 Clinical Supervisors Clinical Supervisors will be experienced practitioners with clinical credibility who are able to demonstrate:

- Knowledge and application of reflective practice skills.
- Professional maturity i.e. willingness, openness and confidence to challenge practice issues.
- Understand the issues concerned with personal accountability and responsibility.
- Good interpersonal skills

They will:

- Within a Clinical Supervision session ensure protected time for each Supervisee to lay out issues in his / her own way.
- Within a group environment be aware of group dynamics and create an environment which will foster trust, so enabling supervisees to fully participate within the sessions.

- Help Supervisees explore and clarify thinking, feelings and beliefs which underlie their practice.
- Enable Supervisees to identify and discuss critical incidents and/or stress-inducing aspects of their professional work.
- Share experience, information and skills appropriately.
- Challenge practice which he / she perceives unethical, unwise or incompetent.
- Challenge personal and professional blind spots which he/she may perceive in individuals or the group.
- Be aware of the organisational contracts that Supervisors and the Supervisees may have with the organisation as the employer and the patient/client in terms of supervision.
- Facilitate professional development

4. Arrangements for Clinical Supervision within LCHST

4.1 Proctor's Model of Clinical Supervision

Sloan (2006) writes that Proctor's model has gained increasing popularity in the clinical environment and is probably the most frequently cited supervision model in the literature. It states that Clinical Supervision is a collaborative dynamic process which includes the components of teaching and mentorship, that goes beyond a pastoral, nurturing role and positively works towards 'enabling' the supervisee to:

- Have time to engage in critical self-examination and reflection on practice.
- Become more self-aware
- Identify practice issues and to consider approaches to practice based on evidence.
- Consider the recipients of the service in terms of their perceptions of what is happening in their lives and in response to interventions.
- Be challenged in a safe environment
- Have the opportunity to consider their training and development needs.

This therefore is the rationale for choosing Proctor's model as the preferred model for use within LCHST.

Clinical Supervision can be offered in terms of three different functions. Within any one supervision session the relationship can focus on just one of these functions or be a mixture of two or three different functions.

The Three Function Interaction Model of Supervision, Proctor (1987) provides a common framework as outlined below:

Formative (Educational) - This is the educational process enabling the practitioner's development of expertise and skills. This learning is achieved through guided reflection on practice in a safe, time protected setting. The supervisee has the opportunity to enhance their understanding of their own skills and abilities, their client/patient, their feelings of and towards client/patient interactions and consider alternative ways of working.

Normative (Managerial) - Ensuring the practitioner maintains established standards of care by dealing with accountability aspects of practice. In the clinical supervision setting this is most powerfully achieved through reflection on practice in the supportive and challenging environment provided by the supervision relationship. It is the shared responsibility of both the Supervisor and the Supervisee.

Restorative (Supportive) - Enabling the practitioner to sustain effective work, by supportive help for those working with stress and distress. This support is achieved by the Supervisor having an unconditional positive regard for the Supervisee (this means holding a continual respect for the

individual despite the circumstances). In this supportive setting, positive challenges to practice can be made. This function of supervision should not be confused with counselling as this is an opportunity to acknowledge success and nurture good practice.

4.2 Delivery of Clinical Supervision

There are a variety ways of organising/delivering clinical supervision and individuals and services should select from the following:

- One to one supervision with a supervisor from your own discipline
- One to one supervision with a supervisor from a different discipline
- Group supervision (shared supervision by teams). Group supervision can be uni-professional or multi-professional. The ratio of supervisor to supervisee is recommended as 1:6/8. It is also recommended that if the team/group is larger than this recommendation then the supervisor should consider the use of 2 supervisors or splitting the group supervision.
- Network supervision – a group of practitioners with similar expertise and interests who do not work together on a day-day basis
- Specialist supervision - it is recognised that certain services have additional professional supervision requirements i.e. Supervision for Deputy Named Nurses / specialist practitioners working is a specialist service.
- Adult and Child Safeguarding supervision sessions will take place as required in accordance with Trust policy with the named safeguarding leads in addition to this policy.

4.3 Alternative Supervision Requirements

Any queries/exceptions to the above arrangements identified within paragraph 4.2 should be referred to the Director of Nursing and Operations as the Clinical Supervision Lead for the Trust for resolution.

4.4 LCHST Model and Delivery

The clinical supervision model within the Trust for the majority of services will be group supervision using Proctors model. This can be participated within as a multi or uni-professional group based on local circumstances and staff needs. However, one to one supervision is available for staff to access should the need arise or if this is a service requirement.

However in small defined areas of service where there are only one or two job roles within a specific area of practice, special arrangements will need to be made to ensure access to clinical supervision. For these individuals consideration should be given to either linking into a multi-professional group or seeking supervision outside of the Trust. If external supervision is sought this can still be recorded via the computerised recording system

4.5 Frequency of Supervision

It is recognised that there will be variability of frequency and type of supervision required according to individual need based on individual roles, responsibilities and areas of practice. However, recommendations from the evaluation study (Porter, I. 1998) identified that clinical staff should participate in clinical supervision as a minimum standard of 4-6 times per year; hence the Trust has identified the minimal standard that clinical supervision sessions need to take place

- Minimum 3 monthly
- Maximum 1 monthly unless an individual situation depicts that supervision is required earlier

- Sessions should comply with an individual's professional body requirements where appropriate.
- It is good practice to plan each supervision session however the organisation recognises the value of opportunistic situations whereby staff can participate within effective clinical supervision
- It is expected that planned group supervision will take between 1-2 hours.

5. Dissemination and Implementation

5.1 Dissemination

This policy will be disseminated using the usual Trust communication mechanisms: Team Brief, website and Service Line communication forums. The policy will be published on the Trust's intranet site. Service Leads are responsible for raising awareness of this policy as part of team meetings.

5.2 Implementation

Training requirements for both refresher and for new supervisors, will be identified as a requirement at appraisal and inform a training needs analysis. Basic awareness training via e-learning package will be available for all clinical staff via ESR and will be mandatory to complete.

6. Process for Monitoring/Auditing Compliance and Effectiveness

The Qlikview dashboard will hold the names of all individuals with a clinical role and record their compliance which will be monitored monthly.
Clinical Supervisors ensure that each supervisee records their attendance at of all supervision sessions they facilitate via computerised recording system which will be underpinned with a record of discussion held by the supervisee that identifies generic topics and themes discussed. These will be used to demonstrate that clinical supervision is taking place to the Trust and contribute to the clinicians portfolio

Monthly compliance for Clinical Supervision will be reported into Quality Scrutiny Group and Quality and Risk Committee.

This policy will be reviewed on an annual basis with a formal audit process undertaken every three years.

7. Further information

Supporting information and recording templates are available within the LCHST Toolkit for Clinical/Professional Supervision.

8. References

- Francis Review 2013
- CQC Standards - www.cqc.org.uk
- Knowledge and Skill Framework - Dept of Health 2004
  NHS Knowledge Skills and Framework
  http://www.dh.gov.uk/en/Policyandguidance/Humanresourcesandtraining/Modernisingpay/Agendaforchange/index.htm
- Carter, A. (2005). *The effectiveness of clinical supervision on burnout in community mental health nurses in Wales.* Cardiff University.
- Grant, A. (2000). *Clinical Supervision and Organisational Health & Learning Disabilities Care*. 3, 12, 398-401.
- Ooijen E.V. (2003) Clinical Supervision Made Easy. Churchill Livingstone. London Proctor, B (1987). *Supervision: A Co-operative Exercise in Accountability* as cited in Marken M and Payne M (Eds). *Enabling and Ensuring: Supervision in Practice.* National Youth Bureau and Council for Education and Training in Youth and Community Work. Leister
- Sloan, G. (2006). *Clinical Supervision in Mental Health Nursing.* Whurr Publishers Ltd, England.
- Department of Health (1998) *A first class service quality in the new NHS.* HMSO London.
- I.Begat et al *First Line Managers' Views of the Long Term Effects of Clinical Supervision: How does Clinical Supervision and Develop Leadership in Health Care?* Journal of Nursing Management 2005 Vol.13 Pg. 221-230

Equality Analysis

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	To provide a framework for the implementation of clinical supervision across clinical groups within LCHST. To improve quality of practice for a positive impact on services and better outcomes for patients		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	Implementation of the policy will support the delivery of improved quality driven care and services		
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	No		
D.	Will/Does the implementation of the policy\service result in different impacts for protected characteristics?	No		
		Yes	No	
	Disability		X	
	Sexual Orientation		X	
	Sex		X	
	Gender Reassignment		X	
	Race		X	
	Marriage/Civil Partnership		X	
	Maternity/Pregnancy		X	
	Age		X	
	Religion or Belief		X	
	Carers		X	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
The above named policy has been considered and does not require a full equality analysis				
Equality Analysis Carried out by:		Annie Burks / Kim Todd		
Date:		17th February 2015		

NHSLA Monitoring

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individuals/ group/ committee	Frequency of monitoring/ audit	Responsible individuals/ group/ committee (multidisciplinary) for review of results	Responsible individuals/group / committee for development of action plan	Responsible individuals/group/ Committee for monitoring of action plan
All staff to receive clinical supervision as per policy unless exemption rationale identified	Audit	Service Leads Q&R Quality and	Monthly	Quality Scrutiny Group	Service Leads Quality Scrutiny Group	Service Leads Quality Scrutiny Group