Lincolnshire Community Health Services NHS Trust

Clinical Supervision Policy

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Chief Executive: Maz Fosh

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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 4.7NHSLA 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	January 2017	Kim Todd

		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		
3.1	Page 11	Minor amendments	June 2017	K Todd

4	Replace QSG with EPAG throughout Page 5 Revision of Policy statement to include consultation Page 6 Revision of NHSLA monitoring template Page 7 Introduction section revised to update related policies Page7 Objectives replaced with Purpose statement Page 7 Scope and definitions sections removed Page 7 Roles and responsibilities, title of Director of Nursing and Operations updated to include AHP's Reporting section removed from under this responsibility Page 8 Roles and	Full review	January 2019	K Todd

	responsibilities of Clinical Supervisors removed			
5	Policy formatted onto Policy and Procedural Document 2020 template Replace EPAG with CSEG throughout **Page 9** Removal of wording in statement paragraph *irrespective of their length of service.* Monitoring paragraph added Equality statement added **Page 12** Change Education and Workforce Development Team to Learning and Development Team **Page 12** Removal of wording at 3.4 *the requirement of a quiet area free from interruptions*	Full review	December 2020	K Todd

	essential **Page 13** Addition of section 4.2 on Resilience based clinical supervision (RBCS) **Page 15** Addition of reference in relation to RBCS **Page 16** Equality Impact Analysis documented on revised template			
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Background

Statement
The Trust is committed to ensuring that there is a systematic process in place for implementing, monitoring and evaluating Clinical Supervision in line with best practice guidance and is committed to ensuring that opportunities present to ensure that supervision takes place, that is recorded, monitored and audited. This policy applies to all full/part time, bank/fixed term clinical staff.

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 and reminded of these during their Mandatory Study Days

Dissemination
Website and Intranet

Resource implication
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

Consultation
This policy will be disseminated throughout the organisation to enable all interested parties to be involved in, and have the opportunity to influence policy development so as to ensure the process is logical and efficient and the outcome meets the needs of staff groups identified within Lincolnshire Community Health Services NHS Trust.

Monitoring
A monthly position statement is produced with data taken from the Qlikview dashboard and presented via Clinical Safety and Effectiveness Group.

Equality Statement
As part of our on-going commitment to promoting equality, valuing diversity and protecting human rights, Lincolnshire Community Health Services NHS Trust is committed to eliminating discrimination against any individual (individual means

employees, patients, services users and carers) on the grounds of gender, gender reassignment, disability, age, race, ethnicity, sexual orientation, socio-economic status, language, religion or beliefs, marriage or civil partnerships, pregnancy and maternity, appearance, nationality or culture.

1.Introduction

Clinical supervision is the term used to describe a 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

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 it 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 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 /guidance

- LCHS Your Performance Matters Policy
- LCHS Safeguarding Supervision Policy
- LCHS Preceptorship Policy
- LCHS Management of Medications Errors Policy
- LCHS Clinical/Professional Supervision Toolkit .

2.Purpose

The purpose of this guidance is to implement a coordinated and uniform approach to clinical supervision which aims to provide all clinicians with support enabling them to maintain and develop their individual competencies with focus on quality and safety of care.

3.Duties / Responsibilities

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

3.2 Director of Nursing, AHP and Operations will have an 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.

3.3 Learning and Development team On induction, new starters will be advised of the Trusts minimum standards for supervision participation and how to access the Clinical Supervision : Guide Study Workbook. At mandatory training staff will be reminded of the requirements for supervision and where to access the workbook

3.4 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. Service Leads will investigate non-compliance with individual members of staff.

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 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.

4.Arrangements for Clinical Supervision within LCHST

4.1 Proctor's Model of Clinical Supervision

Inskipp and Proctor (2001) name the tasks of supervision as support (restorative) learning and growth (formative), and monitoring (normativer) with one on the foreground at any time
This therefore is the rationale for choosing Proctor's model as the preferred model for use within LCHST. However, if a practitioner chooses to use an alternative, provided this is a recognised model this is also acceptable.
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 Resilience Based Clinical Supervision (RBCS)

Resilience based clinical supervision is a forum that, as well as being supportive, will increase an individual's ability to respond positively to the emotional and physiological demands of their role. Current RBCS is delivered in a group format either by TEAMS or face to face. If required an individual can have one to one sessions to support them if appropriate.

RBCS is a facilitated reflective discussion, characterised by:

1. The identification of the unique group conditions needed to create a safe space
2. The integration of mindfulness-based stress-reduction exercises
3. An explicit focus on the emotional systems motivating the response to a situation
4. A consideration of the role of the internal critic in sustaining or underpinning the response to a situation
5. A commitment to maintaining a compassionate flow to self and consequently to others

4.3 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 e.g. non- medical prescribers
- 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.
- Safeguarding supervision sessions will take place as required in accordance with Trust policy with the named safeguarding leads in addition to this policy.

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. Resilence based clinical supervision sessions are also available. One to one supervision is also 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 The Trust has identified 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

5.References

The Health Education and Training Institute (2013)

CQC Supporting Effective Supervision (July 2013)

Making the most of Supervision Inskipp and Proctor (2001)
The Francis Enquiry (Feb 2013)
Proctor, B. (2004). Group Supervision. A Guide to Creative Practice
Carter, A. (2005). The effectiveness of clinical supervision on burnout in community mental health nurses in Wales. Cardiff University.
Ooijen E.V. (2003) Clinical Supervision Made Easy, Bureau and Council for Education and Training in Youth and Community Work. Leister
Stacey, G., Aubeeluck, A., Cook, G. and Dutta, S. (2017) A case study exploring the experience of resilience-based clinical supervision and its influence on care towards self and others among student nurses. International Practice Development Journal. Vol. 7. No. 2. Article 5. pp 1-16. https://doi.org/10.19043 ipdj.72.005.
Plus weblink: https://www.fons.org/resources/documents/Resilience-Based-Clinical-Supervision-Course-Companion.pdf

3 Appendices

Appendix A Equality Impact Analysis Screening Form

4 Review of document

This policy will be reviewed as per policy review schedule

Appendix A **Equality Analysis**

Equality Impact Analysis Screening Form

Title of activity	Review of policy		
Date form completed	06/01/2021	Name of lead for this activity	Kim Todd

Analysis undertaken by:		
Name(s)	Job role	Department
Kim Todd	Practitioner Performance Manager	Quality

What is the aim or objective of this activity?	To ensure a framework for clinical supervision is available across clinical groups within LCHST, in order to improve quality of practice for a positive impact on services and better outcomes for patients.
Who will this activity impact on? *E.g. staff, patients, carers, visitors etc.*	The policy will support the delivery of improved quality driven care and services

Potential impacts on different equality groups:

Equality Group	Potential for **positive** impact	**Neutral** Impact	Potential for **negative** impact	Please provide details of how you believe there is a potential positive, negative or neutral impact (and what evidence you have gathered)
Age	☒	☐	☐	To improve quality of practice for a positive impact on services and better outcomes for patients.
Disability	☒	☐	☐	
Gender reassignment	☒	☐	☐	
Marriage & civil partnerships	☒	☐	☐	

Pregnancy & maternity	☒	☐	☐	
Race	☒	☐	☐	
Religion or belief	☒	☐	☐	
Sex	☒	☐	☐	
Sexual Orientation	☒	☐	☐	
Additional Impacts ***(what other groups might this activity impact on? Carers, homeless, travelling communities etc.)***	☒	☐	☐	The policy will support the delivery of improved quality driven care and services across all groups

If you have ticked one of the above equality groups please complete the following:

Level of impact

	Yes	No
Could this impact be considered direct or indirect discrimination?	☐	☒
If yes, how will you address this?		

	High	Medium	Low
What level do you consider the potential negative impact would be?	☐	☐	☒

If the negative impact is high, a full equality impact analysis will be required.

Action Plan

How could you minimise or remove any negative impacts identified, even if this is rated low?
How will you monitor this impact or planned actions?

Future review date: