Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

CLINICAL SUPERVISION POLICY

POLICY NUMBER & CATEGORY	**C08**	Clinical
VERSION NO & DATE	**7**	July 2018
RATIFYING COMMITTEE	Clinical Governance Committee	
DATE RATIFIED	**August 2018**	
NEXT REVIEW DATE	**August 2021**	
EXECUTIVE DIRECTOR	Medical Director	
POLICY LEAD	Deputy Director of Nursing	
POLICY LEAD REVIEWER	Clinical Supervision Lead	
FORMULATED VIA	Clinical Supervision Steering Group	

Policy Statement

The Trust considers that clinical supervision is an integral part of providing an excellent, compassionate high quality mental health service and that it underpins the safe and effective care provided to service users. It does this by supporting the wellbeing, professional and personal development of staff. The Trust is committed to ensuring that all trust staff engaged in direct clinical interventions are supported to access clinical supervision on a regular basis.

Key Policy Issues

- All trust staff engaged in direct clinical interventions will be responsible for accessing regular clinical supervision.
- Clinical supervision training will be provided by the Trust for those staff who have not received it previously in their training
- Supervisees will be expected to keep a written record of their clinical supervision sessions and to access clinical supervision for at least one hour every 8 weeks.
- Access to different types of supervisor and supervision will be informed by individual choice, professional guidelines, working practices, service expectations and, within the reasonable constraints of available resources, will be supported by the line manager.
- Regular clinical supervision activity will be recorded by all professionally registered clinical staff via their personal training “traffic light” system

Contents

1. Introduction

This policy relates to all trust staff engaged in direct clinical interventions. This includes staff in substantive posts and those solely working within temporary staffing (TSS)

The policy offers clear guidelines for staff to consider supervision from both process and content perspectives. Clinical supervision serves as an opportunity to reflectively examine practice, with the aim of building skills, promoting professional development and improving the quality of service delivery.

Whilst there are a variety of definitions of clinical supervision available, clinical supervision is considered by BSMHFT as a formal process of professional support, reflection, education and learning that enables individual practitioners to develop knowledge and competence, develop autonomy and self-esteem as a professional, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations.

1.1 Rationale

However qualified or experienced we are, we bring our own 'failings', blind spots, areas of vulnerability and prejudices with us to work. We have a responsibility to ensure that the impact these might have on the quality of our working practices is minimised. Supervision can provide a reflective space in which to identify our personal responses and explore their impact, giving us an opportunity to think about how we can contain and manage these.

We need to facilitate and promote reflection on practice issues through clinical supervision with the aim that the practitioner's skills, knowledge and professional values will be enhanced, practice is continually informed by the evidence base and that career development and lifelong learning will be effectively promoted.

1.2 Scope of the Policy

This policy supersedes all previous Clinical Supervision policies and is to be used in conjunction with the attached guidelines.

This policy and associated guidelines are considered as providing a basic framework to facilitate, promote and assure that high quality clinical supervision is undertaken for all trust staff engaged in clinical work. The guidelines define the principles and procedures that underpin the provision and use of clinical supervision and are intended to assist all clinical staff in their practice, including staff working with the parents and carers of young people and who may encounter child safeguarding issues.

Safeguarding is an essential and integral component of good clinical supervision. Integrating safeguarding into clinical supervision maintains compliance with CQC quality care regulations (7 and 14: 2010), Working Together to Safeguard Children Guidance (Chapter 2: 2015) and the Care Act (Chapter 14: 2014)

It is imperative that supervisors and supervisees address safeguarding issues within clinical supervision to embed the delivery of high quality care. Supervision should challenge the supervisee to consider whether there are safeguarding concerns that impact on the welfare of a child or vulnerable adult and, if so, how these will be addressed. This includes consideration of the welfare of children and young people where the primary service user is an adult, or of any vulnerable adults where the primary service user is a child. In addition it is recognised that safeguarding children and vulnerable adults can be emotionally demanding.

Reflection within supervision allows practitioners space to manage their own responses and workload.

The policy and guidelines have been developed to help and support all clinical staff to access regular clinical supervision in the most appropriate way and are not intended to replace existing management or professional supervision arrangements that a number of professions or teams may already have in place.

Managerial supervision (Regular Management Supervision – RMS) is a separate trust requirement and **does not** meet the essential requirements set out in this policy.

1.3 **Principles**

This policy and the accompanying guidelines define the principles and procedures that underpin the provision and use of clinical supervision in order to assist all staff who are engaged in direct clinical interventions.

2. Policy

2.1 The Trust is committed to ensuring that all clinical staff have a basic awareness of what clinical supervision is, why it is necessary, access to clinical supervision and suitable training if required.

2.2 All staff engaged in direct clinical interventions will engage in clinical supervision every 8 weeks as a minimum, with a recommendation of every 4-6 weeks.

2.3 The Trust supports the practice of different forms of clinical supervision. The particular method chosen will depend upon individual preference, working practices, professional or team expectations and will be supported by Line Managers.

2.4 Clinical Supervision arrangements may involve:

- Team supervision: Members of the same team engage in either peer or externally facilitated supervision as a whole team to encourage uniformity of their clinical approach and meet the essential requirements set out in this policy.
- Professional Supervision: A professional Supervisor appointed by a Professional Lead conducts, either 1:1 or group, discussions that cover, caseload review, clinical issues, development of clinical practice and meet the requirements set out in this policy.

2.5 Alternatively, one of the following options may be adopted:

- 1:1 Supervision with a colleague from your own discipline.
- 1:1 Supervision with a colleague from a different discipline who may have specific knowledge or skills relevant to a specific case or piece of work
- Group supervision: Led by an external facilitator e.g. Trust lead for Child Safety.
- Peer group supervision: Jointly led by a group of staff that may have a similar clinical interest, similar client group or similar status.
- Network supervision: where people involved in a similar clinical or therapy interest meet to extend their knowledge and skill base.
- The following could also be counted as clinical supervision:

    - PDP groups, where clinical case material is discussed
    - Team reflective practice groups
    - Case presentation at PGME meetings where clinical case material is discussed

- Balint groups
- Schwartz rounds

2.6 Clinical supervision may be underpinned by theoretical/professional/historical frameworks e.g.Hawkins and Shohet's (2012) Seven eyed model of Supervision, Inskipp and Proctor's (1993) Restorative Approach, BSMHFTs AHP Supervision Framework.

2.7 Some clinicians may access clinical supervision on a more frequent basis, depending upon their role and needs. In addition, it may be that more intensive or expert supervision may be required where the clinician has a requirement for supervision of a specific modality of work which may require specific expertise in that area.

3. Procedure

3.1 All trust staff engaged in direct clinical interventions will agree their clinical supervision arrangements with their line manager.

Regular management supervision (RMS), and clinical supervision are separate requirements.

3.2 Potential supervisors may be approached, without obligation, either by staff members or line managers to take on the role. Line managers will ensure that supervisors have the necessary level of training and experience to carry out the role.

3.3 In the case of the 1:1 options outlined in 2.5 the choice of Clinical Supervisor is a matter for negotiation and agreement between the Supervisee and Supervisor. It is the responsibility of the Supervisee to discuss with their Line Manager their choice of Clinical Supervisor.

Exceptionally, the Line Manager may override the choice of Supervisor if they believe the Supervisor to be inappropriate. The Line Manager should discuss their concerns with the Supervisee before a final decision is reached.

3.4 Although the Supervisor will usually be a member of staff from within BSMHFT, there may be occasions when supervision is required from another person with specialist skills who may only be available from outside the Trust. In this event, agreement to undertake such supervision will be required from the Line Manager who is responsible for ensuring the supervisor selected has the appropriate qualifications and experience to deliver the required clinical supervision for the individual staff member.

To assure governance around supervision, the qualifications and professional obligations of the external supervisor regarding information governance and specifically client confidentiality will need to be denoted and included within an honorary contract.

3.5 If accessing supervision has any cost implication or any other claim for expenses then this must be agreed with the Line Manager in advance.

3.6 A written record of the supervision session including date, time, venue and content will be kept by the Supervisee. Line managers may request proof that the supervision took place.

3.7 Where a need for further training in Clinical Supervision has been identified the Trust will offer in-house training in clinical supervision

3.8 All professionally registered staff members covered by this policy will be responsible for updating their staff training system (traffic lights) each time they have accessed clinical supervision.

The traffic light will turn amber after 6 weeks and red after 8 weeks.

This will be monitored for compliance as a trust internal key performance indicator of quality, and will be regularly reported on in trust clinical governance forums.

It will also be routinely reviewed in Regular Management Supervision.

3.9 Annual audits will be conducted to provide further assurance of compliance and gather information relating to the quality of the Clinical Supervision taking place across the Trust

3.10 The uptake of clinical supervision will be reviewed through the working better together process. Line Managers have a responsibility to ensure appropriate clinical supervision is facilitated and members of staff have a responsibility to ensure that supervision requirements are highlighted and addressed in this process.

3.11 Compliance will be monitored and managed by the line manager using the process laid out in working better together.

3.12 This policy will be subject to formal review, update and amendment.

3.13 Further information relating to the practice and procedures of clinical supervision are detailed in the guidelines (appendix 1) and the process map (appendix 2).

4. Roles & Responsibilities

4.1 Accountability for the provision of clinical supervision across the Trust lies with the Chief Executive and is delegated to the Medical Director.

4.2 The Executive Director of Nursing and the Executive Medical Director have responsibility for ensuring that clinical and professional issues are considered and addressed. Heads of clinical professions other than medical and nursing, will have particular responsibility for their staff groups (e.g. Director of Psychology Services, Heads of Allied Health Professions, Chief Pharmacist).

4.3 The Clinical Supervision Steering Group will develop the clinical supervision policy, monitor its implementation and oversee the delivery of training, reporting to Trust Committees when called upon to do so. The Clinical Supervision Steering Group is responsible for reviewing the policy on the specified review dates.

4.4 The Clinical Supervision Lead will:

- Chair the Clinical Supervision Steering Group
- Develop and maintain systems to support implementation.
- Ensure the design and setup of appropriate training.
- Coordinate annual audit activities e.g.. surveys and focus groups.

4.5 Associate Directors have responsibility for ensuring that:

- There are structures in place within their service areas to facilitate the process of clinical supervision, the monitoring of policy implementation and the management of non-compliance.
- Line Managers and other staff are released to access appropriate training.

4.6 Line Managers have responsibility for ensuring that:

- All trust staff engaged in direct clinical interventions receive basic awareness training, and have further training needs identified and included in their personal development plans.

- All trust staff engaged in direct clinical interventions have access to and participate in regular clinical supervision.
- Compliance with the policy is monitored and issues of poor performance are addressed using the working better together procedures.

4.7 All staff engaged in direct clinical interventions have a responsibility to ensure that:

- They have read and understood the clinical supervision policy.
- They engage in clinical supervision at least every 8 weeks.
- They maintain the clinical supervision log sheets for their own records (appendix 3 and appendix 4).
- They discuss any difficulties that they have in organising or accessing clinical supervision with their Line Manager.
- They participate in clinical supervision audits.

4.8 **Clinical supervisor role**

- The trust lead for clinical supervision and the steering group will be responsible for maintaining a register of approved supervisors internal to the trust and for ensuring that training and support is available for supervisors if needed.

- Where a member of staff takes on the role of Clinical Supervisor they have a responsibility to ensure that, in order to build and maintain trust, matters discussed in clinical supervision are kept in confidence and are not disclosed to other people.

There may be circumstances however when the Supervisor becomes concerned. These may include:

- An issue which breaches a professional code of conduct or a defined standard.
- Where the Clinical Supervisor is made aware of a situation of such a serious nature that they feel it would be negligent not to discuss the matter with a person in authority.

If such a circumstance occurs, the Clinical Supervisor should declare that they feel duty bound to act upon their concerns and to take such concerns to whoever is deemed appropriate outside of the supervisory relationship. It is not possible to specify all of the circumstances that would contribute to such action, but this would include any identified risk to service users, self or others. The breaking of confidentiality without justifiable cause will be treated as a very serious matter and may lead to a disciplinary investigation.

5. Development & Consultation Process

The Policy is published on the Trust Intranet for wider consultation.

Consultation Summary	
Date policy issued for consultation	04 June 2018
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	**Date(s)**
Clinical Supervision Steering Group	21 June 2018
Workforce Forum	
Education Planning and Finance Committee	
Clinical Governance	
Safeguarding Children Group	

6. Reference Documents & useful web links

Skills for Care 2007 - defines 'supervision' as "an accountable process which supports, assures and develops the knowledge skills and values of an individual group or team".

http://www.skillsforcare.org.uk/publications/ProvidingEffectiveSupervision.aspx

CQC Supporting Effective Clinical Supervision
http://www.360supervision.co.uk/wp-content/uploads/2016/08/CQC-GUIDELINES.pdf

NMC Standards for Competence for Registered Nurses
https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-competence-for-registered-nurses.pdf

HCPC Standards
https://www.hcpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics/

IAPT Supervision guidance 2011
https://www.uea.ac.uk/documents/246046/11919343/IAPT+Supervision+Guidance+2011.pdf/3a8f6c76-cea0-4f76-af78-e2f0a1f64c5e

BPS Guidelines on clinical supervision
http://www.bps.org.uk/system/files/documents/pact_guidelines_on_clinical_supervision.pdf

particularly useful for supervision of CBT
http://www.babcp.com/Accreditation/Supervision.aspx

7. Bibliography

Supervision in Clinical Practice: A Practitioners Guide; Scaife 2008

Clinical Supervision: Framework for Western Australia Mental Health Services & Clinicians

Clinical Supervision: Developing, implementing and evaluating practice standards in acute and community mental health; Butler 1999

Does clinical supervision lead to better patient outcomes in mental health nursing; White 2010

A Brief summary of supervision models; Kendra 2009

Clinical supervision in a challenging behaviour unit; Carney 2013

Professional Clinical Supervision handbook for Allied Health Professionals 2010

Supervision for Career Grade Psychiatrists in managed settings; Cope 2010

Supervision in the Helping Professions (Supervision in Context) by Hawkins, Peter, Shohet, Robin 4th (fourth) Edition (2012)

8. Audit and Assurance

Compliance with this policy will be monitored through the Clinical Supervision Steering Group and Local Integrated Quality Groups, reporting to the Clinical Governance Committee.

Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements
Frequency of Clinical Supervision	Deputy Director of Nursing	ESR staff traffic light competency	Bi-monthly	Service Area local Integrated Quality meetings
		Trust Wide Report	Monthly	Clinical Supervision Steering Group
			Annually	Clinical Governance Committee
				Published on Connect
Quality of clinical supervision	Clinical Supervision Lead	Audit – survey and Focus Groups	Annually	Clinical Governance Committee
				Published on Connect

10. Appendices

Appendix 1 - Equality Analysis Screening Form
Appendix 2 - Trust Guidelines for Clinical Staff on Clinical Supervision
Appendix 3 - Clinical Supervision Process Map
Appendix 4 - Clinical Supervision Log
Appendix 5 - Clinical Supervision Record
Appendix 6 - Supplementary information for psychologists and psychological therapists
Appendix 7 - Consent for recording clinical sessions

Appendix 1

Equality Analysis Screening Form

Title of Proposal			
Person completing this proposal		**Role or title**	
Division		**Service Area**	
Date Started		**Date completed**	
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
Who will benefit from the proposal?			
Impacts on different Personal Protected Characteristics – Helpful Questions:			
Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*		*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*	
Please click in the relevant impact box or leave blank if you feel there is no particular impact.			
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age				
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability				
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				

Gender				
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships				
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity				
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity				
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief				
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation				
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being ‘out’ or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment				
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				

Human Rights				
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
If the impact could be discriminatory in law, please contact the Equality and Diversity Lead immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the Equality and Diversity Lead before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the Equality and Diversity Lead.				
Action Planning:				
How could you minimise or remove any negative impact identified even if this is of low significance?				
How will any impact or planned actions be monitored and reviewed?				
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.				

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at hr.support@bsmhft.nhs.uk. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

Appendix 2

TRUST GUIDELINES FOR CLINICAL STAFF ON CLINICAL SUPERVISION

1. Introduction

These guidelines define the principles and procedures, which will underpin the provision and use of Clinical Supervision and are intended to assist all staff engaged in direct clinical interventions.

2. Written Guidelines

By providing written guidelines, the Trust aims to

- Ensure that all clinical staff are aware of and understand the importance of clinical supervision
- Provide encouragement and a framework with which to implement the Clinical Supervision Policy across the Trust
- Provide a framework against which to monitor and assess the Trust's success in implementation of the Clinical Supervision Policy
- Ensure that all clinical staff understand their various roles in the implementation of the clinical supervision policy.

3. What is Clinical Supervision?

3.1 Clinical Supervision offers the opportunity within a safe and supportive process, to critically reflect on the impact, emotional and psychological, of the work on staff.

However qualified or experienced we are, we bring our own 'failings', blind spots, areas of vulnerability and prejudices with us to work. We have a responsibility to ensure that the impact these might have on the quality of our working practices is minimised. Supervision can provide a reflective space in which to identify our personal responses and explore their impact, giving us an opportunity to think about how we can contain and manage these.

We need to facilitate and promote reflection on practice issues through clinical supervision with the aim that the practitioner's skills, knowledge and professional values will be enhanced, practice is continually informed by the evidence base and that career development and lifelong learning will be effectively promoted.

The structure brings staff together to reflect upon clinical work and to identify specific needs; e.g., acquiring new skills, attending a specific course, having further specialised training, etc. Clinical Supervision aims to identify solutions to problems, improve practice and increase understanding of professional and clinical issues, including child and adult safeguarding and in addition to carry out sensitive reviews and appraisals of various elements of practice. Normally, a mutually agreed plan for supervision will be drawn up at the commencement of supervision and reviewed at regular, agreed upon, intervals.

3.2 One definition of Clinical Supervision is:

"A designated interaction between two or more Clinicians within a safe/supportive environment, which enables a continuum of reflective critical analysis of care, to ensure quality patient services" **Bishop (1998)**

3.3 Clinical Supervision is a positive and enabling process.

3.4 Clinical Supervision addresses the need to develop knowledge, skills and learning, the need to be concerned with quality and clinical governance so that professional standards are maintained and the policies and procedures of the organisation are adhered to. It also embraces the need for professional support for Clinicians.

3.5 Clinical Supervision is underpinned by learning from experience and reflective practice.

3.6 Clinical Supervision is not

- Managerial Supervision
- A system of formal appraisal or performance review
- Necessarily hierarchical in nature
- Personal therapy

4. Aims of Clinical Supervision

Clinical Supervision supports good clinical practice, enabling Clinicians to maintain and promote high quality care of service users and families.

Clinical Supervision aims to:

4.1 Improve communication, both with service users their carers and families and between all staff and other agencies where appropriate.

4.2 Develop the potential of each member of staff to function professionally at the highest level.

4.3 Improve the competency of each individual and, through this, the whole organisation.

4.4 Provide focus for enhanced commitment to the professional development of every member of staff and to highlight the importance of the contribution of every member of staff.

4.5 Facilitate the recognition of clinical boundaries and the limitations of skill and competence.

4.6 Boost morale and confidence and encourage the emergence, growth and development of good ideas and practice.

4.7 Examine interventions, outcomes and consequences of those interventions and to explore other possible interventions.

4.8 Develop a greater degree of self-awareness, autonomy and self-esteem in a Clinicians professional practice.

4.9 Assist Clinicians in achieving their personal professional objectives.

4.10 Promote lifelong learning.

4.11 Increase awareness of evidence based practice.

5. Clinical Supervision Structure

5.1 The structure for clinical supervision will be formal and negotiable with regard to frequency, time and documentation.

5.2 Once the clinical supervision contract has been agreed, it should not be changed unless discussion takes place between those people who originally established the contract.

5.3 Supervisees will, wherever possible, be able to choose their own Supervisor or mode of supervision e.g. team, group or one to one

- Wherever possible a Clinical Supervisor should not be the individual's appraiser or Line Manager except in exceptional circumstances when

the Line Manager may be the preferred Supervisor on the basis of professional expertise.

- In the case of one to one supervision the Clinical Supervisor should be seen to have the required expertise and competence to clinically supervise a practitioner.
- A Clinical Supervisor normally cannot be a relative or close personal friend, unless there is some exceptional circumstance that has been agreed by the Supervisees Line Manager
- A Clinical Supervisor can decline an approach from a member of staff seeking clinical supervision if they are unable to comply with the format and structure of clinical supervision because of personal or work related issues. This should be discussed with departmental heads or appropriate professionals e.g. approaching leads for either safeguarding or risk issues and / or Line Managers.
- Clinical Supervisors chosen by staff are subject to approval by the line manager of the supervisee.
- Assistance for deciding upon / choosing a Clinical Supervisor can be sought from the Line Manager

5.4 Clinical Supervision will be conducted in a non-threatening, constructive and caring way.

5.5 A contract should be agreed between those participating in clinical supervision, which outlines structure, process and boundaries.

6 Conduct of Clinical Supervision

These guidelines help to make clinical supervision safe, non-threatening and a valuable experience as well as ensuring that it provides benefits to the organisation.

6.1 **Time -** Each clinician should have regular minimum clinical supervision of one hour at frequency intervals of at least every 8 weeks. Time for clinical supervision should be organised and pre-planned and Clinicians should commit themselves to meet as arranged.

6.2 **Environment -** This should be private and comfortable and disruptions to the supervision meeting should not occur except in cases of emergency. Telephones should be disconnected and bleeps and mobile phones given to someone else.

The atmosphere should be relaxed and chairs used should be of similar design and placed to allow for a comfortable amount of personal space.

6.3 **Records -** It is important for Supervisees to keep records of clinical supervision sessions. The notes may record objectives agreed / issues discussed and will serve as a reminder to aid the Supervisees practice development.

6.4 **Relationships -** The relationships should be based on mutual trust and although it may take time for the parties to relax and for trust and confidence to build up, supervision should be a safe and secure experience for Clinicians.

Quality clinical supervision will depend on the ability of all parties to exploit the potential of this relationship to promote understanding and growth as professionals.

6.5 **Trust and Confidentiality -** The establishment of trust requires a high level of professionalism in the operation of clinical supervisory boundaries. The discussion of clinical and personal issues can have the effect of producing closeness between the parties. It is important to stress that the focus of clinical supervision is on professional matters but may inevitably touch on personal issues as therapeutic care involves use of the self.

The Clinical Supervisor will need to use his/her professional judgement to draw the boundaries between professional and personal links. Clinical supervision may not fully meet personal support needs and Supervisees with particular needs for support should be encouraged to seek additional help.

In order to build trust, it is vital that matters discussed in clinical supervision are not normally disclosed to other people.

6.6 **Exceptions to Confidentiality -** The two examples below provide scenarios where information can be taken beyond the clinical supervision setting

1) The Clinical Supervisor and Supervisee or group may agree that the Clinical Supervisor should discuss outside of the session information discussed in it e.g., action concerning a personal development plan or a safeguarding concern.
2) In extreme circumstances, the Clinical Supervisor may be made aware of a situation of such a serious nature that they feel it would be negligent not to discuss the matter with a person in authority. If such a circumstance occurs, the Clinical Supervisor should inform the Supervisee that they feel duty bound to take appropriate action. It is difficult to specify all the circumstances which would contribute to the undertaking of such action but certainly any risk of harm to Service Users, self or others would be legitimate. In such cases the Supervisor is normally advised to consult with an equal peer or colleague about appropriate action to be taken.

   Should such an extreme circumstance arise both Supervisor and Supervisee are advised to seek advice from the Caldicott Guardian and the Legal Advisor of the Trust.

7. Process

7.1 Setting the Agenda - Those involved may wish to set out, at the beginning of the session, the main issues they wish to discuss. Identifying outcomes at the beginning of a session can help to focus the discussion, checking what the Supervisee is hoping to get from the session may make it easier to gauge how productive the session has been should you decide to evaluate at the end.

7.2 **Content -** What is discussed is a matter for those involved in the supervision. A Line Manager might have a place in contributing to this via the Supervisee; for example, in a situation when a repeated area of poor practice/clinical difficulty comes before a Line Manager, they could recommend the Supervisee take it into Clinical Supervision.

7.3 **Time for Reflection -** This is an opportunity for those involved to reflect and consider how they are fulfilling their role. The Supervisors / Participants can negotiate the meaning of constructive feedback and possibly engage in it.

7.4 **Working Relationships -** Working relationships may be discussed if they are impacting upon the delivery of care, and non-constructive complaining or gossip should be avoided.

7.5 **Objective Setting -** The setting and achievement of goals should be discussed with the aim of making the session productive and worthwhile.

7.6 **Professional Development -** Encouraging Clinicians to consider whether there any additional areas of knowledge, experience or skill they would like to develop in order to do their job more effectively, inviting consideration of lifelong learning issues and their development.

7.7 **Personal Experiences in relation to work -** Strong personal emotions and issues not directly connected with work and clinical practice may be identified and Supervisees may benefit from being referred to somebody else to help deal with them e.g. Staff Support. The Supervisor may be able to identify the appropriate source of help or professional support.

7.8 **Ideas -** Focus on innovation and practice development should be encouraged.

7.9 **Date, time and place of next meeting -** Clinical Supervisees are encouraged to take a lead here, deciding whether to continue with this Supervision or whether they wish to seek out an alternative Supervisor or method of supervision.

7.10.1 **Records -** Clinical Supervision notes made by the Supervisee should be brought to supervision sessions.

7.10.2 **Consent to recording –** in certain situations it may be a requirement of training that clinical supervision includes the use of video or sound recordings. I this is the case then the supervisee will be responsible for ensuring that the correct procedure for obtaining and documenting consent is followed. An approved template is in appendix

8. Rights, Responsibilities and Guidance

8.1 As Clinical Supervisor

- To establish a safe environment in which practice issues may be explored.
- To assist the Supervisee in clarifying thinking and reflecting on feelings, behaviour and perceptions underlying their practice.
- To negotiate the meaning of constructive feedback and when called upon to do so give clear, concise and constructive feedback.
- To facilitate appropriate information, experience and skill sharing.
- To question assumptions and attitudes which may be influencing practice.
- To question all practice that is considered unethical or incompetent using the particular professions code of conduct/practice, Trust and Directorate Philosophies, Policies and Procedures.
- To be aware of organisational and political constraints.
- To encourage the Supervisee to take up issues with others where appropriate .e.g. Colleagues, Managers.

8.1a **Positive Approach**

In order for clinical supervision to be positive, efforts should be made to spend time on areas of success and how those were achieved.

It is important to let people know when they have done well. Can the same approach, which helped to achieve success, be applied to those areas in which there are identified and agreed weaknesses or difficulties?

8.1b **Listening**

When someone is talking about himself or herself, they are generally saying something important and it follows that they should be listened to carefully.

It is important to understand that the Supervisee's view of events, behaviours or circumstances may differ greatly from those of the Supervisor, particularly when the Supervisee's behaviour is under scrutiny. Nevertheless, the Supervisor needs to listen to and try to make sense of the Supervisee's perspective.

In case of an impasse, or where there is a block on progress, it may be helpful for the Supervisor to consult with their own Supervisor, whilst maintaining appropriate confidentiality.

8.2 As Supervisee

- To attend arranged meetings.
- To identify practice issues which require exploration, assistance or developing.
- To share issues and information freely, the Supervisee remains accountable for their practice and the delivery of interventions. Where there is concern about a therapeutic decision or intervention the Supervisee should discuss this concern with their Line Manager.
- To negotiate and be receptive to feedback.
- To become more aware of organisational political constraints and their implications.

The Clinical Supervisee must inform his or her Line Manager that:

1. They are receiving Clinical Supervision
2. The name of their Clinical Supervisor
3. The date supervision commenced and the frequency

9. Evaluation

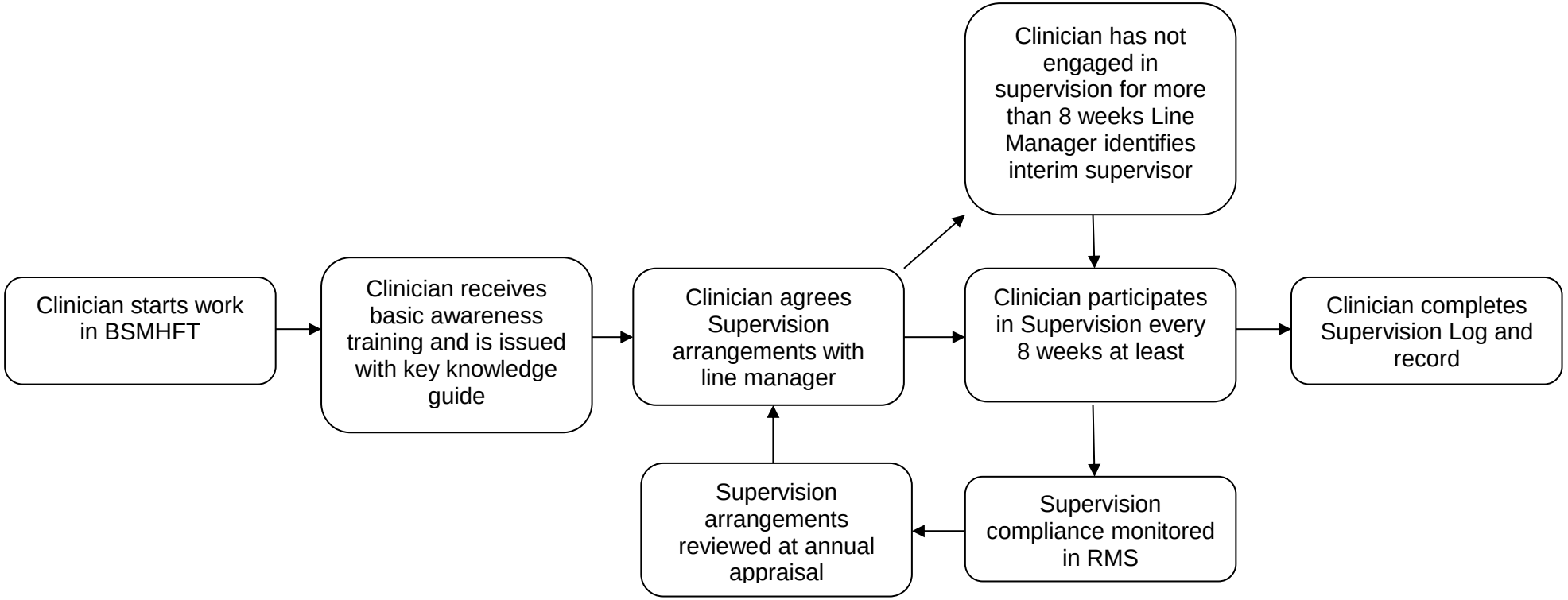
A key component of any process is the evaluation of its usefulness against a range of measures. In the context of clinical supervision there are a number of perceived benefits and positive outcomes, which could be tested against an evaluation process.

Clinical audit is one method by which some clearer impressions of positive outcomes, and benefit, can be linked to clinical supervision with some indicators being:

- Better therapeutic outcomes for Service Users.
- Increased use of evidence based practice.
- Safer practice and greater awareness of accountability.
- Reduction in untoward incidents and complaints.
- Clearer focus of educational and professional development.
- Increased incorporation of service user contributions/opinions.
- Reduction of stress and absenteeism in the workforce.
- An increase in practice innovation and development.

Appendix 3

Clinical Supervision Process Map



Appendix 4

Supervision Log

Clinical Supervision Log for:	*Supervisee name here*

Date of Supervision	Supervisor	Supervisor Signature	Next Supervision

Appendix 5

Supervision Record

Name:	**Date:**
What I want from the session. What I want to cover and how I want to cover it. What I might consider doing after the session. Areas for development in my knowledge and skills. What I got from the session. Ideas for next session.	

Appendix 6

Supplementary information for psychologists and psychological therapists

Supervision is a critical element of clinical practice in the provision of psychology and psychological therapies (HCPC, 2011; BPS, 2008, 2009, 2010, 2012). According to the DCP (2014) clinical supervision is one strand of clinical governance for professions within the health service alongside CPD and lifelong learning. It is to ensure safe and accountable practice and high quality clinical and professional service. This supplement aims to provide additional guidance on clinical supervision to psychologists and psychological therapists.

Whilst it is the responsibilities of psychologists and psychological therapists to seek appropriate clinical supervision for their clinical work the following standards and recommendations for good practice on clinical supervision which incorporates the DCP (2014) is valuable to consider:

1. All psychologists and psychological therapists at all stages of their career and in all work contexts will engage in regular planned supervision of their work.

2. All aspects of psychologists and psychological therapists work including clinical, consultancy, supervisory, research, educational, or managerial, will be subject to supervision.

3. The time allocated and frequency for supervision is dependent on job role, job plan and working hours will need to be agreed with the line manager:

3.1 An absolute minimum will be one hour per month, one to one and/or group supervision with a psychologist, for all staff, however part time.

3.2 It is recommended that a full time newly qualified psychologist will have fortnightly clinical supervision for a minimum of one hour. For instance, In the Trust, the Psychology service of Adults of Working Age supervision standards recommends 3 hours per month.

3.3 It is recommended that a full time mid-career psychologist (8a) will have clinical supervision for a minimum of one hour per fortnight. For instance, the Trust Psychology service of Adults of Working Age supervision standards recommends 3 hours per month (additional for DBT lead facilitators as required by DBT competency framework).

3.4 It is recommended that a senior psychologist (8b and above) would have clinical supervision for a minimum of one hour per month. For instance, the Trust Psychology service of Adults of Working Age supervision standards recommends between 1.5 – 3 hours per month

4. It is recommended that a supervision contract, agreed and signed by supervisor and supervisee be established, and reviewed regularly, at least annually. The annual review will identify the amount of supervision required and incorporate supervision time in relation to the demands of the work and may be reflected in a work plan (DCP, 2012).

5. All clinical supervisors will be appropriately trained for the role.

6. All supervision will be documented and records kept.

7. The individual has a responsibility to identify the need for and to seek access to supervision within their work situation.

8. Supervisors apply supervision models and best evidence to their supervisory practice and attend carefully to their supervisor relationships.

9. Supervisors demonstrate ethical practice and are respectful of diversity in all its forms.

10. The frequency and duration of professional supervision will be of a standard that allows all aspects of work to be discussed, and enables the development of a beneficial supervisory relationship. A minimum standard is one professional supervisory session per month.

11. Where the clinician is working to develop clinical skills within a particular modality (e.g. CBT, psychodynamic, systemic etc...) there may be external determined standards required for accreditation for both the supervisor and supervisee. For example the acquisition and maintenance of BABCP accreditation requiring supervision by a BABCP accredited supervisor. In this case there will be an expectation that the supervisor providing the supervision already offered is suitably qualified to meet those requirements. Accordingly staff will be supported within their supervision entitlement with additional supervision (e.g. when working towards accreditation) requirements coming from CPD entitlement in discussion with their line manager.

12. As supervision is competency based it is possible for a more 'junior' staff with specific expertise to provide clinical supervision to a more 'senior' staff. However, this would need to be carefully negotiated and managed.

13. Given that in some settings clinicians work with complex and difficult to manage situations regular supervision may be supplemented with ad hoc sessions known as consultation.

14. Clinical supervision is normally provided one-to-one and face-to-face. However there are different types of provision of clinical supervision could be accessed. These could be group based, with an identified facilitator, or peer based, with all members sharing expertise. It can be conducted by telephone, Skype or other instant messaging solutions as well as email. Some models (e.g. systemic) use reflective teams or live supervision with supervisor, clinician and client in the same room. Good practice would indicate the use of audio/video recorded or observed material within supervision at times.

Useful documents on supervision:

British Psychological Society (2008). Generic professional practice guidelines. Leicester: Author.

British Psychological Society (2009). Code of ethics and conduct. Leicester: Author.

Division of Clinical Psychology (2010). Continuing professional development guidelines. Leicester: British Psychological Society.

Division of Clinical Psychology (2012). Guidelines on activity for clinical psychologists.
Leicester: British Psychological Society.

Division of Clinical Psychology (2014). DCP Policy on Supervision. Leicester: British Psychological Society.

Health and Care Professions Council (2011). Continued professional development and your registration. London: Author.

Health and Care Professions Council (2012). Standards of proficiency – practitioner psychologists. London: Author.

Appendix 7

Consent for recording clinical sessions

AUDIO AND VIDEO RECORDING - CONSENT TO PARTICIPATE

SERVICE USER'S/ EMPLOYEES NAME	
DATE OF AUDIO/ VIDEO RECORDING	
VENUE **WHERE RECORDING TAKES PLACE**	

Audio/ video recording is carried out in accordance with Professional and Trust guidelines.

_____ would like to record an interview with you.

PLEASE PRINT FULL NAME & ROLE OF HEALTH CARE PROFESSIONAL

He / she, as a representative of the Trust, will be responsible for the security and confidentiality of the recording in line with Trust policy.

The recording will be locked securely away in a cabinet.

The recording will only be used for the purpose of

_____

PLEASE BE AS SPECIFIC AS POSSIBLE TO ALLAY ANY CONCERNS OF THE SERVICE USER OR THEIR REPRESENTATIVE

It will be used within BSMHFT by

_____

NAMED INDIVIDUALS OR GROUP

The recording will be erased after use OR by

_____

WHICHEVER DATE IS THE SOONER

You do not have to agree to being recorded. If you choose <u>not</u> to have a recording made, this will not affect your treatment in any way.

<u>If you do agree:-</u>

[a] you can change your mind at any time
[b] you can request the equipment is turned off during the recording
[c] you can withdraw your consent at any time – before, during or after the interview.

All persons participating in a recording will be given the opportunity to review the content.

If you agree to being recorded, please sign below.

PRINT NAME IF YOU AGEE TO RECORDI NG			
SIGN HERE IF YOU AGREE TO RECORDING		**DATE**	

<u>THANK YOU VERY MUCH FOR TAKING PART</u>

After the interview has finished, please sign below to confirm that you are still happy to have the recording used.

PLEASE SIGN HERE IF YOU ARE HAPPY FOR THE CONTENT OF THE RECORDING TO BE USED AS INDICATED ABOVE	
DATE	

The Department of Health (D of H) supports the use of such recordings and below is a quote from a recent D of H publication:

"Video and audio recordings of treatment may be used both as a medical record or treatment aid in themselves, and as a tool for teaching, audit or research. The purpose and possible future use of the recording must be clearly explained to the person, before their consent is sought for the recording to be made. If the video is to be used for teaching, audit or research, patients must be aware that they can refuse without their care being compromised and that when required or appropriate the recording will be anonymised."