Birmingham and Solihull Mental Health NHS Foundation Trust

CLINICAL SUPERVISION AND REFLECTIVE PRACTICE POLICY

Policy number and category	**C08**	**Clinical**
Version number and date	**9**	**May 2025**
Ratifying committee	**Trust Clinical Governance Committee**	
Date ratified	**June 2025**	
Next anticipated review	**June 2028**	
Executive Director for Quality and Safety	**Executive Director of Quality and Safety (CNO)**	
Policy lead	**Associate Chief Nurse for Policy and Practice**	
Policy author *(if different from above)*	**Clinical supervision and Reflective Practice Lead**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

Clinical supervision and reflective practice are mandated and accountable processes which support and develop the skills, knowledge and values of an individual or team. They allow staff to:

- Reflect and review their practice in order to deliver safe, quality services
- Process the emotional and psychological impact of the work
- Access support and containment and attend to their own well being

For the purpose of this policy, reflective practice is recognised as a distinct but complementary process to clinical supervision and should not be used as a substitute for it.

This policy relates to all BSMHFT staff engaged in direct clinical interventions (with the exception of doctors as they have separate arrangements).

Policy requirement (see Section 2)

• All staff involved in clinical activities are expected to take part in clinical supervision and reflective practice at a **minimum** of every **8 weeks**, with a recommended frequency of every 4-6 weeks. Reflective Practice should be adjunct to Clinical supervision.
• Clinical supervision and reflective practice must follow the guidance detailed below.
• Each service / team should decide the most appropriate model for their area and approve this with the relevant Clinical Director or Governance lead for the service.
• All supervision should be considered confidential.
• All staff should update their training record as soon as possible after a supervision session using the Trust approved database, (Traffic Light Training record).

Change Record

Date	Version	Author (Name & Role)	Reasons for review / Changes incorporated	Ratifying Committee
February 2025	9	Silvia Miranda Consultant Practitioner Psychology – Lead for Clinical Supervision and Reflective Practice	• Current version not fit for purpose. • Additional Appendices with supplementary information for different professional groups excluding of medical doctors as they have separate arrangements. • Partial re-write of policy and guidance.	Trust CGC

Contents

1: Introduction:

The policy offers guidance for substantive clinical staff to consider clinical supervision from both process and content perspectives. Clinical supervision and reflective practice serve as opportunities to reflectively examine practice, with the aim of building skills, promoting professional development and improving the quality-of-service delivery.

This policy explains clinical supervision and reflective practice and what each constitutes, within BSMHFT. This policy is intended for the use of all trust staff in roles where they are providing direct clinical interventions, including all professional groups, with the exception of medical doctors as they have separate arrangements.

Direct Clinical interventions include: all staff who are patient facing and provide assessment, treatments and management of care of patients/ service users.

- Activities that involve in person contact with individuals to provide treatment, prevention, investigation and diagnosis of illness in individuals.
- Activities that support individuals' ability to function and perform activities of daily living and ability to participate in society.
- Whereas there is some overlap between clinical supervision and reflective practice, they are different and have different functions. Reflective Practice is adjunct to Clinical supervision and not stand alone in terms of compliance. There are various models that can be used for clinical supervision, please access the e-learning module available on the Trust's Learning Zone for more information on clinical supervision, roles, responsibilities and benefits. This module can also be reached via the traffic lights system (please see appendix 12 for details).

1.1 Rationale:

Clinical supervision is a supportive, structured process whereby clinical staff have protected time to discuss their clinical practice with a supervisor. Its primary focus is on the quality of clinical skills, to ensure the supervisee remains working within trust, national and professional standards. Supervision may at times include identifying areas for personal and professional development and have a pastoral element.

Reflective practice refers to interventions which provide staff with a facilitated setting in which to reflect on the impact of their work on themselves, colleagues and patients. Often discussion will focus on the impact of distressing or challenging situations in which staff have conflicting roles, feelings or views. Reflective practice is supported by a facilitator and can be conducted in an individual or group format.

This policy outlines who is expected to have clinical supervision and who should engage in reflective practice. It lays out the procedure for accessing clinical supervision, how to record

compliance, what the procedure is for non-compliance and how overall compliance in the trust will be monitored. Standards and requirements regarding clinical supervision varies between professions. Please refer to the appendices at the end of the policy for the specific statutory requirements and/ or recommendations for each professional group.

1.2 Scope (when, where and who): this defines where the policy will apply, whether a corporate or local procedure supports the implementation of the policy and to whom the policy applies. It also identifies key staff and outlines their responsibilities.

This policy supersedes all previous Clinical supervision and Reflective practice policies and is to be used in conjunction with the attached appendices and toolkits. This policy and associated appendices and toolkits are considered as providing a basic framework to facilitate, promote and assure that high quality clinical supervision and reflective practice is undertaken for all trust staff engaged in clinical work.

This policy defines the principles and procedures that underpin the provision and use of clinical supervision and reflective practice and is intended to assist all clinical staff in their practice, including those working with the parents and carers of young people and who may encounter child safeguarding issues.

Safeguarding is an important consideration in clinical supervision. Staff working with vulnerable children are required to attend mandatory safeguarding supervision as there is an additional regulatory requirement to offer specialist safeguarding supervision to some service areas and teams. For further information on safeguarding vulnerable adults, young people and children, please refer to the relevant safeguarding policies available on the BSMHFT intranet. i.e. Safeguarding Supervision Policy.

Safeguarding supervision may be recorded as clinical supervision if there is a reflective element to the safeguarding supervision session, however clinical supervision is not an alternative to planned safeguarding supervision.

1.3 Principles

Clinical supervision and Reflective practice are important processes for developing staff, promoting safe practice and quality care. Clinical supervision should be a positive exercise, providing clinical staff with protected, planned, and structured time with an experienced supervisor for reflection on clinical activities and discussion of personal and professional development, in the context of ensuring best practice.

The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.

Purpose of Clinical supervision:

- Normative Element:
    - Quality of practice and accountability for that practice
    - Awareness of local policy and codes of conduct to aid accountability.
- Formative Element:
    - Continual learning from practice
    - Support clinical staff to focus on development of skills knowledge, attitudes and insightfulness.
- Restorative Element:
    - Ensuring wellbeing and resilience of clinical staff in relation to their work.
    - Foster resilience through nurturing supportive relationships that offer motivation and encouragement.

Regular clinical supervision empowers clinical staff to improve their practice with the objective of providing optimum care to patients/ service user.

- **Ensuring fidelity to evidence-base**
    - Ensuring clinical staff choose treatments and use them in a way which is as close as possible to the protocols tested in clinical trials which have led to these treatments being recommended in clinical guidelines.
- **Case management**
    - Ensuring all patients are reviewed according to specific clinical and organisational criteria in order to make effective and efficient clinical decisions, often relating to treatment response, treatment length, treatment intensity or treatment alternatives.
- **Clinical governance**
    - Ensuring safety for patients and clinical staff, by routinely reviewing patient risk and practitioners' clinical practice for all patients, not just those that a supervisee or supervisor selects for discussion.
- **Skills development**
    - Allow clinical staff to reflect on clinical experiences, learn from challenges and improve decision-making.
    - Supports the delivery of safe and effective patient care through continuous learning.

- **Practitioners support**

- Assisting clinical staff to improve their own clinical and therapeutic skills by supervisor feedback on their sessions, e.g., through direct observation, review of notes or taped recordings.
- Ensuring that clinical staffs' own mental health is addressed where they are working with emotionally difficult material, high clinical volumes or are themselves in distress unrelated to their work

Purpose of Reflective Practice:

To provide an environment where staff can explore feelings and dilemmas stirred up by their work, including interactions with patients, colleagues, and the wider organisation. This can relieve clinical impasses, contain anxiety, enhance communication between staff, and thereby support safe and effective clinical decision-making. When carried out in a group setting, reflective practice can help team members appreciate each other's perspectives, better understand how their team is functioning, and support team cohesion.

2: **Policy**:

This policy and the accompanying appendices and toolkits define the principles and procedure that underpin the provision and use of clinical supervision and reflective practice in BSMHFT to assist all staff who are expected to have or deliver clinical supervision. The specific requirements of each professional group can be found from Appendix 5 to Appendix 10.

2.1 The Trust is committed to ensuring that all clinical staff with the exception of medical doctors (as they have separate arrangements) have a basic awareness of what clinical supervision and reflective practice are, why they are necessary, have access to clinical supervision and reflective practice and suitable training if required. Training should be identified with line manager and/or professional lead as part of personal development and CPD. Clinical supervision training on BSMHFT learning zone is role recommended as a baseline for all clinical staff. (Please see Appendix 12 on how to access it)

2.2 All staff except medical doctors 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 and reflective practice. The particular method chosen will depend upon individual preference, working practices, professional or team expectations and will be supported by Line Managers. Reflective Practice should be adjunct to Clinical supervision.

2.4 Some clinical staff may access clinical supervision and reflective practice 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 except medical doctors (who have different arrangements) engaged in direct clinical interventions will agree their clinical supervision arrangements with their line manager. Regular management supervision (RMS) one to one and clinical supervision are separate requirements. Reflective practice is adjunct to clinical supervision and not a stand-alone in replacing clinical supervision.

Temporary staff, students, and trainees, though not accountable to this policy, should engage in regular clinical supervision organised by them, following their professional codes and standards. They should provide confirmation of this supervision, though it won't be recorded on the traffic light system.

3.2 There may be occasions when supervision is required from a specialist external to BSMHFT. 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.

3.3 a) Identify an appropriate clinical supervisor and inform line manager of who it is.

b) Ensure there is a supervision contract between supervisor and supervisee that both parties understand and agree to. Include:

- Reason for the supervision.
- Frequency of supervision.
- Both supervisor and supervisee keeping a written record of the discussion.

c) Ensure clinical supervision takes place every 4-6 weeks, every 8 weeks at a minimum, as per this policy.

d) A written record of the supervision session including date, time, risk issues and summary of discussion will be kept by the Supervisee. Line managers may request proof that the supervision took place. Please see **appendix 2** for further guidance.

e) Supervisee is responsible for recording on the Trust on Traffic light system when they had clinical supervision and reflective practice immediately after or at the soonest opportunity. Please see appendix 12 for further information on recording it on Traffic Lights system.

f) If staff are having difficulty identifying a supervisor, they should escalate this to their line manager, and it should be discussed in their regular management supervision.

g) When approaching expiry of compliance with clinical supervision, staff will be sent an amber email alert.

h) When clinical staff are not compliant with clinical supervision as per this policy, they and their line manager will receive a red email alert, and this will be discussed in their regular management supervision.

i) If problems persist with accessing, arranging or complying with clinical supervision, this will be escalated to the service manager.

4: Roles and Responsibilities

Post(s)	Responsibilities	Ref
Chief Executive but is delegated to the Medical Director	• Accountability for the provision of clinical supervision and reflective practice across the Trust.	
Policy Lead	• To ensure the policy is reviewed every three years at least. • To act as an expert for the Trust on the accessible information.	
Executive Director for Quality and Safety	• Have responsibility for ensuring that clinical and professional issues are considered and addressed. Heads of clinical professions, will have particular responsibility for their staff groups (e.g. Chief Psychological Professions Officer, Chief Nursing Officer, Chief Allied Health Professional Officer, Chief Pharmacist).	
Associate Directors	Ensure that: • There are structures in place within their service areas to facilitate the process of clinical supervision and reflective practice, the monitoring of policy implementation and the management of non-compliance. • Line Managers and other staff are released to access appropriate training.	
Head of Nursing & Allied Healthcare Professionals (AHP), Chief AHP, Head of AHP, Chief Psychological Professions Officer and Divisional Professional Leads for Psychological Professions	• Hold overall responsibility for ensuring compliance with the clinical supervision policy within the directorate. • Develop and maintain systems to support implementation. • Provide strategic direction to matrons and CNMs to ensure clinical supervision is embedded into the organisational culture. • Advocate for resources or training programs to enhance clinical supervision availability and quality.	

	• Identify and address organisational barriers to access to clinical supervision.	
Clinical Nurse Manager / Service Lead	• To have responsibility for the oversight of compliance as a KPI. • Identify barriers at an operational level to clinical supervision access. • To ensure the policy is consistently applied across teams • Ensure systems are in place to monitor compliance with clinical supervision and reflective practice • Compliance to be reviewed at appropriate governance meetings	
Matron or Clinical Lead	• To ensure clinical staff are aware of the professional responsibility to access clinical supervision as outlined by the NMC to enable the delivery of safe, effective care and to support continuous professional development. • To ensure clinical staff are aware of suitable supervisors and routes to access clinical supervision. • Monitor weekly compliance data and ensure staff understand the importance of the recording of supervision within the trust traffic light system.	
Line Managers	• 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 and reflective practice. • Compliance with the policy is monitored and issues of poor performance are addressed using the values-based appraisal.	
Clinical Supervisors and Reflective Practice Facilitators	• Where a member of staff takes on the role of Clinical Supervisor or reflective practice facilitator, they have a responsibility to ensure that, in order to build and maintain trust, matters discussed in clinical supervision and/or reflective practice group 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. Supervisors should be knowledgeable about professional bodies, therapeutic modalities, and trust rules on confidentiality. The breaking of confidentiality without justifiable cause will be treated as a very serious matter and may lead to a disciplinary investigation. It is the responsibility of the supervisor and supervisee to manage the supervision records in accordance with their own professional registration requirements. All individuals providing clinical supervision should have formal training recognised by the Trust. This may be achieved through in-house training programs or accredited external training courses. For those who may not have had formal training but have significant relevant experience delivering clinical supervision, they may continue to deliver supervision if evaluated by their service lead to have the necessary skills. This will be decided on a case-by-case basis.	
All Staff (Engaged in direct Clinical Interventions)	Ensure that: • They have read and understood the clinical supervision and reflective practice policy. • They engage in clinical supervision at least every 8 weeks and regular reflective practice. • They discuss any difficulties that they have in organising or accessing clinical supervision	

	and reflective practice with their Line Manager. • Each staff member is responsible for updating the clinical supervision traffic light record of compliance with this policy's requirements.	

5: Development and Consultation process:

Consultation summary		
Date policy issued for consultation	March 2025	
Number of versions produced for consultation	1.12	
Committees / meetings where policy formally discussed	**Date(s)**	
Clinical Supervision and reflective practice Working Group	20th May 2024, 9th June 2024, 23rd July 2024, 12th August 2024, 3rd September 2024, 24th September 2024	
Safer Staffing Committee	3rd October 2024, 7th November 2024, 17th December 2024, 21st January 2025, 18th February 2025, 18th March 2025	
Nursing Advisory Council (NAC)	22nd Feb 2025	
Where received	**Summary of feedback**	**Actions / Response**
Safer Staffing Committee	Agreement of executive lead for clinical supervision, agreement that medical doctors would be removed from present policy and have their own separate arrangement, traffic light compliance alerts feedback, ESR roles attribution to Clinical Supervision, Clinical supervision for temporary staffing should have a separate policy, supplementary information for each professional	Incorporated action discussed into present policy.

	groups to be included in appendices.	
Nursing Advisory Council (NAC)	Roles & Responsibilities table updated Audit & Assurance table updated	Incorporated tables revised by NAC into present policy.

6: Reference documents

Section 10: Using health and social care information –direct care and indirect care purposes - NHS England Digital

https://digital.nhs.uk/services/national-data-opt-out/operational-policy-guidance-document/appendix-2-definitions

https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/a-guide-to-confidentiality-in-health-and-social-care/hscic-guide-to-confidentiality-references/section-10

7: Bibliography:

Standards of proficiency for registered nurses - The Nursing and Midwifery Council
Standards of conduct, performance and ethics | The HCPC
NHS England » NHS Talking Therapies, for anxiety and depression
Enablers and barriers to effective clinical supervision in the workplace: a rapid evidence review | BMJ Open

What is clinical supervision and how can it be delivered in practice?
Nursing Times [online] January 2022 / Vol 118 Issue 2
What is clinical supervision and how can it be delivered in practice? | Nursing Times

National Council for the Professional Development of Nursing and Midwifery Clinical Supervision A Structured Approach to Best Practice
http://hdl.handle.net/10147/116308

Contribution of peer group supervision to nursing practice: An interpretive phenomenological study- www.elsevier.com/locate/issn/14715953

Clinical supervision unit 3 : effective facilitation of clinical supervision | Turas | Learn

FAQ-Clinical-Supervision-for-Registered-Nurses.pdf

Guidance-and-resources-for-clinical-supervisors.pdf

HEE Workplace Supervision for Advance Clinical practice (ACPs).pdf

'Barriers to overcoming the barriers': A scoping review exploring 30 years of clinical supervision literature wileyonlinelibrary.com/journal/jan J Adv Nurs. 2022;78:2678–2692.
'Barriers to overcoming the barriers': A scoping review exploring 30 years of clinical supervision literature - Masamha - 2022 - Journal of Advanced Nursing - Wiley Online Library

NHS England » Supervision guidance for primary care network multidisciplinary teams

Peer_group_clinical_supervision_Qualitative_perspe.pdf

8: Glossary:

- None

9: Audit and assurance:

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Completion of Clinical supervision and reflective practice	Heads of Nursing and AHPs and Heads of Professions	ESR Staff traffic light competency	Monthly	Local and Trust CGC Finance and Performance and Productivity
Provision of Clinical Supervision training	Matron /Clinical Lead/Professional Lead	Trust Wide Report	Monthly	Local Clinical Governance Committee
Number of trained staff in service areas	Heads of Nursing and AHPs	Traffic light system (role recommended)	Quarterly	Workforce and Education Group
Quality of clinical supervision and practice	Head of Nursing and Allied Healthcare Professionals	Trust Wide Report via AMaT	Annually	Trust Clinical Governance Committee

10. Appendices

Appendix 1

Equality Analysis Screening Form

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

Title of Policy	**Clinical Supervision & Reflective Practice C08**		
Person Completing this policy	Silvia Miranda	**Role or title**	Consultant Practitioner Psychologist
Division	Psychology	**Service Area**	Corporate Psychology
Date Started	29th January 2025	**Date completed**	30th January 2025
Main purpose and aims of the policy and how it fits in with the wider strategic aims and objectives of the organisation.			
This policy is intended for the use of all trust staff (with the exception of doctors as they have separate arrangements) engaged in direct clinical interventions. It provides a basic framework to facilitate, promote and assure that high quality clinical supervision and reflective practice is undertaken for all trust staff engaged in clinical work This policy outlines who is expected to have clinical supervision and who should engage in reflective practice. It lays out the procedure for accessing clinical supervision, how to record compliance, what the procedure is for non-compliance and how overall compliance in the trust will be monitored. Guidelines and requirements regarding clinical supervision varies between professions. Please refer to the appendices at the end of the policy for the specific statutory requirements and/ or recommendations and guidance for each professional group.			
Who will benefit from the policy?			
All staff involved in direct clinical interventions.			
Does the policy affect service users, employees or the wider community?			

Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward
This policy will affect service users indirectly as the policy is directed for staff
Does the policy significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***
It will improve clinical delivery and patient care. This policy will hopefully provide better quality of care for service users.
Does it involve a significant commitment of resources? ***How will these reduce inequality?***
Designated staff will need to be trained in clinical supervision. They will have better understanding on how to address inequality issues and expectations. This policy will ensure that staff who require clinical supervision will have access to clinical supervision across the Trust.
Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)
Currently not all staff have access to clinical supervision and this policy will make sure that staff will access it.
Impacts on different Personal Protected Characteristics – *Helpful Questions:*

Does this policy 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 and include relevant data

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	✓			Regardless of age this policy should not prevent staff accessing clinical supervision.
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your policy? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	✓			If staff declare a disability to the Trust, there should be reasonable adjustments in place to support staff in accessing clinical supervision.
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	✓			Regardless of gender this policy should not prevent staff accessing clinical supervision.
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 policy?				
Marriage or Civil Partnerships	✓			Regardless of marriage or civil partnership this policy should not prevent staff accessing clinical supervision.
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	✓			Regardless of Pregnancy or Maternity this policy should not prevent staff accessing clinical supervision. If staff are pregnant, there should be

				reasonable adjustments in place to support staff in accessing clinical supervision.
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 to pregnancy and maternity?				
Race or Ethnicity	✓			Regardless of Race or Ethnicity this policy should not prevent staff accessing clinical supervision.
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	✓			Regardless of Religion or Belief this policy should not prevent staff accessing clinical supervision.
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	✓			Regardless of Sexual Orientation this policy should not prevent staff accessing clinical supervision.
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	✓			Regardless of Transgender or Gender Reassignment this policy should not prevent staff accessing clinical supervision.
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 policy or service?				
Human Rights	✓			This policy is written to promote equality and remove any discrimination to ensure that everyone can fulfil their full potential within a Trust that is inclusive, compassionate, and committed. This is keeping in line with our Trust values, the NHS People's Plan commitment to equality, diversity and inclusion and reflects the provisions of the Equality Act 2010. This policy applies to **all**, including applicants applying for a job, staff including agency, bank and volunteers, services users and carers, visitors, stakeholders, an any other third-party organisations who work in partnership with the Trust.
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**		
	High Impact	**Medium Impact**	**Low Impact**	**No Impact**

What do you consider the level of negative impact to be?				✓

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 policy 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?
This policy is reviewed at least every three years.
How will any impact or planned actions be monitored and reviewed?
Risks impact or planned actions will be monitored and reviewed through our governance routes and committees.
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.
This policy will be shared in various different forums and will be available on Connect.
Please save and keep one copy and then send a copy with a copy of the policy to the Senior Equality and Diversity Lead at **bsmhft.edi.queries@nhs.net** 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 Clinical Supervision Guidance

This Guidance is intended to be a toolkit that is flexible and can be adapted to suit the requirements of each profession.

It is important that clinical supervision is led by the supervisee with support from the supervisor. There is a difference between clinical supervision, professional supervision and regular management supervision (RMS).

Clinical supervisors can provide pastoral support directly during supervision. Pastoral issues do not always need to be referred externally, as supervisors often handle them within the supervisory relationship.

1. Introduction

This guidance outlines the principles and procedures, which will underpin the provision and use of Clinical supervision and Reflective practice and are intended to assist all staff engaged in direct clinical interventions.

2. Written Guidance

By providing written guidance, 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 and reflective practice Policy
• Ensure that all clinical staff understand their various roles in the implementation of the clinical supervision and reflective practice policy.

2. What is Clinical supervision?

3.1 Clinical supervision is a structured process that provides clinical staff with protected time to reflect on and discuss their practice with a supervisor. It helps identify areas for personal and professional development, ensuring the supervisee remains within trust, national, and professional standards. It also explores the impact of the supervisee's work on their emotions and wellbeing. Regular clinical supervision empowers clinical staff to improve their practice and provide optimal care to patients/service users.

Clinical supervision offers a safe and supportive space for critical reflection on the emotional and psychological impact of work. Despite our qualifications and experience, we bring our own biases and vulnerabilities, which we must minimise to ensure the quality of

our work. Clinical supervision provides a reflective space to identify our personal responses, identify specific needs and explore their impact, allowing us to manage them effectively.

It's important to facilitate and promote reflection on practice issues through clinical supervision and ensure that it is continually informed by the evidence-base, so it allows for career development and lifelong learning. Clinical supervision aims to find solutions to problems, improve practice, and increase understanding of professional and clinical issues, including safeguarding. A mutually agreed plan/contract for supervision is typically drawn up at the start and reviewed regularly.

3.2 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 clinical staff. Clinical supervision is an important part on continuing professional accreditation with respective professional bodies.

3.3 Clinical supervision is not:

- Regular Management 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 clinical staff to maintain and promote high quality care of service users and families and supports the wellbeing of staff. Clinical supervision aims encompass the following areas:

a) Reflective Practice: Encouraging clinical staff to reflect on their experiences and clinical practice to gain insights and improve their skills.
b) Support and Guidance: Providing emotional support and professional guidance to practitioners, helping them to deal with the stress and challenges of clinical work.
c) Professional Development: Assisting clinical staff in identifying learning needs, setting goals, and developing their careers.
d) Quality Improvement: Aiming to improve the quality of patient care by ensuring that practitioners are competent, confident, and supported in their roles. Increase awareness of evidence-based practice.
e) Confidentiality: Maintaining a confidential and safe environment where practitioners can discuss their work openly and honestly.

f) Structured Process: Regular, scheduled sessions that are well organised and focused on the supervisee's needs.

5. Clinical Supervision Structure

5.1 The structure for clinical supervision will be structured, formal and negotiable with regard to frequency, time, session recording and documentation according to the context and professional practice requirements.

5.2 Clinical supervision will be conducted in a non-threatening, constructive and compassionate way.

6. Conduct of Clinical supervision

This guidance helps 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. Protected time for clinical supervision should be organised with the supervisor and pre-planned and Clinicians should commit themselves to meet as arranged.

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

6.3 Relationships - The relationships should be based on mutual trust and respect. 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.

6.4 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 personal matters discussed in clinical supervision are confidential and not normally disclosed to other people unless there are safeguarding concerns where limits of confidentiality apply.

6.5 Exceptions to Confidentiality - The two examples below provide scenarios where information can be taken beyond the clinical supervision and reflective practice 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 may 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. Pastoral issues don't always need to be referred externally, as supervisors often handle them within the supervisory relationship, so supervisors can provide pastoral support directly during supervision.

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

7.9 Consent to recording – in certain situations it may be a requirement of training that clinical supervision and reflective practice includes the use of video or sound recordings. In 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 a**ppendix 11**.

Appendix 3
Trust Reflective Practice Guidance

What is Reflective Practice:
The term 'reflective practice' refers to interventions which provide all staff regardless of their role with a facilitated setting in which to reflect on the impact of their work on themselves, colleagues and patients promoting learning from their practice, enhancing patient care, and improving staff wellbeing. Often discussion will focus on the impact of distressing or challenging situations in which staff have conflicting roles, feelings or views. Reflective practice is supported by a facilitator and can be conducted in an individual or group format.

1. Purpose of reflective practice:
To provide a psychologically safe environment where staff can explore feelings and dilemmas stirred up by their work, including interactions with patients, colleagues, and the wider organisation. This can relieve clinical impasses, professional dilemmas, contain anxiety, enhance communication between staff, and thereby support safe and effective clinical and professional decision-making. When carried out in a group setting, reflective practice can help team members appreciate each other's perspectives, better understand how their team is functioning, and support team cohesion.

2. Objectives:

2.1 Aim: To provide a structured, supportive inclusive environment for all staff regardless of their role, to reflect on their practices, enhance personal and professional development, support clinical. governance, support quality assurance for continuous quality improvement processes, enhance quality of care and promote wellbeing.

2.2 Fundamental Goals:

- Improve clinical and/or professional practice through self-awareness and learning.
- Foster a culture of continuous improvement and professional development.
- Enhance staff wellbeing and resilience by providing a safe space to process emotional experiences linked to the impact of their work.

3. Modalities of Reflective Practice

3.1 Reflective Practice Groups:

- Regularly scheduled sessions (e.g., monthly or quarterly).
- Facilitated by trained clinicians and or professionals.
- Focus on team functioning and/or specific themes such as clinical cases, professional casework, ethical dilemmas, or personal wellbeing.

3.2 Individual Reflective Practice:

- Encouragement of personal reflection through journals, self-assessment tools, or one-on-one mentoring.
- Optional one-on-one sessions with a trained facilitator for deeper exploration.
-

3.3 Peer Support Groups:

- Small, consistent groups of peers who meet regularly and have a structure to discussions.
- Focus on sharing experiences, providing mutual support, and exploring reflective questions.
- Confidentiality and psychological safety are prioritised.
- Reflective practice is confidential unless certain conditions are observed such as …. SH will provide statement
- Ensure that all participants feel respected and supported when sharing their experiences, particularly when discussing sensitive issues related to discrimination or microaggressions.

4. Fundamentals of Reflective Practice

4.1 Governance:

- Ensure reflective practice aligns with organisational policies, including confidentiality, professional boundaries, and safeguarding protocols.
- Ensure reflective practice is linked to clinical governance structures, including risk management, clinical audit, and patient safety reporting, incident reporting, to support systematic quality assurance.
- Gain approval and guidance from senior management and establish a governance structure to oversee sessions.
- Reflective sessions discussions could address incidents, adherence to clinical guidelines, and the implementation of quality improvement projects.

4.2 Consent and Confidentiality:

- Obtain informed consent from participants, emphasising the voluntary nature of participation.
- Clarify the limits of confidentiality, including mandatory reporting requirements for risk concerns.

4.3 Facilitator Selection and Training:

- Appoint skilled trained facilitators with experience in mental health and group dynamics and preferably training in a reflective practice intervention.
- Supervision is essential and reflective practice space for facilitators is also best practice.
- If facilitator is external to the Trust, aim to seek:
  - Senior management approval – Service Lead and/or Division Lead
  - Agreement on a contract regarding reflective practice delivery.

- Confirmation of facilitators' supervision arrangements. It is their responsibility to have appropriate training and supervision to deliver reflective practice.
- Facilitator notes to be available on request (ensuring appropriate levels of confidentiality).
- Carry out regular reviews of provision effectiveness, outcome and continuation of reflective practice group.

5. Setting Up Reflective Practice Groups:

5.1 Governance:

- Define the purpose and scope of reflective practice sessions (e.g. clinical improvement, team dynamics improvement).
- Establish a clear structure, including frequency, duration, and participants.
- Document processes for feedback, evaluation, and reporting outcomes without breaching confidentiality.

5.2 Contracting:

- Create a shared understanding of session goals and expectations.
- Identify logistical needs such as a neutral meeting space and time allocation within work schedules.
- Ensure protected time for participants and facilitators.
- Develop written agreements outlining roles, responsibilities, and session boundaries.

5.3 Session Planning and Coordination:

- **Equitable Access:**
  - Aim to schedule sessions at times where different shifts and roles are accommodated, ensuring equitable access for all staff members, including those in non-clinical roles.
- **Commitment:**
  - Aim for staff to commit to attending sessions and that all team members regardless of role engage in session.
  - Consider establishing a process for non-engagement and reporting of attendance.

- **Establish ground rules:**
  - Reiterate the importance of confidentiality, respect, and active listening to create a safe space for sharing.
  - Consider including respect for diversity and any discriminatory behaviours or language.

- **Structured Discussion:**
  - Ensure session is structured and follows evidence-based models. Examples of these are Gibbs' Reflective Cycle (1988) or Kolb's

Experiential Learning Model (1984). These are not modality specific and are broad based models.

5.4 Session Evaluation:

- **Session feedback**
  - Feedback significantly impacts the effectiveness of interventions. Consider obtaining feedback from group participants at regular intervals throughout group facilitation.
    - Aim to receive feedback from everyone.
- **Impact assessment:**
  - Consider evaluating the impact of sessions on areas such as clinical practice, patient care, clinical governance processes, quality improvement, barriers to participation and equitable access, incident reporting, staff wellbeing.

6. Engagement in Reflective Practice Groups:

6.1 For Managers: Commissioning Reflective Practice:

- Identify the team or individual needs that reflective practice will address.
- Consult staff to ensure the intervention is relevant and beneficial.
- Consider resource allocation
  - Room bookings
  - Staff release time / ringfenced time to attend
  - Cross cover for another team
- Integrate reflective practice into the team's professional development plans / appraisals.
- Monitor and Evaluate outcome and benefits of Reflective Practice Groups
  - Regularly review the impact and effectiveness of sessions.
    - Using metrics such as staff feedback, patient outcomes, and team performance indicators.
  - Adjust the approach based on evaluation findings.

6.2 For Facilitators: Conducting Effective Sessions:

- Develop a session plan with participants with clear objectives, themes, and activities.
- Familiarise yourself with the group’s team dynamics and individual needs.
- Encourage open and respectful communication, establish ethical and professional boundaries and foster psychological safety.
- Evidence-based models such as Gibbs' Reflective Cycle or Kolb's Experiential Learning Model could be considered if not trained in a specific Reflective Practice intervention.

- Manage conflicts constructively and ensure all voices are heard.
- Maintain professional boundaries and ethics and remain impartial.
- Recognise and address signs of distress or resistance.
- Ensure facilitator has access to appropriate reflective practice and supervision for their role.
- Be mindful of the challenges that arise during reflective practice, see section 7, and gain supervision early when these arise.

6.3 For Participants:

- Actively engage, apply learning to practice, and maintain group agreements on confidentiality and respect.
- Record attendance in the Trust Traffic Light System.

7. Challenges:

Psychological safe spaces can be created within consistent and thoughtful reflective practice sessions. It is commonplace to experience significant challenges while building a firm and trusted foundation. Managing and overcoming challenges in a compassionate and committed way can result in a more effective space where people trust that conflict is resolved in a meaningful, inclusive way. In this environment people are more likely to share complex experiences, feelings or conflicts, promoting growth and development for all.

7.1 Disengagement:

- Irrespective of time being protected, staff being encouraged, or staff making a commitment, disengagement can be physical or emotional, as the opportunity for space to discuss challenges can be difficult for all of us sometimes. There is no one way to respond to this by the group or the facilitator, and thoughtfulness and patience are encouraged.

7.2 Parallel processes:

- The issues arising in the service user population being served by the team, or the organisation as a whole, may be unconsciously replayed within the reflective practice space. This can be challenging and can go somewhat unnoticed by members and facilitators for many sessions. However, it is a powerful way that the serious issues being faced within the team are being ‘played out’ in a safer environment and can be transformative. Paying careful and caring attention is ideal and leaning into the capacity of the group or pair to work through what is happening to solve the problem.

7.3 Crisis and breakdown:

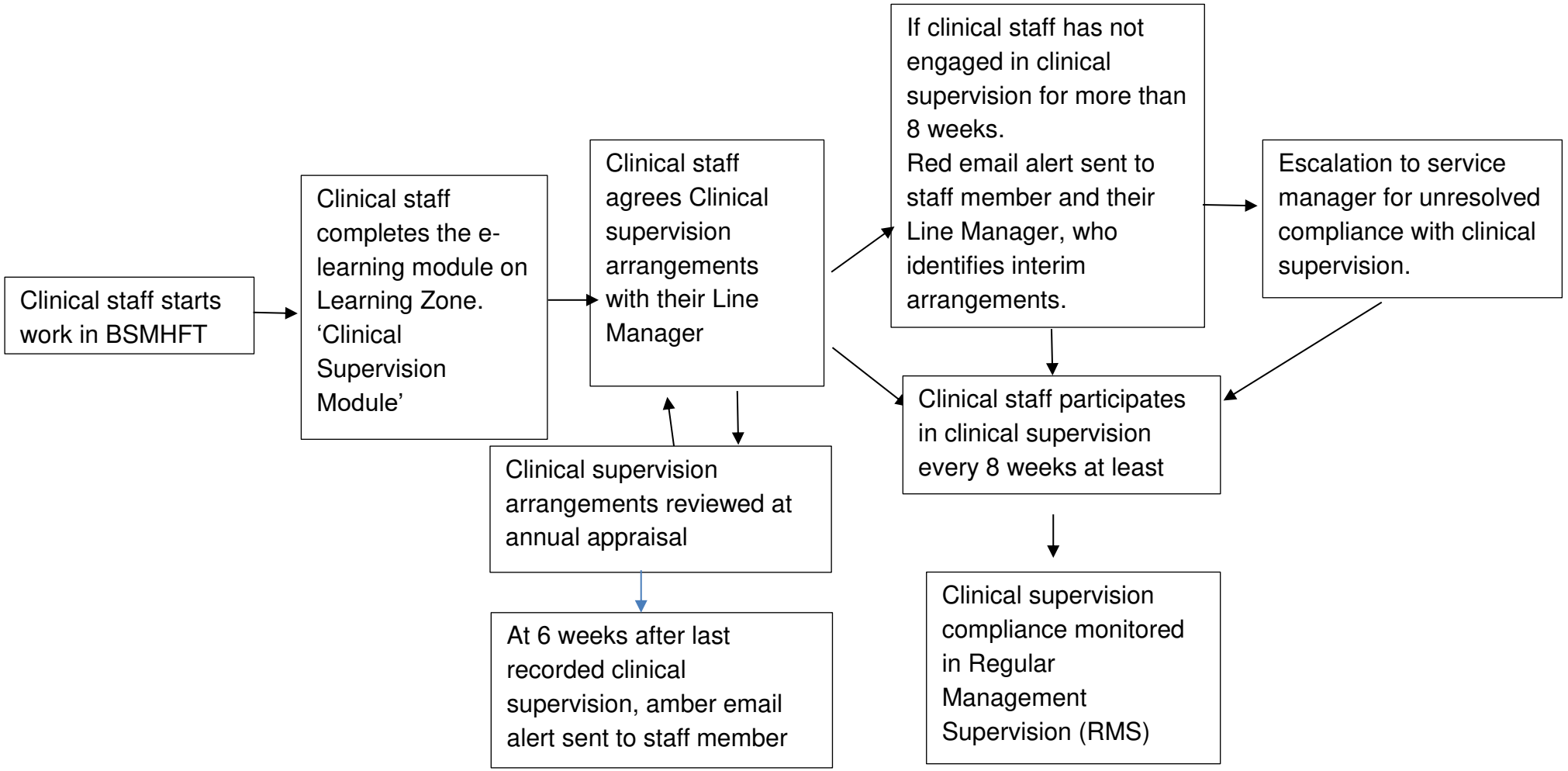
- The issues raised above can lead to crisis or breakdown of the group or reflective practice pair. Let no crisis go to waste. Together take a step back to see what can be done to facilitate transformational change.

8. References

1. Borton, T. (1970). Reach, Touch, and Teach: Student Concerns and Process Education. McGraw-Hill.
2. Boud, D., Keogh, R., & Walker, D. (1985). Reflection: Turning Experience into Learning. Kogan Page.
3. Gibbs, G. (1988). Learning by Doing: A Guide to Teaching and Learning Methods. Oxford Polytechnic.
4. Kolb, D. A. (1984). Experiential Learning: Experience as the Source of Learning and Development. Prentice Hall.
5. Mann, K., Gordon, J., & MacLeod, A. (2009). Reflective practice in health professions education: A systematic review. Advances in Health Sciences Education, 14(4), 595-621.
6. Moon, J. (1999). Reflection in Learning and Professional Development: Theory and Practice. Kogan Page.
7. NHS Health Education England. (2019) NHS Staff and Learners' Mental Wellbeing Commission Report.
8. Royal Collage of Psychiatrists: Guidance for setting up a Team-based Reflective Practice Group – unpublished guidance.
9. Schön, D. A. (1983). The Reflective Practitioner: How Professionals Think in Action. Basic Books.
10. West, M., Coia, D., & The Royal College of Physicians of London. (2019). Caring for Doctors, Caring for Patients. Report of the Working Group on Doctors' Wellbeing.

Appendix 4

Clinical supervision Process Map



Appendix 5
Supplementary information for Psychological Professions

Supervision is a critical element for all Psychological Professionals, at all career stages and in all work contexts. This is to ensure, safe and accountable practice and high quality clinical and professional services. It is expected that all work contexts including clinical, consultancy, supervisory, research, educational, or managerial, will be subject to supervision.

The Psychological Professionals in England encompass the following nationally recognised occupational groups:

Psychologists

- Clinical Psychologists
- Counselling Psychologists
- Forensic Psychologists
- Health Psychologists

Associate and Assistant roles

- Clinical associate in psychology
- Assistant Psychologist

Psychological Therapists

- Cognitive Behavioural Therapists
- Counsellors
- Child and Adolescent Psychotherapists
- Adult Psychotherapists
- Family and Systemic Psychotherapists
- Psychological Therapists (other)
- Art, Drama and Music Therapists (with national Allied Health Professions leadership)
- Medical Psychotherapies (with national Medical leadership)

Psychological Practitioners

- Psychological Wellbeing Practitioners
- Children's Wellbeing Practitioners
- Education Mental Health Practitioners
- Mental Health and Wellbeing Practitioners
- Youth Intensive Psychological Practitioners

The time allocated and frequency for supervision is dependent on occupational job role, job plan and working hours. This and the mode(s) of supervision (e.g. in person, on-line, one-to-one, group etc) will need to be agreed with the line manager in consideration with guidance from the relevant regulatory body and/or professional body and agreement with the Divisional Professional Lead for Psychological Professions and/or the Chief Psychological Professions Officer for the Trust. In the case of Psychological Professions in training (on pre-registration or on post-registration training programmes), the supervision standards set by the relevant accrediting training body and the higher education institute, will also need to be considered.

The absolute minimum standard for all full-time working and registered Psychological Professionals is one hour supervision per month, one to one and/or group supervision with a suitably qualified practitioner. It is expected that there will be additional frequency for students, assistant psychologists, colleagues in training or colleagues newly qualified in a registered psychological professional role. Additional supervision e.g. for caseload review or for specific therapy modality may also need to be considered dependent on the occupational job role.

Psychological Professionals will follow this policy's guidance on the recording and reporting of supervision and storage of supervision notes in addition to noting the considerations within this appendix note.

Any queries on the application of this supplementary information should be raised with the relevant Divisional Professional Lead for Psychological Professions and/or the Chief Psychological Professions Officer for the Trust.

National guidance on supervision relevant to Psychological Professionals:

1. Association for Family Therapy (2022) *Continued Professional Development Policy (including supervision requirements*). Warrington: Author

2. British Association of Art Therapists' (2019) *Guidelines for Supervision*. London: Author

3. British Association for Behavioural and Cognitive Psychotherapies (2022) *Standards of Conduct, Performance and Ethics*. Bury: Author

4. British Psychological Society (2024a). *Supervision Guidance for Psychologists*. Leicester: Author

5. British Psychological Society (2024b). *Expected standards for the recruitment and employment of assistant psychologists*. Leicester: Author.

6. Health and Care Professions Council (2017). *Standards of continuing professional development*. London: Author.

7. Health and Care Professions Council (2023a). *Standards of proficiency for arts therapists.* London: Author.

8. Health and Care Professions Council (2023b). *Standards of proficiency for practitioner psychologists*. London: Author.

9. Health and Care Professions Council (2024). *Standards of conduct, performance and ethics*. London: Author.

10. UK Council for Psychotherapy (2018) *Supervision Statement*. London: Author

Appendix 6
Supplementary information for Nursing

This guidance is to support our registered nursing workforce who are in a substantive post.

1. Introduction

Nursing staff are access supervision as it provides us with the assurance, we are maintaining professional standards, and we are adhering to the policies and procedures our organisation has set out.
Clinical supervision supports in developing skills and knowledge, which enhances patient care and safety.
Accessing clinical supervision is an expectation of all registered nurses in the workforce.
The NMC Code (2018) sets professional standards, which clinical supervision helps to uphold:

- Prioritising people
- Practicing effectively
- Preserving safety
- Promoting professionalism and trust

Accessing clinical supervision enhances well – being and resilience. Learning from supervision can support with revalidation. It demonstrates professional growth and adherence to the code.
"The Royal College of Nursing (RCN) current position on clinical supervision as a means of reflective practice and potential conduit for the critical advancement of a contemporary nursing and midwifery workforce."

2. Supervision within BSMHFT

Within BSMHFT, supervision for Registered Nurses is currently provided in two formats, Regular Management Supervision (RMS) and Clinical Supervision.
All registered nurses will have a line manager who will either complete or delegate to a senior nurse.
The discussion that takes place in RMS is not exhaustive but is likely to include.

- General wellbeing of the member of staff.
- The day-to-day operational duties within the role
- Learning and development for the individual

Access to Clinical Supervision is set out in the RCN Workforce Standards (2022)

3. There are diverse types of clinical supervision.

Individual Clinical Supervision also known as 1:1 supervision.
This supervision takes place between the registered nurse and a clinical supervisor. This can take place virtually or face to face.

Peer Clinical Supervision

Peer supervision normally takes place within the same team. This is an option, as it provides staff with the opportunity to discuss/reflect on clinical situations. It can be seen as being structured as it will enable others to have the opportunity to discuss.

Other access to supervision

Reflective Practice

Professional Nurse Advocates (PNA) can also support with being able to access clinical supervision. PNA's are likely to use the A-EQUIP model in supervision.
There is a menu of opportunities available to our workforce where a professional Nurse Advocate can support with staff.

It is good practise to use a model of supervision. As an example, Hawkins Seven Eyed Supervision Model. However, it is at clinical supervisors' discretion should they use a model to follow.

Recording of Supervision.

It is the responsibility of the registered nurse to ensure they have regular access to clinical supervision. This should be a minimum of every six weeks.

It is the responsibility of the registered nurse to update their own traffic light detailing what type of clinical supervision they have had access to.

Registered nurses and line managers are aware via notification email clinical supervision has expired.

It is the responsibility of the registered nurse to report when they have, they not ben able to access clinical supervision. To do this the registered nurse must

- Report to line manager.
- Red flag on SAFECARE – inpatients only
- Complete an eclipse form.

Heads of Nursing and Allied Health Professionals are to be notified if clinical supervision is not happening.

Clinical Supervision should be allocated as protected time.

4. Confidentiality/Escalation

Clinical Supervision is considered a safe space for registered nurses. All registered nurses accessing clinical supervision should be made aware that there could be times where confidentiality needs to be breached due to the nature of concerns discussed. Examples of these are, unsafe practises, disclosure of safeguarding incidents that have not been reported appropriately.
This not exhaustive of examples

If it is deemed confidentiality needs to be breached, it is ideal for this to be discussed first between both parties, but there should be no time delay in the confidentiality being broken.

5. Reporting

Clinical Supervision compliance will be reporting in the Safer Staffing Committee each month.
The purpose of this will to be capture our compliance levels and how the committee can support with access supervision.

6. References

ICCS (2020). The 7 Eyed Model of Supervision: A Map to Navigate Your Coaching Supervision | ICCS. [online] Available at: **https://www.iccs.co/7-eyed-model-of-supervision/**
Nursing and Midwifery Council (NMC), (2018) The code: Professional Standards of Practise and Behaviour for Nurses and Midwives. London: NMC
Royal College of Nursing (RCN), (2022) RCN position on Clinical Supervision. London
Royal College of Nursing (RCN) (2021) Nursing Workforce Standards, Supporting a safe and effective nursing workforce. London

Appendix 7
Supplementary information for Allied Health Professionals (AHP)

1. Introduction

Supervision addresses the need to ensure that professional standards are maintained, and that policies and procedures of the organisation are adhered to. It also embraces the need for support for staff and is underpinned by learning from experience and reflective practice.

This framework applies to all HCPC registered AHPs and aligned roles including the support workforce. It outlines the requirements for

1.1. Management Supervision - mandatory

1.2. Profession Specific Supervision – mandatory (record as clinical supervision)

1.3. Non profession specific Clinical Supervision - recommended

1.4. Reflective Practice – recommended particularly at team and service level

2. Supervision within BSMHFT

Within BSMHFT, supervision for AHPs is provided in three formats through Managerial One to One Meetings (formerly known as RMS), Professional Supervision and Clinical Supervision.

2.1. Management Supervision - mandatory

Every member of the AHP workforce has a named Line Manager whom will provide **management supervision** and is responsible for:

- The day-to-day operational direction of staff
- Management and the implementation of employment policies
- Monitoring team member's performance, training and personal development

2.2. Profession Specific Supervision – mandatory (record as clinical supervision)

Every member of AHP staff will also have a named **professional supervisor** to whom they are accountable for their professional practice. In some cases, this person will also be their line manager but where AHP staff are managed within multidisciplinary/integrated teams this may not be the case. This may require an external arrangement which may require a contractual fee, or reciprocal agreement. Professional supervision should include, but not limited to:

- Escalating concerns regarding proficiency and conduct,
- Ensuring quality and safety of clinical intervention are evidenced and based on clinical reasoning.
- Identification of individual professional training and development needs

- Participating in the Values Based appraisal with their line manager.
- Facilitating peer support and development activities.

2.3. Non profession specific Clinical Supervision - recommended

Every member of AHP staff is also encouraged to have access to **clinical supervision** which aims to:

- Facilitate the recognition of clinical boundaries and the limitations of skill and competence.
- Boost morale and confidence and encourage the emergence, growth and development of good ideas and practice.
- Develop a greater degree of self-awareness, autonomy and self-esteem in a clinician's professional practice.

2.4 Reflective Practice This is encouraged for all AHPs to participate at either profession specific, AHP wide or service level.
This does not replace the requirement for individual profession specific supervision.

3. Documentation

Staff receiving the supervision are responsible for completing appropriate reflection and or supervision records. The HCPC Supervision template is recommended and can be found here **Supervision templates |**

Where there has been a specific discussion regarding a patient, a short entry into the Service User care record must be made in the Progress Notes. Details of the supervision do not need to be shared, but a record of the discussion can be useful in future reviews of practice and outcomes. E.g. "Discussed in clinical supervision" is sufficient.

4. Escalation

Where concerns arise from a supervision session, the Supervisor must communicate without delay to the Supervisee's line manager and also either the Head of AHP or Chief AHP as appropriate.

5. Further Support

AHPs can contact the Lead for Professional Development, or see the AHP Supervision pages on Connect at **https://bsmhftnhsuk.sharepoint.com/sites/connect-bu-alliedhealthprofessionals**

Example AHP Professional Supervision Agenda Items

1. Workload

- Overall workload
- Balance of generic / profession specific cases
- Balance individual / group work
- Number of allocations / targets
- Waiting lists

2. Clinical Issues / **Case Discussions** (cases pre-selected by supervisee)

- Individual cases requiring guidance
- Monitoring of professional practice:
    - evidence of clinical reasoning in decision making
    - clearly identified treatment goals/outcomes

3. Case Note Review (random selection of cases by supervisor)

- Completion of note audit
- Monitoring of professional practice:
    - evidence of clinical reasoning in decision making
    - clearly identified treatment goals/outcomes

4. Incidents, Complaints and Compliments Learning

5. Training / **CPD**

- Competencies and reference progression
- Progress in line with Personal Development Plan
- Attendance at relevant training/learning, action from same
- Maintenance of CPD portfolio
- Professional Networks

6. Service Development

- Audit/Evaluations/Outcomes

7. Evidence Based Practice and Research

8. Any Other Business

- Changes in circumstances
- Supervision of others
- Professional objectives review
- Service pressures
- Team issues and dynamics

AHP Professional Supervision Record

Matters Arising from Previous Professional Supervision

AGENDA

1. Workload
2. Clinical Issues / Case Discussions
3. Case Note Review
4. Incidents, Complaints and Compliments Learning
5. Training / CPD
6. Service Development
7. Evidence Based Practice and Research
8. Staffing
9. Any Other Business

No:	Item Discussed	Action/Timescale

Supervisee Signature: _____ **Date:** _____

Supervisors Signature: _____ **Date:** _____

Date of next Professional Supervision: _____

Appendix 8
Supplementary information for Pharmacy

Clinical supervision and reflective practice will be an increasingly important activity for pharmacists and pharmacy technicians as they develop more clinical activities and as pharmacists become prescribers and clinical practitioners. It is one important element of continuing professional development for pharmacists and pharmacy technicians. It also helps pharmacists and pharmacy technicians meet the Standards of Pharmacy Practice (GPhC 2017)

Individual pharmacists and pharmacy technicians are responsible for maintaining clinical supervision records. The following activities will be an essential part of pharmacists and pharmacy technician's clinical supervision.

1. Pharmacists and pharmacy technicians will participate in planned supervision of their clinical activities.
2. This will include all aspects of their clinical activities including clinical, educational, medicines information, patient advice, audit activities, quality improvement projects
3. The time allocated may depend on job role, job plan, working hours and will be agreed with line managers.
4. The minimum for any pharmacy professional will be one hour per month which can be done as part of a one-to-one clinical peer discussion or group supervision meeting with peers.
5. Newly qualified pharmacists or pharmacy technicians will have fortnightly clinical supervision discussions with directorate pharmacists or senior professional leaders to cover clinical issues, educational needs and other professional development needs.

In addition,

1. Senior professional leaders and directorate pharmacists should have appropriate training for the role.
2. Records should be kept of all clinical supervision activities
3. Clinical supervisors should apply models of supervision appropriate to their supervisory practice and build good supervisory relationships.
4. Clinical Supervisors should act in an ethical manner in line with GPhC standards.
5. Pharmacists and pharmacy technicians can request more frequent clinical supervision where there is an identified need. In addition, clinical supervisors can advise, recommend or arrange additional clinical supervision sessions if they identify needs.
6. Clinical Supervision should be provided face to face wherever possible. Use of videoconferencing may be appropriate in certain situations, for example, additional sessions where face to ace meetings cannot be arranged.

Additional Information

Standards for Pharmacy Professionals (2017). General Pharmaceutical Council

Revalidation and Renewal. General Pharmaceutical Council **https://www.pharmacyregulation.org/pharmacists/revalidation-renewal** (accessed 3rd December 2024)

Appendix 9
Supplementary information for physician associates

This guidance complements the Birmingham and Solihull Mental Health Foundation Trust's Clinical Supervision and Reflective Practice Policy, detailing the standards for Physician Associates (PAs) regarding supervision. Recognising the critical role of quality supervision, this document aims to ensure PAs practice safely while maintaining their emotional and psychological well-being.

Supervision Requirements for Physician Associates

- **Newly Qualified PAs**: Given their two-year clinical training, newly qualified PAs require structured supervision to ensure patient safety and professional development. They should have a named Clinical Supervisor, typically a senior doctor, responsible for overseeing their clinical activities. Regular supervision sessions should be scheduled, with the frequency determined by the PA's experience and competencies. Initially, this may involve daily check-ins, progressing to weekly sessions as the PA gains confidence and proficiency.
- **Experienced PAs**: For PAs with substantial experience, supervision can be less frequent but should still occur regularly to discuss complex cases, professional development, and any challenges encountered. Supervision can occur bi-weekly, or at a minimum of monthly sessions, with additional support available as needed.

Supervision Structure

- **Clinical Supervision**: Each PA should have a designated Clinical Supervisor who is a senior doctor within the team. This supervisor is responsible for providing guidance, support, and oversight of the PA's clinical practice.
- **Educational Supervision**: In addition to clinical supervision, PAs should have access to an educational supervision through their line manager to support their ongoing professional development, ensuring they meet the competencies required for their role.

Documentation and Record-Keeping

- All supervision sessions should be documented, noting the date, duration, topics discussed, and any agreed actions. Both the supervisor and supervisee should retain copies of these records. Supervision should also be recorded in the Trust’s learning and development system to monitor compliance and facilitate audits.

Peer Support and Continuing Professional Development (CPD)

- PAs are encouraged to participate in peer support groups, providing opportunities for shared learning and reflection. Engagement in CPD activities is essential to maintain and enhance competencies, with supervision sessions serving as a platform to identify and plan for these developmental needs.

Integration with Trust Policies

- Supervision for PAs should align with the Trust's appraisal and revalidation policies, ensuring a cohesive approach to professional development and quality assurance.

Appendix 10
Supplementary Information for Social Work

Reflective practice is a key cornerstone that Social Work England have written into their professional standards for registered social workers.

BSMHFT acknowledges reflective practice is important for supporting forensic social work and social supervision practice under the Ministry of Justice. (Social Work England, 2020).

Reflective practice should be used as protected time, usually with a member of staff from BSMHFT, to discuss an individual social workers experiences as a way to increase self-awareness and develop a conscious knowledge base at both macro and micro levels, while reflecting on their own psychological health and wellbeing.

Forensic social work reflective practice should adhere to BSMHFT reflective practice Policy (C08) which is a separate requirement from Regular Management Supervision policy (HR17)

Forensic Social Work

Forensic social workers operate in a range of contexts, both in secure inpatient settings and in community teams supporting, and supervising individuals subject to Conditional Discharge following Restriction Orders.

The Mental Health Act 1983 (amended 2007) is the main legal framework under which individuals are treated.

Forensic Social Workers need to have a well-developed knowledge and skill base to negotiate the various legal interfaces, considering complex issues such as risk and public protection, and balancing aspects of human rights.

Forensic Social Work: Key Areas of Reflective Practice

1) Ministry of Justice: Social Supervision

'The social supervisor should anticipate the patient may resent the continuing control over his / her life imposed by a conditional discharge and fear the 'policing' role of the supervisor. (MoJ: 2023)

- Carrying out the role of Social Supervisor following Ministry of Justice guidance
- Maintaining contact with a restricted community patient following MoJ guidance
- Writing and submitting reports to the Ministry of Justice within MoJ timescales
- Implementing MoJ warrants
- Managing risk through MAPPA
- Victim Liaison Service
- The Mental Health Casework Section expects all professionals working with restricted patients in the community to adopt a high level of *professional curiosity*. This should be maintained throughout the period of discharge, regardless of its duration. Supervising teams must use the full range of their knowledge, abilities, and opportunities to engage with patients in the community, actively reviewing their

compliance with conditions of discharge and not become complacent that because a patient has been discharged for some time, and appears settled, that their risk has dissipated. (MoJ: 2023)

2) Mental Health Tribunals

- First Tier Tribunals: Supplying Social Circumstances Reports and attending Tribunal hearings.
- Managers Hearings: Supplying Social Circumstances Reports and attending Manager's hearings.

3) Safeguarding Adults under the Care Act 2014

- Undertaking safeguarding role under BSMHFT policies and procedures
- Ensuring appropriate referrals are made to Adult Services for s42 and undertaking enquiries on behalf of Local Authorities if requested.

4) Hospital Discharges

Making referrals for assessments under Care Act 2014 / Section 117 of the Mental Health Act 1983.

- *AMHP 'reflective practice' should be provided by Birmingham City Council under the terms of BSMHFT / BCC Memorandum of Understanding.*

Useful Documents:

Mental Health Act (1983); Code of Practice

Ministry of Justice (2003): Conditionally Discharged Patients: Supervision and Reporting

Appendix 11
Supplementary information for Advanced Clinical Practitioners

Supporting Advanced Clinical Practitioners who are developing in their roles either in training or post qualification through high quality workplace supervision is essential. It requires consideration for not only professional development but also to ensure safe, effective care for service users. For those working towards or in Advanced Clinical Practice roles supervision needs to be an integrated multi-disciplinary approach. Advanced Clinical practitioners can come from multiple professional backgrounds therefore these supervision requirements should be considered in conjunction with other supplementary information for their core professions within this policy.
Advanced Clinical Practitioners will have an integrated approach by having multiple supervisors who will be equipped to support the breadth of development necessary across all four pillars, Clinical, Education, Research and Leadership and Management. To enable an integrated approach, it is recommended an Advanced Clinical Practitioner will have a co-ordinating Educational Supervisor as well as Associate Workplace Supervisors. Education Supervisors will provide a consistent approach to the Advanced Clinical Practitioners practice development, guiding them from educational studies to professional practice. The below is not exhaustive of the requirements of an Education Supervisor however they are the core elements.

The Education Supervisor will:

- Have in depth knowledge and understanding of the Advanced Clinical Practitioner's role in their speciality, pathway or setting.
- Have an advanced awareness of the range of potential professionals and practice scope of eligible professions.
- Any pathway or speciality specific standards, competencies or capabilities required for the Advanced Clinical Practitioners role.
- Help the Advanced Clinical Practitioner to identify associate workplace supervisors who can support speciality or pathway practice competencies and capabilities.
- Maintain an overview of the practitioners practice and educational progress against agreed learning/Job plan and local/area specific requirements.

Example of Educational Supervisors (Not an Exhaustive list):

- Professional Lead for Advanced Practice
- HEI Personal Tutors
- Advanced Clinical Practitioners (Not in your area or your clinical supervisor)
- Education Leads in the organisation who understand Advanced Practice.

The Associate Workplace Supervisors are practice based practitioners who are advanced and experienced in practice-based education and supervision. The Associate workplace supervisor will be appraised with the multi-professional considerations associated with Advanced Clinical Practice development and supervision. This will include however is not

limited to the Advanced Clinical Practitioners management and clinical supervisor. The below is not exhaustive of the requirements of Associate workplace supervisors however are the core elements.

The Associate Workplace Supervisors will:

- Work collaboratively with the Education Supervisor and the Advanced Clinical Practitioner to support continuing development of specified competencies and clinical capabilities in practice that relate to the role.
- Have completed their own professional development with a focus on supervision and practice-based education.
- In depth understanding of all four pillars of Advanced Practice to support the ongoing development of the Advanced Clinical Practitioner in clinical practice and improve quality of care.
- Be based within the Advanced Clinical Practitioners speciality/clinical area and spend a minimum of 3 hours per week with the Advanced Practitioner when they are in training.
- Upon qualification the Advanced Clinical Practitioner and their associate workplace supervisor will decide on the frequency and duration of their supervision sessions based on the developing practitioners' capabilities and competencies which will be outlined in their job plan. There will be a minimum standard of every five weeks in the first-year post qualification which will be reviewed at each supervision session following progress.

Examples of Associate Workplace Supervisors (Not an exhaustive list):

- Consultant Psychiatrist (Clinical Practice)
- Substantive Middle Grade (Clinical Practice)
- ACP who has been qualified 3 years (Clinical Practice)
- Matrons (Line Management)
- Clinical Nurse Managers (Line Management)
- Head of Nursing & AHP (Line Management)

Continuing Professional Development and Reflective Practice

The Advanced Clinical Practitioner and their nominated supervisors will work collaboratively focusing on providing support, feedback, sharing and enhancing knowledge and skills to support the ongoing professional development of the Advanced Clinical Practitioner. There will be a shared understanding of the supervisory sessions where open, honest reflection and communication will take place to support development and lead to better care.

Documentation and Record Keeping

All supervision sessions will be documented and be in line with the Advanced Clinical Practitioners Annual development review, Job plan and ongoing needs. Both the Advanced Clinical Practitioner and the supervisor will keep a record of this and update any plans where required. It is also important to ensure supervision sessions are recorded in

the organisations learning and development systems, to track progress, ensure oversight and accountability and support quality improvement.

Alignment with Trust Policies and Revalidation

Supervision for Advanced Clinical Practitioners will incorporate the organisations appraisal and when available revalidation process in line with national regulation requirements. This ensures a linear contribution to a high-quality approach to ongoing professional development in advanced level practice.

Useful Documents:

https://advanced-practice.hee.nhs.uk/our-work/supervision/
https://advanced-practice.hee.nhs.uk/resources/supervision-and-assessment-resources/
https://advanced-practice.hee.nhs.uk/multi-professional-framework-for-advanced-practice/
https://advanced-practice.hee.nhs.uk/our-work/credentials/
Health Education England's (2020) Workplace Supervision for Advanced Clinical Practice.

Appendix 12
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

They, 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 saved on a secure network drive.

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 not to have a recording made, this will not affect your treatment in any way.

If you do agree:

[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**	

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

THANK YOU VERY MUCH FOR TAKING PART

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

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."

Appendix 13

Recording clinical supervision and reflective practice on Traffic Light System Guide

If you work clinically, engaging with direct clinical interventions with patients you will have to have clinical supervision every 4-6 weeks with a minimum requirement of every 8 weeks. You will also be expected to engage in regular reflective practice groups and record compliance.

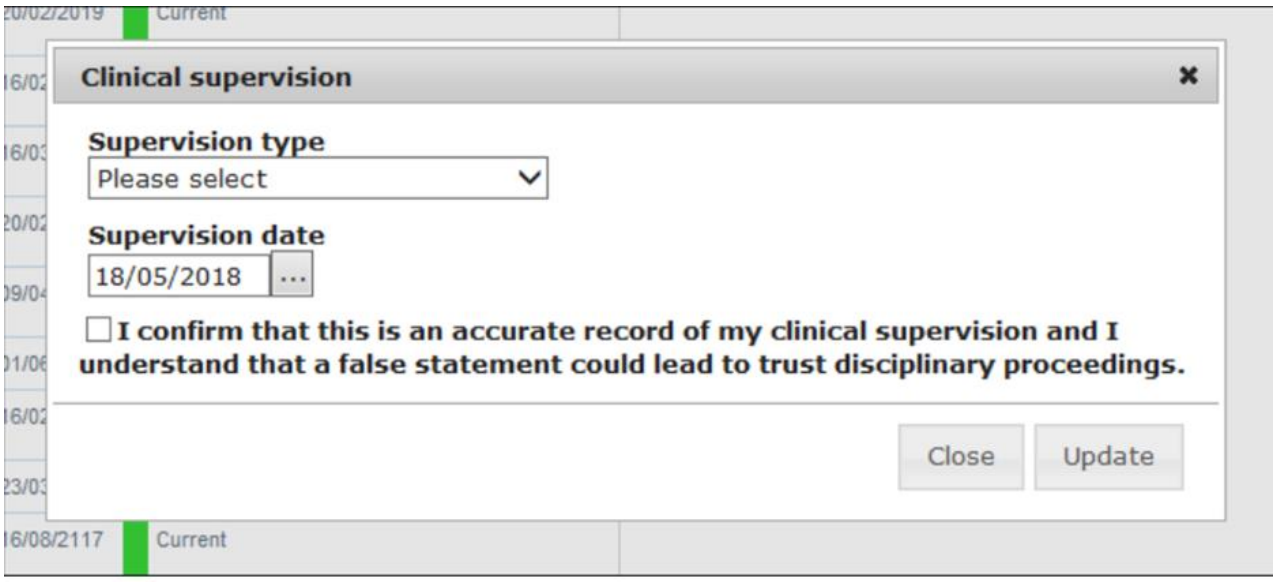
If you are required to have clinical supervision you will see a competency called 'Clinical supervision' on your training statement under the general heading 'Role Essential Mandatory Training':

As shown in the example above when you first see the Clinical supervision competency on your training statement, your traffic light will be showing amber, indicating it is approaching expiry. Once it has expired the traffic light will turn red.

Recording a clinical supervision

To record a clinical supervision, you must click on the icon on the clinical supervision line on your training statement:

Having clicked the icon, you will see the following pop-up dialogue appear:



You can use this to record your supervision event.

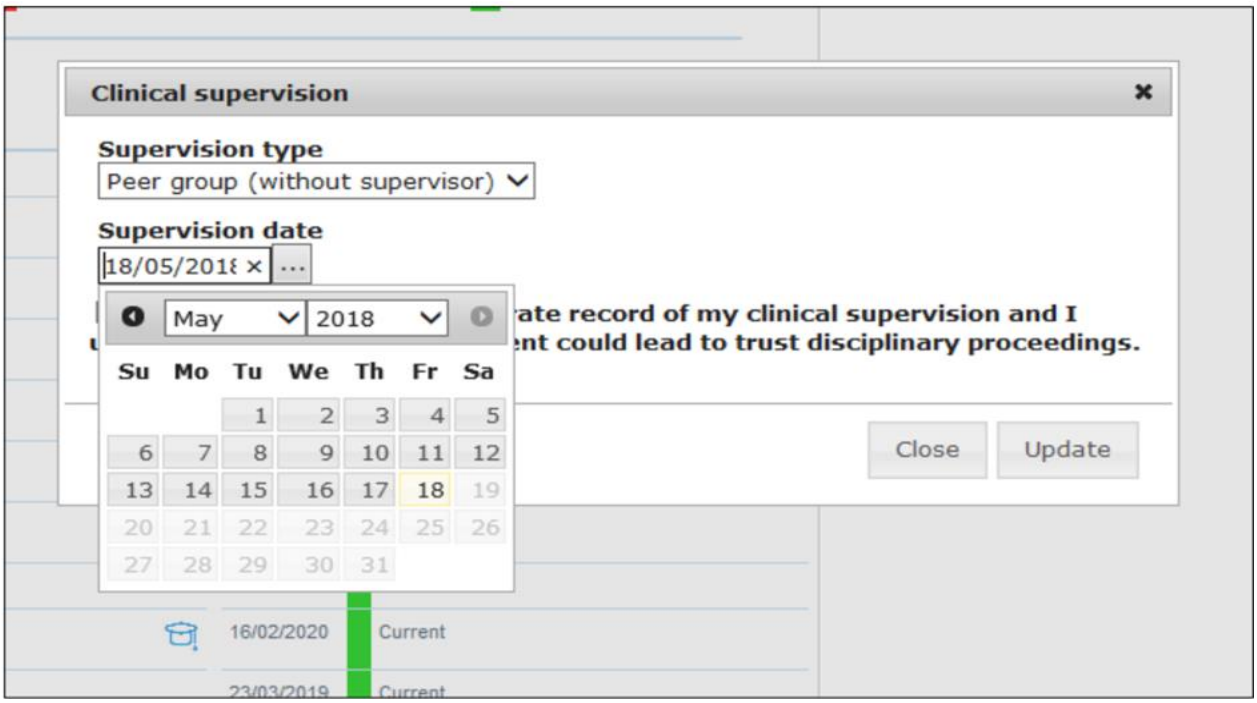
You must first select the type of supervision you undertook; you have the following choices:

Supervision type addition details

Individual (with supervisor)	You must also either specify another member of staff as the supervisor. This is done by invoking a staff search by starting to type the name of the supervisor in the Supervisor field. As you type the system will match your input to possible matches. Once you see a match you can click on the name from the list to select it. If the search matches a single name, then the system will automatically pick it. If the supervisor was not a member of staff, for example they were an external person then you can type in their name into the External supervisor input field. You must either select a **supervisor** or input an **external supervisor** or both if you were supervised by both a Trust member of staff and an external supervisor.
Group (with supervisor)	As with the case above you must either select a supervisor, input an external supervisor or both.
Peer group (without supervisor)	For this selection you do not need to specify the supervisor.
Other	You must specify what other is and then specify a supervisor, an external supervisor or both.

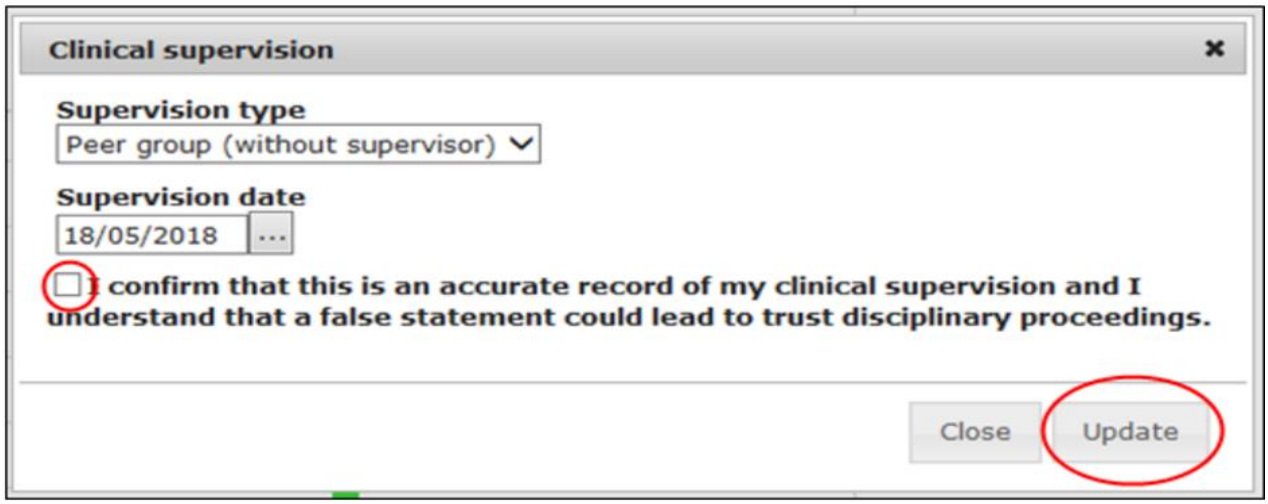
Depending on the type of supervision you are recording the dialogue will require you to specify additional details.

Having selected a supervision type and then specified the additional details required for that supervision type you must input the date that the supervision took place on. This is done by either typing in the date in the format dd/mm/yyyy e.g. 09/07/2018 or using the calendar widget that pops up when you click the button next to the date input box:



The date input will default to today's date; if the supervision took place on the same day as you are recording it then you do not need to change the date.

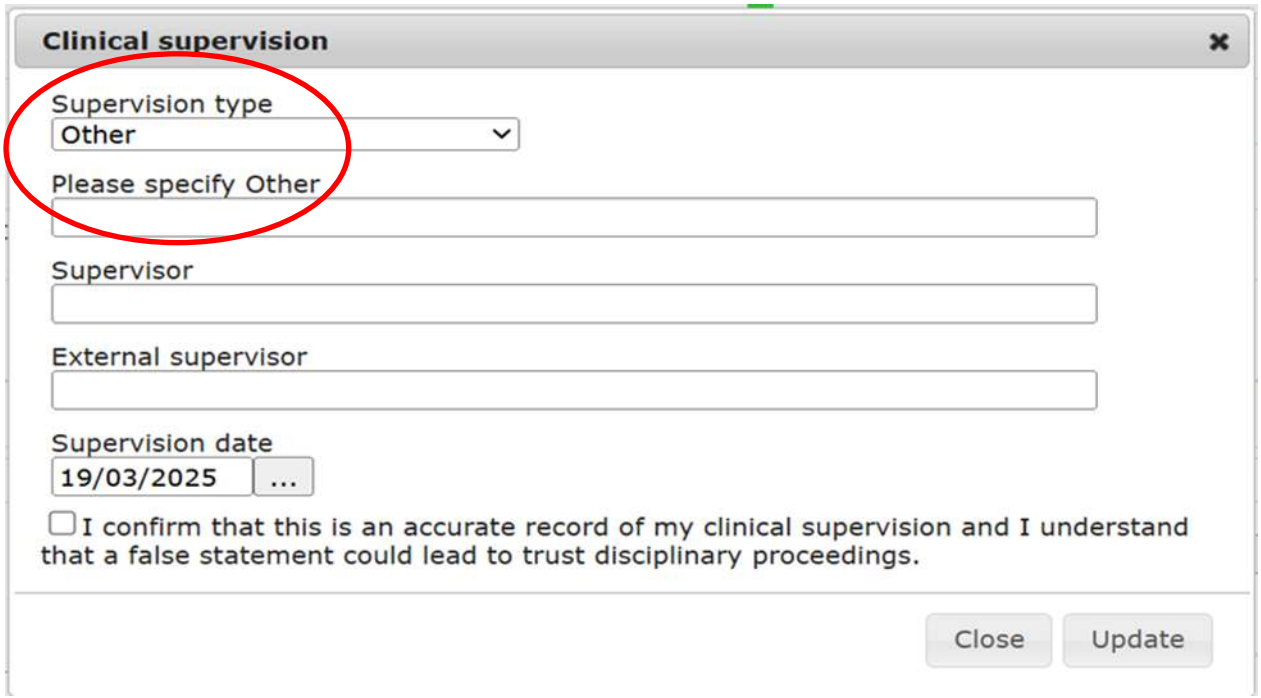
Having input all the details of the supervision you must check the check box next to the declaration and then click the **Update** button to save the supervision record:



Recording Reflective Practice

To record reflective practice compliance, click on the icon on the clinical supervision line on your training statement:

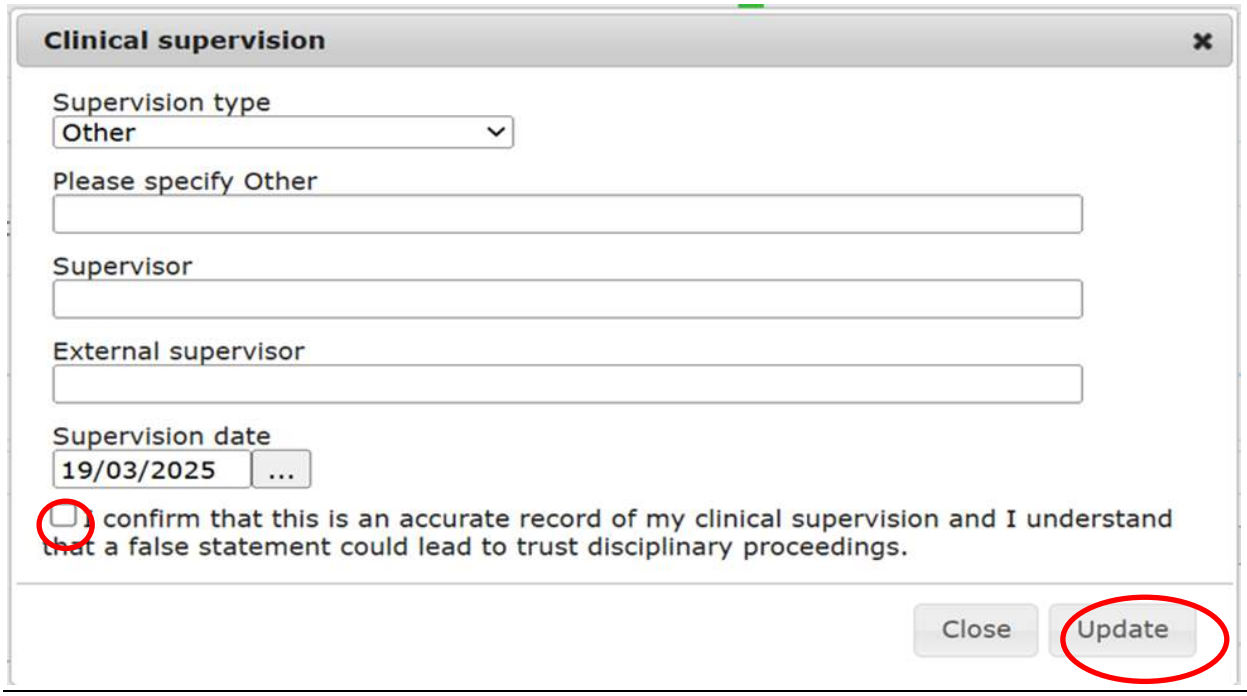
When the pop-up dialogue appears, select ‘other’ in the drop-down menu and write ‘reflective practice’ in the ‘please specify other’ box and complete supervisor (facilitator) details:



Input the date that the reflective practice took place on. This is done by either typing in the date in the format dd/mm/yyyy e.g. 09/07/2018 or using the calendar widget that pops up when you click the button next to the date input box.

The date input will default to today’s date; if the reflective practice took place on the same day as you are recording it then you do not need to change the date.

Having input all the details of the supervision and the name of the supervisor (either internal or external), you must check the check box next to the declaration and then click the Update button to save the record: -



Clinical Supervision Awareness Module

All staff with roles required to have clinical supervision should complete the core supervision module on the learning zone. The session provides awareness of what clinical supervision is, it's role and purpose. The module can be accessed via the graduation hat icon on the clinical supervision line on your training statement.