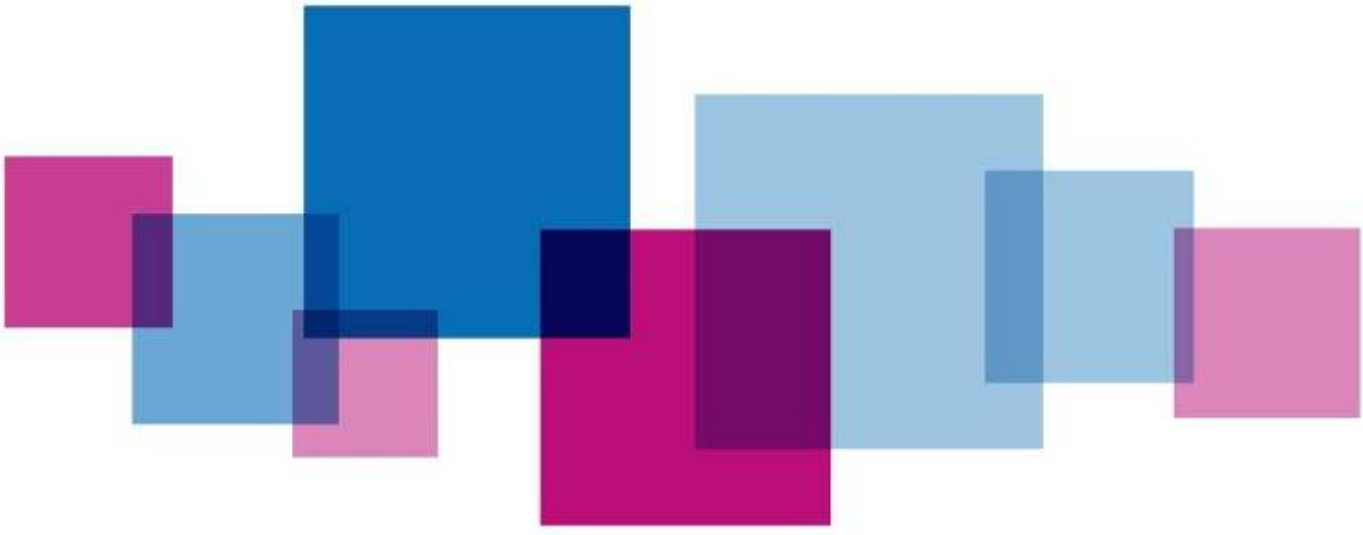
NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Clinical Supervision Policy

Supporting registered professionals to oversee the delivery of safe and effective clinical care

July 2021



Shaping better health

Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy ref no:	73
Responsible Executive Director:	Rosi Shepherd, Director of Nursing
Author and Job Title:	Denise Moorhouse, Associate Director of Nursing and Quality Renata Jerome Head of Funded CHC Operations
Date Approved:	July 2021
Approved by:	Governing Body
Date of next review:	September 2022

Policy Review Checklist

	Yes/ No/NA	**Supporting information**
Has an Equality Impact Assessment Screening been completed?	Yes	Appendix F
Has the review taken account of latest Guidance/Legislation?	Yes	See references
Has legal advice been sought?	N/A	
Has HR been consulted?	N/A	
Have training issues been addressed?	Yes	Learning and development policy
Are there other HR related issues that need to be considered?	No	
Has the policy been reviewed by Staff Partnership Forum?	No	

	Yes/ No/NA	Supporting information
Are there financial issues and have they been addressed?	Yes	Funding will be required to fund training for staff
What engagement has there been with patients/members of the public in preparing this policy?	N/A	Staff have been engaged through various meetings and engagement events where clinical supervision was discussed
Are there linked policies and procedures?	No	
Has the lead Executive Director approved the policy?	Yes	Rosi Shepherd, Director of Nursing
Which Committees have assured the policy?		Draft policy considered at Funded care Delivery Group, Nursing and Quality Business meeting, Policy Review group and Quality committee
Has an implementation plan been provided?		Appendix 10
How will the policy be shared with staff?	Yes	Cascaded through training & implemented at service level
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?	Yes	Bi-annual audit of sessions undertaken at PDR meetings. Staff responsibility to keep record with themes. Also required for CQC if requested. This will be managed through the N&Q directorate
Has a DPIA been considered in regards to this policy?	N/A	
Have Data Protection implications have been considered?	Yes	Staff to keep own records and confidentiality considerations included in process.

Table of Contents

Supervision

1 Introduction

Clinical Supervision within the workplace was introduced as a way of using reflective practice through shared experiences as part of continuing professional development by registered professionals. It is supported by not only professional governing bodies such as the NMC who mandate it for revalidation purposes, but by employers as a means to aid personal and professional development in staff.

Indeed supervision has been described as 'a formal process of professional support and learning which enables individual to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations.' (NHSE 1993).

The functions of clinical supervision have been described by Proctor (1986) as:

• **Formative-** the educative process of developing skills

• **Restorative**- supportive help for professionals working constantly with stress and distress and;

• **Normative**- concerned with developing competent practice, the internalisation of professional ethics, standards, self-management and monitoring.

Supervision it is not a management led tool and is different to routine one to one reviews with your line manager, nor is it a tool to be "delivered" by an organisation in response to performance concerns, rather, it is facilitated support for the development and improvement or maintenance of high quality clinical and professional practice. This is different to the measurement and sign of clinical competencies within the workplace, but can be used alongside this to support staff development. Supervision is not directed learning, but facilitate reflection by the individual, allowing time to explore their strengths and areas for development.

BNSSG CCG is committed to ensuring that all registered professionals working within the CCG have the opportunity to access appropriate clinical supervision sessions.

1.1 BNSSG CCG Values

This Policy is in-line with BNSSG CCG Values:

- We act with integrity,
- We support each other,

- We embrace diversity,
- We work better together,
- We strive for excellence,
- We do the right thing.

Supporting staff and investing time in their personal and professional development will allow them to feel valued and by aiding reflection will allow them to explore areas of their own practice, identifying areas of strength and areas which may require further development. It is also useful in allowing staff to debrief and explore issues around challenging and difficult aspects of their role which may otherwise cause increased stress and strain on them as individuals, ultimately impacting on their mental and physical wellbeing. It should be noted that this is not a counselling opportunity, nor intended to replace the Employee Assistance Programme which is provided by the CCG for staff who are experiencing stress or distress at work.

2 Purpose and scope

This policy provides a framework for all registered nurses, allied professionals, pharmacists and other registered staff, who are delivering or planning patient care and working for BNSSG.

For the purpose of this policy the term 'clinical staff' is used as a collective term to describe the above groups. The term "staff" will be used for inclusion of non-clinical staff working within BNSSG CCG.

It is recommended that independent contractors (including BNSSG Bank Staff) and social service partners abide by the principles of this policy as good practice.

3 Responsibilities and Accountabilities

This policy describes the responsibilities of BNSSG CCG as employers, managers and staff, setting out a framework for the process of undertaking and recording clinical supervision.

The policy recognises the range of formats for supervision and that supervision in any format is not to be punitive, management led with set objectives related to performance or capability or to be used as a "control measure". Any issues relating to performance, capability or attitude should be addressed under the relevant policy.

Supervision does not replace the necessity for ensuring "managerial supervision" is in place or the support required for individuals through one to one's with line managers and the policy recognises the importance of the line management relationship between

staff in ensuring effective performance with achievement and maintenance of core competencies for each role. Care must be taken when engaging staff in clinical supervision that they are aware if the purpose is to facilitate reflection or to assess their competency, and a clear distinction must be made.

All clinical and some non-clinical staff will be required to participate in competency led supervision and this is to be considered separate from the provision of clinical supervision and more closely linked to the policies pertaining to staff learning and development.

BNSSG is therefore committed to ensuring clinical staff engaging in clinical supervision have protected time, trained facilitators, confidentiality assured (with caveats as below) and a clear recording mechanism to allow audit of engagement.

The CCG recognises that some roles undertaken by non-clinical staff require exposure to cases and material which can be distressing. It is important that line managers are sensitive to this within their teams and that they address this with colleagues in one to one reviews. All CCG staff have access to the various methods of support including Employers Assistant Programme (EAP) and Mental Health First Aiders etc.

BNSSG CCG will be responsible for:

• Ensuring an appropriate framework for supervision is in place for all clinical staff taking into account the diversity of registered professions and roles.

• Championing the importance of supervision in all registered staff groups, offering supervision sessions with protected time to allow them to reflect and explore their own abilities and strengths.

• The provision of training and development for clinical staff to enable them to act as clinical supervision facilitators and with the expectation that they do so. This is to include the identification and training/update of individuals who currently provide supervision within BNSSG CCG.

• Ensuring staff have the opportunity to share learning outside their team or individual supervision sessions if they feel others may benefit from their experiences and confidentiality is not breached, or all participants agree.

• Linking systems of supervision to clinical governance and performance management where safety, safeguarding or quality issues are identified which need to be acted upon. Otherwise confidentiality of themes discussed will be maintained with awareness of the Caldicott Principles and the Data Protection Act.

All managers of registered professional are responsible for:

• Championing the use of supervision within their teams, and that clinical supervision is mandatory for clinical staff.

Managers are required to create a rota or other measured approach to ensure a minimum of 3 clinical supervision sessions are facilitated per year.

• Ensuring appropriate arrangements for supervision are in place for their teams and providing protected time and links to trained facilitators. Identifying and addressing any gaps in capacity or provision that may hinder this.

• Ensuring key staff are identified and supported to access training and development to enable them to act in a supervisory capacity.

• Ensuring appropriate records of supervisory arrangements are kept by the individual staff member and an overview of dates, times and duration of sessions by the manager. It should be noted that managers have no automatic right to know the contents of the session as this is held confidential between the supervisor and supervisee; however, if discussed outside the session the same duty of confidentiality and caveats will stand.

• Ensuring staff are encouraged and supported to share with other colleagues learning points from their own sessions where appropriate.

• Supporting staff in highly specialised roles to identify and access appropriately trained supervisors.

Registered professionals are responsible for:

• Actively engaging in supervision activities in accordance with their Code of Professional conduct, guidance from their own professional body and/or the supervision arrangements in place for their service area.

• Ensuring they access supervision in the most appropriate way for their personal needs and record attendance at sessions, date, time, duration and themes for evidence in revalidation (e.g. NMC) and audit by visiting bodies (CQC). They must also notify their line manager of attendance, but do not have to share the content of their supervision session merely, their attendance and any identified learning.

• Highlighting key issues which would be appropriate to share with colleagues to facilitate wider learning and service development.

• Duty of disclosure if participating in a supervision session where there are safeguarding, legal or other concerns raised that need addressing under other policies. Please seek help from your manager if unsure.

Where trained in the facilitation of clinical supervision, the CCG has an expectation that sessions will be are offered by these trained individuals.

4 Definitions and Application

The Service / Team Leads will determine the supervision arrangements most appropriate for their staff and the working environments within which they are employed. The following are likely formats for supervision however it is acknowledged that alternative formats may need to be utilised:

Examples of clinical supervision are:

a) **One to one supervision with a trained supervisor from your own discipline**. (The supervisor does not need to be more senior as this is not management led but facilitated reflective practice). This can be helpful when exploring service-related practice issues that are more specific to role.

b) **One to one supervision with a supervisor from a different discipline or area of practice.** (The supervisor does not need to be more senior as this is not management led but facilitated reflective practice). This can be helpful when exploring more professional practice issues to have a new perspective on discussion and facilitate wider thinking and application.

c) **Group Supervision**

Group supervision can be uni-professional, multi-professional or multiagency. It is recommended that the ratio of supervisor to supervisee is limited so that all parties can contribute. Whilst there is no definitive number, it is thought that a maximum of 10 per group is optimal. It can be helpful to have a common service theme within the group if discussion service-related practice issues and to ensure that all participants are coming with the same expectation and understanding of principles. Therefore, setting of ground rules is most important before any discussion and reflection begins.

d) **Peer Supervision** can be between two members of clinical professional staff in similar roles or similar grades within a profession or from a supervisor from a different health or social care background. This approach can be used where staff are working together and one member of staff can then facilitate the reflective session for the other. It can develop from a peer debrief after a challenging event or in peer discussion about clinical approach to practice that has arisen.

e) **Managerial Supervision (NB: this is not part of Clinical Supervision but is included for comparison purposes)**

This is the practice of line managers and individual staff members reviewing work on a regular basis to ensure clinical competence and confidence in staff. This also includes undertaking identification of capability issues and subsequent performance management. This process is undertaken to ensure employees are meeting the objectives of their department and of the organisation and ensuring that their future

training and development needs are identified. As previously noted, Clinical/Non-Clinical supervision should be separated from the line management process and should be undertaken as a complementary clinical / professional development process not as part of formal learning and development or performance management processes. This includes separating supervision from matters relating to pay, promotion and discipline.

Access to Supervision

a) A supervision matrix will be devised by the team leader for each area where supervision has been identified as a requirement in conjunction with the team manager. Although the formulation of the matrix can be delegated, the responsibility for ensuring adherence to the matrix sits with the team manager and individual clinical staff who have a requirement to attend a minimum of 3 facilitated sessions a year.

b) All clinical staff working within BNSSG CCG are required to engage in management supervision. This should include competency-based supervision, face to face meetings with patients and clinical discussion. These sessions should not be counted as the reflective supervision sessions but may compliment them and lead onto reflective supervision if agreed by both parties. Thereby a clear distinction can be drawn between clinical supervision and management supervision of competency.

c) It is recognised that some staff may be required to engage in more sessions than this in accordance with their professional guidance.

d) All clinical staff will be required to participate in clinical supervision. It is essential that all clinical supervisors are in receipt of clinical supervision themselves and can demonstrate competency in this role.

Supervision following Capability Concern

a) If supervision is recommended for someone who is on the performance and capability framework, clarification should be sought involving HR and a distinction drawn between managerial supervision of capability issues, and reflective practice to aid the member of staff to explore, reflect and identify within their own areas of practice. As previous stated, clinical supervision in its true sense is not a management or performance tool and should not be used as such but may be offered as a supportive measure to allow the staff member time to reflect and build on their abilities.

Management supervision in this context should be used to measure capability and this person should not perform unsupervised until deemed competent performing specific tasks (applicable to clinical staff only). See: BNSSG CCG Management of Performance (capability) policy.

Advice can be sought from a member of the clinical directorate and HR if further guidance is required.

Supervision Contract

a) Confidentiality between supervisor and supervisee is to be maintained unless there are clear reasons for breaching this such as duty of care under Caldicott Guidelines, the Data Protection Act or similar circumstances whereby non-disclosure may lead to continued unsafe or harmful practice or events continuing.

Confidentiality cannot be maintained if it is clear that either party has broken:

• The law

• BNSSG Policies

• Their professional code of conduct

BNSSG CCG can provide further specific advice regarding confidentiality through a clinical line manager, the safeguarding team or HR. If uncertain staff are advised to seek support as unauthorised breaches may/will be dealt with via BNSSG disciplinary procedure depending on severity of breach.

b) Documentation as to the approach to supervision agreed, the date, time, duration and theme should be recorded by both supervisor and supervisee. It is responsibility of the supervisee to ensure clear contemporaneous account of reflection is stored and available as evidence to NMC for revalidation purposes and also to the CQC if requested during a visit. However, this document remains the property of the individual and they retain the right to withhold the contents, sharing only the evidence of engagement if requested.

c) The expectations and responsibilities of the supervisee can be found at **Appendix B**

d) The expectations and responsibilities of the supervisor can be found at Appendix **C**

Record Keeping

a) A record of supervision will be completed jointly by the supervisor and supervisee and the supervisor will keep their own records of supervision sessions. Individuals will keep copies in their personal portfolios. The appropriate BNSSG Supervision Form can be found at **Appendix D.**

This form can be used as presented; the free-text box "feedback" is expected to vary from profession to profession and dependent on whether the role is clinical or Non-Clinical. The section titles in the left-hand column of the form should not be changed.

b) As managers are responsible for ensuring appropriate records of supervisory engagement are kept, a suggested appropriate Audit Form can be found at **Appendix E.**

5 Training requirements

Training to support individuals to undertake the role of clinical supervisor can be accessed through support provided by the CCG. Refer to the Learning and Development Policy for arrangements to access support.

Staff are required to attend a recognised training course and remain competent in this skill in order to practice as a clinical supervisor within role with BNSSG. If competencies lapse or the individual has concern as to their effectiveness in this capacity, this should be discussed with their line manager at the earlier opportunity and they should refrain from undertaking this role until resolved.

BNSSG CCG will keep a record of all trained clinical supervisors organisation wide to allow cross facilitation and support to develop. This is particularly important for teams and individuals that have worked in isolation prior to the increase in clinical staff within the services.

6 Equality Impact Assessment

Equality Impact Assessment has been completed and located in Appendix F.

There is no anticipated negative impact on any member of staff or group identifying with protected characteristics – this policy and process is designed to be inclusive and supportive in personal and professional development.

7 Implementation and Monitoring Compliance and Effectiveness

Implementation of this policy will be monitored through line managers and reported annually through Strategic Finance Committee which in turn, reports into Governing Body.

Individual engagement with clinical supervision will be monitored by line managers and staff will be required to keep evidence of their clinical supervision sessions as above.

8 Countering Fraud

The CCG is committed to reducing fraud in the NHS to a minimum, keeping it at that level and putting funds stolen through fraud back into patient care. Therefore, we have given consideration to fraud and corruption that may occur in this area and our responses to these acts during the development of this policy document.

There is no expected financial risk to the organisation other than time dedicated for engagement with clinical supervision being utilised for other purposes and fraudulently claimed as completed. This will be monitored and reported with appropriate disciplinary and or criminal action if highlighted as occurring.

If during supervision sessions evidence of fraud or potential fraud are disclosed then this will necessitate management in: BNSSG Fraud and Bribery Policy.

9 References, acknowledgements and associated documents

British Psychological Society (2006) Continued Supervision Policy Document

Chartered Society of Physiotherapists (2003) A Guide to Implementing Clinical supervision for qualified and Associate Members

Department of Health (1999) Clinical Governance in the New NHS Health Professions Council (2007) Standards of Proficiency

McGill and Beaty (1992) Action Learning: A Practitioners Guide. Kogan Page Ltd

NHS Executive (1993) A vision for the future: the nursing, midwifery and health visiting contribution to health and health care. London:

Nursing and Midwifery Council (2006) Clinical Supervision

Proctor B (1991) Supervision: a cooperative exercise in accountability. In Marken M, Payne M (eds) Enabling and ensuring: supervision in practice. Leicester. National Youth Bureau and Council for education and Training in Youth and Community Work.

10 Appendices

Appendix A

An example format for Group Supervision:

Introduction and Aims

This type of supervision is based on a number of practitioners who agree to work together and can be additional to existing professional supervision structures. This may be used for example with the non-medical prescribers. Groups of up to 10 practitioners work together, either from the same interdisciplinary team or clinicians from different service areas. Clinicians choose an issue which they wish to reflect on e.g. complex, clinical situation, ethical dilemmas. The group decide how often and for how long they will meet.

The aims of group supervision are to:

1. Provide an opportunity for staff to review and clarify issues, within a safe but professionally challenging environment.
2. Provide staff with documented learning or action points.
3. Promote reflective practice.
4. Identify, share and standardise good practice.
5. Provide a forum for staff and service development.
6. Promote evidence based practice/benchmarking with other clinicians and services.
7. Explore the management of risk.
8. Provide a mechanism for documenting gaps in service.

Process

This model is based on McGill and Beaty's "Action Learning Sets" (1992).

Action Learning Sets provide a safe, supportive and challenging environment characterised by trust and confidentiality where set members work on issues and solve problems through a process of reflection and action. Thereby it is problem solving in approach rather than allowing the group to dwell on issues without moving forward.

Action learning gives particular structure to a group which, although very simple, radically alters the normal flow of normal conversation. The presenter presents their issue to the group in order to reflect on it and design ways of progressing with it.

The group members act as supporters, listening, observing, commenting and questioning the presenter with the aim of helping in the exploration of the issue and in forming new action points.

The **facilitator** enables this interaction to be most useful to the presenter who listens and notes any useful ideas or comments and takes these forward. They do not "answer" the group as such but use them as prompts to next steps.

Action or learning points are written up afterwards by the facilitator, as are any areas identified as unmet need.

If any areas of unmet need are identified the group agree as to which Team Leader/ Service Manager should be informed.

Because in "normal" interactions within groups, people rarely focus on one issue at a time, the following structure and time scale for presenting are suggested:

8 minutes - member of staff discusses and presents their issue to the group, no-one else speaks.

8 minutes - discussion amongst group, presenter listens and does not speak. Group asks reflective questions and discusses with each other but does not address the presenting member of staff. One person takes notes for the presenter and the presenter can make their own notes.

5 minutes - clarification where the presenter selects one question arising from the discussion and explores this with the group discussing more in depth that aspect.

5 minutes - presenter gives feedback, if any for next meeting Group listens and action

With this format 1-2 topics can be presented per hour session, depending on whether process and ground rules need to be addressed first. A rolling rota can be developed for which staff are presenting at which sessions.

Appendix B

Expectations of the Supervisee in Clinical Supervision

• To be treated with respect as an equal partner in the supervision relationship

• Set the agenda to meet your own professional needs

• Confidentiality, with the exceptions of revealing anything that breaks the law, trust policy, professional code of conduct or may allow safeguarding concerns to go unchecked.

• Protected time, a minimum of two hours at least three times per year, for clinical supervision (and management supervision) respectively

• Protected space, in private with no interruptions barring emergencies.

• Talk about any difficulties and vulnerable feelings, if you so wish, without being criticised for having or expressing these thoughts.

Responsibilities of the Supervisee in Supervision

• Take responsibility for contacting your Clinical Supervisor to book the required supervision sessions into your diaries. Protecting time by giving the appointments a high priority and turning up punctually

• To attend a minimum of two hours of Supervision at least three times per year and to provide evidence to their line manager as requested and at your annual performance appraisal (applicable to clinical staff).

• Preparing for Supervision by identifying clinical/professional issues upon which you wish to reflect

• Arrange cover as appropriate so you can attend clinical supervision supported by your line manager.

• Make and follow through action plans that arise from your reflection

• Being open to/or be prepared to challenge yourself, not interpreting challenge as personal attacks or discriminatory practice

• Giving feedback to the supervisor about their facilitation e.g. what is helpful what is least helpful

• Using the time to reflect in depth on issues affecting clinical/professional practice and avoiding non-productive conversation

• Keep a copy of the Supervision Form in your personal CPD portfolio folder and provide these at annual performance appraisals. These can also be used as evidence for professional re-registration/re-validation.

Appendix C

Expectations of the Supervisor in clinical supervision

• To be treated as an equal partner in the Supervision relationship, not blamed for any shortcomings of the supervisee or organisation

• Only break confidentiality in relation to the agreed contract or the circumstances outlined in this policy

• Refuse requests which make inappropriate demands on you in your role as supervisor

• Set personal and professional boundaries on what issues you listen to the supervisee talking about.

Responsibilities of the Supervisor

• Prepare for the supervision session, ensuring no interruptions, settling yourself beforehand and remembering previous sessions

• Be reliable, sticking to agreed appointments, time boundaries, supervision contract and agreed confidentiality

• Ensure that management or educational assessment is not part of the role and the individual is freely engaging in the session.

• Encourage the supervisee to seek specialist help or advice when necessary and avoid trying to answer the issues yourself unless appropriate to your role.

• Challenge any behaviour that the supervisee displays or talks about which gives rise to concern about their practice, development or use of supervision. Don't promise confidentiality when disclosure is required.

• Ensure you have the necessary backup support e.g. your own supervision and support system and don't view seeking support as a weakness.

• Keep a record of supervision sessions provided via Audit Forms **(example in Appendix E)** and provide these to the Clinical Services Manager as requested, sharing non-attendance and engagement concerns appropriately for managerial support.

Appendix D

These forms can be used as presented; the free-text box "feedback" is expected to vary from profession to profession and dependent on whether the role is clinical or Non Clinical. The section titles in the left hand column of the form should not be changed.

Clinical Supervision Form

CLINICAL SUPERVISION FORM.

Non Clinical Supervision Form

Non Clinical Supervision Form.doc

Appendix E

CLINCIAL SUPERVISION AUDIT FORM

Clinical Supervision Audit Form.doc

Non Clinical Supervision Audit Form

Non Clinical Supervision Audit For

Appendix F

Equality Impact Assessment Screening		
Query	**Response**	
What is the aim of the document?	To use reflective practice through shared experiences as part of continuing professional development. To support by not only professional bodies but workplaces in general.	
Who is the target audience of the document (which staff groups)?	Clinical BNSSG staff	
Who is it likely to impact on and how?	Staff	Yes- to improve and develop services
	Patients	Yes- to improve and develop services
	Visitors	No
	Carers	No
	Other – governors, volunteers etc.	No
Does the document affect one group more or less favourably than another based on the 'protected characteristics' in the Equality Act 2010:	Age (younger and older people)	N/A
	Disability (includes physical and sensory impairments, learning disabilities, mental health)	No
	Gender (men or women)	No
	Pregnancy and maternity	No
	Race (includes ethnicity as well as gypsy travellers)	No
	Sexual Orientation (lesbian, gay and bisexual people)	No
	Transgender people	No
	Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)	No
	Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)	No

10.1 Implementation Plan

The policy will be posted on 'The Hub' and discussed in directorate meetings, team meetings, during appraisals and one to ones

Target Group	Implementation or Training Objective	Method	Lead	Target Start Date	Target End Date	Resources Required
Clinical	Clinical Supervision Training	Training to enable staff to train as clinical supervision facilitators and gain a greater understanding of the role of reflective practice in a learning organisation.	L & D	Jan 2021	July 2021)	Training for staff to develop skills and competency to undertake this role
Clinical	Clinical Supervision Training Refresher	Training to enable staff to maintain competencies in this role sharing experiences and best practice.	L & D	Jan 2022	Ongoing (Yearly update)	Face to face session with facilitator.