Supervision Policy

Amendment to S2.1.5 relating to Consultant Psychiatrists Clinical Supervision.
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>INTRODUCTION</th>
<th>PURPOSE</th>
<th>SCOPE</th>
<th>RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</th>
<th>PROCEDURE/IMPLEMENTATION</th>
<th>TRAINING IMPLICATIONS</th>
<th>MONITORING ARRANGEMENTS</th>
<th>EQUALITY IMPACT ASSESSMENT SCREENING</th>
<th>LINKS TO ANY ASSOCIATED DOCUMENTS</th>
<th>REFERENCES</th>
<th>APPENDICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>INTRODUCTION</td>
<td>PURPOSE</td>
<td>SCOPE</td>
<td>RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</td>
<td>PROCEDURE/IMPLEMENTATION</td>
<td>TRAINING IMPLICATIONS</td>
<td>MONITORING ARRANGEMENTS</td>
<td>EQUALITY IMPACT ASSESSMENT SCREENING</td>
<td>LINKS TO ANY ASSOCIATED DOCUMENTS</td>
<td>REFERENCES</td>
<td>APPENDICES</td>
</tr>
<tr>
<td>2.</td>
<td>INTRODUCTION</td>
<td>PURPOSE</td>
<td>SCOPE</td>
<td>RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</td>
<td>PROCEDURE/IMPLEMENTATION</td>
<td>TRAINING IMPLICATIONS</td>
<td>MONITORING ARRANGEMENTS</td>
<td>EQUALITY IMPACT ASSESSMENT SCREENING</td>
<td>LINKS TO ANY ASSOCIATED DOCUMENTS</td>
<td>REFERENCES</td>
<td>APPENDICES</td>
</tr>
<tr>
<td>3.</td>
<td>INTRODUCTION</td>
<td>PURPOSE</td>
<td>SCOPE</td>
<td>RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</td>
<td>PROCEDURE/IMPLEMENTATION</td>
<td>TRAINING IMPLICATIONS</td>
<td>MONITORING ARRANGEMENTS</td>
<td>EQUALITY IMPACT ASSESSMENT SCREENING</td>
<td>LINKS TO ANY ASSOCIATED DOCUMENTS</td>
<td>REFERENCES</td>
<td>APPENDICES</td>
</tr>
<tr>
<td>4.</td>
<td>INTRODUCTION</td>
<td>PURPOSE</td>
<td>SCOPE</td>
<td>RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</td>
<td>PROCEDURE/IMPLEMENTATION</td>
<td>TRAINING IMPLICATIONS</td>
<td>MONITORING ARRANGEMENTS</td>
<td>EQUALITY IMPACT ASSESSMENT SCREENING</td>
<td>LINKS TO ANY ASSOCIATED DOCUMENTS</td>
<td>REFERENCES</td>
<td>APPENDICES</td>
</tr>
<tr>
<td>5.</td>
<td>INTRODUCTION</td>
<td>PURPOSE</td>
<td>SCOPE</td>
<td>RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</td>
<td>PROCEDURE/IMPLEMENTATION</td>
<td>TRAINING IMPLICATIONS</td>
<td>MONITORING ARRANGEMENTS</td>
<td>EQUALITY IMPACT ASSESSMENT SCREENING</td>
<td>LINKS TO ANY ASSOCIATED DOCUMENTS</td>
<td>REFERENCES</td>
<td>APPENDICES</td>
</tr>
<tr>
<td>6.</td>
<td>INTRODUCTION</td>
<td>PURPOSE</td>
<td>SCOPE</td>
<td>RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</td>
<td>PROCEDURE/IMPLEMENTATION</td>
<td>TRAINING IMPLICATIONS</td>
<td>MONITORING ARRANGEMENTS</td>
<td>EQUALITY IMPACT ASSESSMENT SCREENING</td>
<td>LINKS TO ANY ASSOCIATED DOCUMENTS</td>
<td>REFERENCES</td>
<td>APPENDICES</td>
</tr>
<tr>
<td>7.</td>
<td>INTRODUCTION</td>
<td>PURPOSE</td>
<td>SCOPE</td>
<td>RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</td>
<td>PROCEDURE/IMPLEMENTATION</td>
<td>TRAINING IMPLICATIONS</td>
<td>MONITORING ARRANGEMENTS</td>
<td>EQUALITY IMPACT ASSESSMENT SCREENING</td>
<td>LINKS TO ANY ASSOCIATED DOCUMENTS</td>
<td>REFERENCES</td>
<td>APPENDICES</td>
</tr>
<tr>
<td>8.</td>
<td>INTRODUCTION</td>
<td>PURPOSE</td>
<td>SCOPE</td>
<td>RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</td>
<td>PROCEDURE/IMPLEMENTATION</td>
<td>TRAINING IMPLICATIONS</td>
<td>MONITORING ARRANGEMENTS</td>
<td>EQUALITY IMPACT ASSESSMENT SCREENING</td>
<td>LINKS TO ANY ASSOCIATED DOCUMENTS</td>
<td>REFERENCES</td>
<td>APPENDICES</td>
</tr>
<tr>
<td>9.</td>
<td>INTRODUCTION</td>
<td>PURPOSE</td>
<td>SCOPE</td>
<td>RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</td>
<td>PROCEDURE/IMPLEMENTATION</td>
<td>TRAINING IMPLICATIONS</td>
<td>MONITORING ARRANGEMENTS</td>
<td>EQUALITY IMPACT ASSESSMENT SCREENING</td>
<td>LINKS TO ANY ASSOCIATED DOCUMENTS</td>
<td>REFERENCES</td>
<td>APPENDICES</td>
</tr>
<tr>
<td>10.</td>
<td>INTRODUCTION</td>
<td>PURPOSE</td>
<td>SCOPE</td>
<td>RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</td>
<td>PROCEDURE/IMPLEMENTATION</td>
<td>TRAINING IMPLICATIONS</td>
<td>MONITORING ARRANGEMENTS</td>
<td>EQUALITY IMPACT ASSESSMENT SCREENING</td>
<td>LINKS TO ANY ASSOCIATED DOCUMENTS</td>
<td>REFERENCES</td>
<td>APPENDICES</td>
</tr>
<tr>
<td>11.</td>
<td>INTRODUCTION</td>
<td>PURPOSE</td>
<td>SCOPE</td>
<td>RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</td>
<td>PROCEDURE/IMPLEMENTATION</td>
<td>TRAINING IMPLICATIONS</td>
<td>MONITORING ARRANGEMENTS</td>
<td>EQUALITY IMPACT ASSESSMENT SCREENING</td>
<td>LINKS TO ANY ASSOCIATED DOCUMENTS</td>
<td>REFERENCES</td>
<td>APPENDICES</td>
</tr>
</tbody>
</table>

Appendix 1 – Supervision Template for Management
Clinical

Appendix 2 – Supervision Template for Clinical Supervision only

Appendix 3 – Clinical Supervision Contract

Appendix 4 – Guidelines for Safeguarding Supervision
Children and Adults
1. **INTRODUCTION**

Rotherham Doncaster and South Humber NHS Foundation Trust (the Trust) is committed to providing the framework and resource for effective supervision to enhance and inform practice. Different types of supervision are required to provide efficient and effective care and service delivery. The types used may overlap.

2. **PURPOSE**

The purpose of this policy is to provide a formalised, structured framework for the facilitation and monitoring of supervision of all staff employed by the Trust and for those who provide supervision to those staff.

Clinical staff, depending on profession and role, will have differing clinical supervision requirements. No single model of supervision can be adopted across the Trust as services must use the model that enables best practice delivery.

This policy seeks to establish the expectation of a minimum level of all types of supervision. Focus in the sessions is based on the needs/issues identified by the supervisor and supervisee/s and is consistent with their training and development needs.

2.1 **Definitions/Explanation of Terms Used**

2.1.1 **Clinical Supervision**

This term is used to refer to the supervision for all staff who directly care for people who use services, including registered professionals, support workers and those staff that work on the bank contract. Clinical supervision maintains the professionalism of these staff groups.

In some professions and occupations, alternative titles may be used, such as ‘peer supervision’, ‘developmental supervision’, ‘reflective supervision’ or just ‘supervision’, but generally clinical supervision is seen as complementary to, but separate from managerial supervision.

This is regular, protected time for facilitated, in-depth reflection on complex issues influencing clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development.

To summarise, clinical supervision is a structured process to:

- reflect on and review practice
- discuss individual cases in depth
- change or modify practice and identify training and continuing development needs
2.1.2 Safeguarding Supervision

This is a formal, accountable process which affords professional support and learning. It involves one or more practitioners meeting with a suitably experienced supervisor to develop skills and competence, assume responsibility for their practice and enhance safety and protection of those at risk in complex situations (DoH 1993, Morrison 2005, Skills for Care and CWDC 2007),’ (Policy and Procedures on the Protection, Safeguarding and Promoting the Welfare of Children (incorporating the Safeguarding Children Supervision Guidance) 2016).

Sessions are facilitated by supervisors who are trained in safeguarding supervision and are based on a safeguarding supervision record and action plan. Safeguarding supervision is specifically targeted at clinical staff working routinely with children and adults at risk and may present with a range of vulnerabilities.

2.1.3 Professional Supervision

This term is often interchangeable with clinical supervision. This term is sometimes used where supervision is carried out by another member of the same profession or group. This can provide staff with the opportunity to:

- review professional standards
- keep up to date with developments in their profession
- identify professional training and continuing development needs
- ensure that they are working within professional codes of conduct and boundaries

There can be varying professional and role specific types of supervision:

2.1.4 Non-Medical Prescribing Supervision

Non-Medical Prescribers (NMPs) must have in place arrangements for supervision which supports their prescribing practice. NMPs should meet regularly with their Supervising Practitioner (SP) to discuss prescribing practice.

Supervision sessions will be documented and signed by both the NMP and SP as a true account of the discussion (see Non-Medical Prescribing Policy).

2.1.5 Medical Staff Supervision

Consultant Psychiatrists Clinical Supervision

In the line with the requirements of the RCPsych, Consultant Psychiatrists are expected to be a member of a peer-supervision group, which provides a supportive and reflective space to monitor healthy practice.
It is the choice of the individual Consultant, with the agreement of their line-
manager, which of these options they would like to take part in, the option to
mix and match would provide flexibility and allow Consultants to partake in
sessions most suitable for them. The total hours of supervision should reach
the RDASH-specified requirement of at least 12 hours (annually).

Below are the options for the supervision format:

1) 1:1 clinical supervision sessions between supervisee and supervisor – to
   be arranged by supervisee
2) Structured group supervision, akin to a Balint group– to be arranged by
   those wishing to take part in such a group
3) Open group supervision (peer supervision) – this type of supervision can
   be arranged on a monthly basis for any consultant to attend if they wish to.
   For these regular organised sessions, the proposal is that the dates, room
   bookings and attendance register can be undertaken by Medical
   HR/education; similar to the current arrangements for the weekly
   education meetings on a Wednesday.
4) External group supervision – this option may be preferable to those
   working in a sub-speciality where there are limited or no peers of that sub-
   speciality within RDaSH or for those who may already be part of external
   clinical supervision groups. For those who wish to take up this option,
   attending out of area supervision sessions every 3-4 months may be a
   suitable solution. This would be arranged by those wishing to partake in
   this type of clinical supervision.
5) Non face to face clinical supervision – through digitally facilitated case
   discussions and reflection, as arranged by supervisee/supervisor.

**Specialty Doctors**

Specialty doctors should similarly be a member of a peer group and, as such,
will also receive 1:1 clinical supervision from the consultant supervisor in their
clinical area.

**Training Grade Doctors**

Training Grade Doctors have different mandatory requirements for clinical
supervision depending on the nature of their scheme. The Royal College of
Psychiatrists requires that core and higher psychiatric trainees have one hour
of 1:1 supervision each week from their consultant supervisor and this should
form part of the consultant job plan where relevant. At this Trust this has
been extended to all trainees of any type (foundation doctors and General
Practitioners (GPs) on the Vocational Training Scheme) and (non-trainee)
specialty doctors.

**2.1.6 Management Supervision**

This is the setting and monitoring of management objectives with an individual
and is guided by the organisation, Care Groups and team/service business
plans. All staff employed by the Trust will have an identified line manager
who has a responsibility to ensure that their members of staff undertake induction, comply with the Trust’s appraisal process, monitor performance, staff health and wellbeing and identify any training and development requirements. For all employees providing direct clinical care, this will also include some form of caseload review where focus will include promoting safety, quality, and defensible practice in record keeping and identifying safeguarding issues.

All medical staff have an annual job plan review, which will take into account the annual business plan and the priorities of the Care Group as well as meeting the needs of the service.

To summarise; management supervision is a regularly scheduled mechanism between managers and staff to:

- review performance
- set priorities/objectives in line with the organisation’s objectives and service needs
- identify training and continuing development needs

3. SCOPE

This policy applies to all Trust employees and covers the supervisory needs of the workforce, based on their job role.

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

4.1 Board of Directors

On behalf of the Executive Team, the Director of People and Organisational Development will provide assurance to the Board that supervision is carried out in accordance with this policy. The Board of Directors are responsible for providing assurance to the Board that:

- the implementation of all policies and procedures are in place to maintain the safety of service users, staff and the public
- there is provision, monitoring and ensuring the resourcing of supervision for all employees
- there is provision and monitoring of local induction for all staff
- there are arrangements for annual Personal Development Reviews (PDRs) for all staff
- provide assurance that attendance at clinical/professional and management supervision sessions is monitored.

4.2 Care Group Triumvirate (Care Group Director, Associate Nurse Director, Associate Medical Director).

The Care Group triumvirate have the responsibility to set the culture that supports the requirement for all staff to participate in supervision and to ensure that staff are given the time to fulfil their supervision responsibilities.
4.3 Managers

Managers are responsible for ensuring that staff are given the time and resources to take part in supervision provision and monitoring of the supervision for staff within their areas of responsibility:

- Creating an environment where supervision is valued as an essential activity which supports the delivery of high quality, safe and effective care
- Actively promoting an understanding of the aims of supervision amongst their staff and teams on an ongoing basis
- Ensuring arrangements are made to provide a suitable alternative supervisor for when supervisors are absent for long periods of time
- Making effective use of their operational management structure so that supervisory responsibilities are shared amongst staff according to the care model identified for the service
- Ensure that management, clinical and safeguarding supervision is available to all staff within their service

It is the responsibility of clinical/professional leads, Modern Matrons and Service Managers within the Care Groups to monitor the number of clinical supervisors that are available in their clinical area and to determine the number of new supervisors required on a yearly basis. These requirements will be to meet workforce demand and counteract staff turnover; this information will be brought to the attention of operational management. It is also their responsibility to ensure that arrangements are made to cover long term absences of clinical supervisors.

4.4 Supervisors

All supervisors are responsible for ensuring that they have received relevant training and are competent to provide whichever form of supervision they are facilitating. The supervisor is also responsible for inputting supervision activity into the staff portal. If the supervisor is new to role, then developmental needs should be addressed with their line manager to then facilitate additional support.

http://nww.intranet.rdash.nhs.uk/rdashstaffportal

4.5 All Staff

All staff have a duty to ensure that they seek out and participate in supervision in line with organisational and professional requirements and draw any shortfalls to the line managers attention.

5. PROCEDURE/IMPLEMENTATION

This policy should be read alongside relevant professional guidance.

For example:
5.1 Types of supervision

Employees need to access the form(s) of supervision they require to meet the purpose and function of their role, profession and any specific therapeutic function they are developing and/or delivering.

**Clinical supervision** - is facilitated around an agreement or contract between the supervisor and supervisee/s that details the responsibilities of the parties involved and sets the boundaries of the sessions. All clinical supervision agreements/contracts must include details of the boundaries of confidentiality and should be reviewed annually.

These agreements/contracts must always stipulate where confidentiality breach would occur, in all cases harm to self or others either real or perceived would result in a breach and where behaviour contravenes the practitioner’s code of conduct or the law. Supervisors may negotiate additional breach conditions as part of the agreement. Outside of the breach conditions detailed on the agreement/contract, consent to share information should be obtained from the supervisee. Breaching of confidentiality without good cause could result in a disciplinary investigation/action in accordance with the Disciplinary Policy.

Clinical supervision must be provided by practitioners with experience and competencies in the relevant area of clinical practice. This will usually be from a member of the same profession. However in some instances, clinical supervision may be delivered by practitioners outside of the supervisee’s profession, providing they have the required skills and experience and their guidance reflects any differences in professional code of conduct/practice. For example, a clinical nurse specialist in Older People’s Mental Health could provide some elements of clinical supervision to an occupational therapist in the same specialty.

If the clinical supervisor is not of the same profession as the supervisee then the effectiveness, scope and any limitations of the supervision must be considered and arrangements made for profession/specific elements to be fulfilled.

The quality of supervision is paramount to good practice and therefore all registered practitioners who express an interest in becoming a clinical supervisor should be assessed by their clinical/professional lead as having:

- credible clinical practice
- evidence of continuous professional development
• qualities consistent with good quality supervision provision such as warmth, honesty, integrity, empathy, respect and the ability to be reflective.

It is the responsibility of the supervisee to input into the relevant healthcare record where discussion of the case has occurred in clinical supervision with any actions arising from this.

**All services across the Trust should work to the 12 hours of supervision per year as a minimum requirement. This figure should be adjusted pro-rata for staff working part-time hours. In some Care Groups, there may be an expectation that the hours are apportioned over quarters, for example 3 hours a quarter. As long as the minimum requirement is maintained then the type of supervision (1:1, group etc.) and frequency is flexible.**

Across all services, staff providing clinical supervision must undertake their own clinical supervision at the recommended minimum of 12 hours per year, as research has showed a detrimental effect on supervisor wellbeing where effective supervision is not accessed (White et al 1998).

**Management supervision should NOT be included as part of the minimum hours.**

Supervision can be delivered in a variety of ways and does not always need to be a formal 1:1 session. It may be facilitated within a group setting, via the telephone, via video conferencing or in ward/team reviews of cases. It can be received from outside of the Trust with the agreement of the line manager/budget holder and the understanding of the supervisee that they have a responsibility to check that organisational policy and procedure allows them to follow guidance/advice from external supervisors. This arrangement would need to be formalised during the management supervision session.

Documentation of clinical supervision sessions must be maintained in line with standards for clinical record keeping. It is recognised that the confidentiality of these records is paramount in order to facilitate disclosure within the sessions and make the best use of clinical supervision. No personal identifiable information should be recorded in these records, e.g. full names or NHS or SystmOne numbers. Documentation should be stored securely to maintain confidentiality; supervisors and supervisees are advised where possible to scan their records to an electronic format.

*All information disclosed in the supervision session will be kept confidential with the following exceptions:*

• where harm (real or perceived) to self or others is disclosed or potential for harm is recognised by the supervisor
• where unsafe, unethical or illegal practice is disclosed that the supervisee has failed to recognise or is unwilling to go through appropriate procedures/channels to address.
To maintain high quality clinical supervision, the supervisor may take anonymised issues they feel appropriate from the session forward for their own clinical supervision. The supervisee will be informed of this and the information shared will be kept to the minimum necessary, unless the above applies.

**Safeguarding supervision** - at every supervision session safeguarding should be discussed, however safeguarding supervision is required for those staff working at level 2 and above as outlined in the [intercollegiate document](#) for children or the [intercollegiate document](#) for adults. It should be held a minimum of 3 monthly with a safeguarding supervisor and recorded on the staff portal. Documentation will be held securely by the safeguarding supervisor and a copy provided to the supervisee. It is the responsibility of the supervisee to record within the healthcare record that they have accessed safeguarding supervision and any actions arising from this.

Further guidelines for safeguarding supervision can be found in Appendix 4.

**Safeguarding supervision hours will count towards the 12 hours minimum requirements.**

**Management supervision** will be delivered through the Trust’s current performance/personal development review and is line-management led, with the exception of doctors in core training (including those who are not directly employed by the Trust) who will follow the supervision requirements of the Deanery.

Management supervision is carried out by the supervisee’s line manager or delegated other. It is often hierarchical in nature and the agenda is set by the supervisory manager (a template for the agenda can be found in appendix 1). It is compulsory as part of terms and conditions of employment.

Management supervision includes an annual performance/personal development review and additional meetings can be arranged in response to staff and service need. All medical staff have an annual job plan review, which will take into account the annual business plan and the priorities of the Care Group as well as meeting the needs of the service.

5.2 **The minimum frequency for management supervision is every eight weeks.**

The environment chosen for management supervision must be conducive to facilitating confidentiality during the session. However, material from these sessions can be shared on an anonymous basis with the wider organisation where this is appropriate e.g. with senior management and the Learning and Development Department. It is good practice to inform the supervisee of the intention to share information but their consent is not required.

Documentation of supervision sessions must be maintained in line with standards for clinical record keeping, remaining the property of the Trust and should be filed/electronically stored within the staff member’s personal file.
When a staff member fails to reach required standards, managers should deal with the minor performance problems of their staff as they arise and document them in the supervision record. If these problems are on-going or significant, the performance and/or conduct should be discussed immediately with a member of Human Resources (HR) to explore options available.

Supervisors who are subject to the performance, conduct and capability procedure should be advised by their manager that they must not carry out their clinical supervisor role during this period.

5.3 Documentation of supervision

Attached to the Policy (Appendix 1 and 3) is a template that is to be used to document discussion points raised in supervision. The templates are to be used to record safeguarding and management supervision. The template for clinical supervision is not mandated but acts as an aid and is based around good practice standards, as the agenda will be focused on what the supervisee wishes to discuss.

The documentation will form part of and support the employee’s annual performance/personal development review. See Appendix 1 for further information.

6. **TRAINING IMPLICATIONS**

<table>
<thead>
<tr>
<th>Supervision Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff groups requiring training</strong></td>
</tr>
<tr>
<td>All Clinical and Management Supervisors</td>
</tr>
<tr>
<td>Safeguarding Supervisors</td>
</tr>
</tbody>
</table>

Supervisors will be trained to carry out the various types of supervision that conform to professional requirements. The demands for training will be identified through the performance/personal development review.

Staff with professional leadership responsibilities will provide advice to managers and staff to support this process.

Undertaking safeguarding supervision and specialist clinical supervision as part of an academic course can be counted towards minimum clinical supervision requirements, unless this is not permitted professionally.
6.1 Management supervision

Management supervisor training needs can be met through a variety of leadership and development opportunities which include mentoring, coaching and experiential learning as well as accredited and in-house formal training therefore development is considered an ongoing process. Managers or the appraiser if not the line manager should be confident in their knowledge of the appraisal process prior to carrying out staff appraisal, it is acknowledged that many of the skills required for supervision are transferable from other areas of competence. Those new to line management responsibilities or fulfilling the role of management supervisor can access additional support from the Human Resources (HR) team.

All registered practitioners who meet the above criteria and are supported by their line manager may access Clinical Supervisor training; this can either be accessed in-house or through accredited training depending on professional requirements. People who have attained clinical supervisor qualifications in other employment and who are supported by their team manager to take on the clinical supervisor role should provide details of their past training and experience to the Learning and Development Department, to determine that their training meets the minimum learning outcomes recognised by the Trust. Clinical supervisor training is a one-off event however, there is an expectation that clinical supervisors will use their own clinical supervision to embed and further develop their skills.

A variety of means such as:

- All user emails for urgent messages
- One to one meetings / Supervision
- Continuous Professional Development sessions
- Posters
- Daily email (sent Monday to Friday)
- Practice Development Days
- Group supervision
- Special meetings
- Intranet
- Team meetings
- Local Induction

The Training Needs Analysis (TNA) for this policy can be found in the Training Needs Analysis document which is part of the Trust’s Mandatory Risk Management Training Policy located under policy section of the Trust website.

7. MONITORING ARRANGEMENTS

<table>
<thead>
<tr>
<th>Area for Monitoring</th>
<th>How</th>
<th>Who by</th>
<th>Reported to</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency and hours of clinical and management supervision</td>
<td>Data grab from reportal</td>
<td>Performance and Information</td>
<td>Care Group People meeting</td>
<td>Annual</td>
</tr>
</tbody>
</table>
Area for Monitoring | How | Who by | Reported to | Frequency
--- | --- | --- | --- | ---
Effectiveness and compliance with the Policy | Data from P&I and L&D | Associate Nurse Directors | People and Organisational Development committee | Annual
Compliance with hours of clinical supervision | Data from reportal | Performance and Information | Care Group People meeting | Monthly
Staff training | Training records | Learning and Development | Associate Nurse Directors | 6 Monthly

8. **EQUALITY IMPACT ASSESSMENT SCREENING**

The completed Equality Impact Assessment for this Policy has been published on this policy’s webpage on the RDaSH Policy Library (Trust website).

8.1 **Privacy, Dignity and Respect**

| Indicate how this will be met | No issues have been identified in relation to this policy. |

The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi's review of the NHS, identifies the need to organise care around the individual, 'not just clinically but in terms of dignity and respect'.

As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all service users with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).

8.2 **Mental Capacity Act 2005**

| Indicate How This Will Be Achieved | All individuals involved in the implementation of this policy should do so in accordance with the Principles of the Mental Capacity Act 2005. |

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individuals capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individual's informed consent, or the powers included in a legal framework, or by order of the Court.

Therefore, the Trust is required to make sure that all staff working with individuals who use our service are familiar with the provisions within the Mental Capacity Act. For this reason all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the rights of individual are protected and they are supported to make their own decisions where possible and that any decisions made on their behalf when they lack capacity are made in their best interests and least restrictive of their rights and freedoms.
9. **LINKS TO ANY ASSOCIATED DOCUMENTS**

Supporting effective clinical supervision - CQC supporting information and guidance (2013).

10. **REFERENCES**


[Accessed 30 September 2019].

11. **APPENDICES**

Appendix 1 – Supervision template for Management Clinical

Appendix 2 – Supervision template for Clinical Supervision only

Appendix 3 – Clinical Supervision Contract

Appendix 4 - Guidelines for Safeguarding Supervision Children and Adults
# Supervision Record

<table>
<thead>
<tr>
<th>Attendee name:</th>
<th>Supervisor:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Title:</td>
<td>Supervisor’s Job Title:</td>
</tr>
<tr>
<td>Care Group / Directorate:</td>
<td>Date of Supervision:</td>
</tr>
</tbody>
</table>

## Type of Supervision

- Choose an item
  - Provides staff with time to discuss personal and professional demands created by the nature of their work. Reflect on and challenge their own practice, seek advice and support and manage the personal and emotional impact of undertaking their role.

Supervision is a safe, confidential and protected period of time for staff to reflect and discuss, with their supervisor, how they are, raise any issues of concern and highlight anything they may need support with in relation to work or personal issues.

Structure following areas around: **What is going well? What isn’t going so well? What’s our plan / what action do we want to take?**

### Work related:

*For clinical supervision this is where the supervisee could discuss caseloads, complex cases, meetings, plans/goals for patients/families*

### Personal related:

*For clinical supervision this could be where CPD, PDR outcomes, work life balance, courses on offer etc. could be discussed.*

### Wellbeing related:
Workload level/pace, work life balance, any caring responsibilities, any corporate services supervisee may wish to ‘use’

<table>
<thead>
<tr>
<th>Items carried forward from a previous supervision?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
</tbody>
</table>

Supervision Record
*From the main discussion above, is there anything that requires action?*

<table>
<thead>
<tr>
<th>Tasks/work/cases discussed</th>
<th>Action to be taken</th>
<th>Action owner</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Records Management
*(Please use this section to discuss clinical or management record keeping)*

For clinical supervision this is where; notes, reports, assessments, care plans could be discussed.
### Achievements

*(Please use this section to discuss where you are at with your PDR objectives & any areas of achievement)*

For clinical supervision this is where training, awards, events could be discussed as well as any positive / good clinical outcomes or work they’ve been involved in

### Continuing Professional Development

*(Please use this section as an opportunity to gather and record evidence for any professional bodies and document discussion about personal and professional development)*

For clinical supervision; further training & development, plans for the future, conferences, events, specific roadshows or 'weeks' they are involved in

### Mandatory & Statutory Training

*(Please use this section as an opportunity to review mandatory & statutory training (MAST) compliance)*

<table>
<thead>
<tr>
<th>Are you up to date and fully compliant with your training?</th>
<th>Yes / No</th>
</tr>
</thead>
</table>

*If not, please note below which training is required and timescale for completion*
<table>
<thead>
<tr>
<th>Date of Next Supervision</th>
<th>Venue of Next Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisee Signature</td>
<td></td>
</tr>
<tr>
<td>Supervisor Signature</td>
<td></td>
</tr>
<tr>
<td>Was supervision cancelled?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Supervisor</td>
</tr>
<tr>
<td>Reason for cancellation</td>
<td></td>
</tr>
<tr>
<td>Did the supervisee fail to attend?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
**APPENDIX 2**

**PROMPTS FOR CLINICAL SUPERVISION**

This prompt sheet has been designed as a way of supporting & structuring your clinical/safeguarding supervision discussion, please use if you feel this would be helpful to you.

<table>
<thead>
<tr>
<th>The following are additional questions for clinical staff only:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUPERVISORS WHAT THEORETICAL MODEL WILL YOU BE USING? e.g. Gibbs model of reflection</td>
</tr>
</tbody>
</table>

**Gibbs (1988) model of Reflection**

**Theoretical model we will use:**

**CASE DISCUSSION**

*Think about what you would like to gain from this supervision session and how it can best support you.*

*Do you have any specific cases / work in mind that you would like to discuss?*
<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>How are you managing your caseload / workload at the moment?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Are you working with any challenging patients/families?</td>
</tr>
<tr>
<td>Are there any particular challenging cases you’d like to speak about?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Are there any interventions where you feel you’d benefit from further</td>
</tr>
<tr>
<td>improvement / gaining entry skills?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Are there any cases you’d like to discuss in relation to length of time</td>
</tr>
<tr>
<td>on your caseload / workload / in service?</td>
</tr>
<tr>
<td>Would you like to discuss a patient / family's goal, what it may be and how to support them reach it?</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td><em>Where would they like to get to as part of their care / recovery? What interventions are being offered?</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is the plan of care for the case(s) discussed? <em>(long term / end goal)</em></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>RISKS / COMPLEXITY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>This section is to reflect around any risks with complexity there may be on any cases you hold…</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is the complexity?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is there any previous history that needs to be taken into consideration?</th>
</tr>
</thead>
</table>

<p>| How are you finding managing this complex case(s)? |</p>
<table>
<thead>
<tr>
<th>Have you experienced any difficulties where practice has changed because of the complexity &amp; risk?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>REFLECTION / SAFEGUARDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>What has worked well?</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>What hasn’t worked so well?</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>What needs to happen?</td>
</tr>
<tr>
<td>---</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUMMARY OF ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Main reflections during this discussion and the next steps / actions are you going to take?</em></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>•</td>
</tr>
<tr>
<td>•</td>
</tr>
<tr>
<td>•</td>
</tr>
</tbody>
</table>
# Clinical Supervision Contract

**Supervision contract agreed between** ........................................ (Supervisee (name and designation))

and .......................................................... (Supervisor (name and designation))

**For the period** .............................................. (insert date) to .............................................. (insert date)

Tick box if the contract is for a group

<table>
<thead>
<tr>
<th>Names of group members</th>
<th>Designations of group members</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Identified Needs**

2. **Frequency of supervision**

3. **Length of Supervision Sessions**

4. **Place to meet**

5. **Record keeping**

6. **Agenda setting mechanism**

7. **Confidentiality**

**Review of Effectiveness of Supervision**

**Process for resolving conflicts/issues of difference/tensions within the supervisory relationship**

**Process for feedback to line manager (where the contract if for clinical supervision)**

| Signature: |  (Supervisee) | DATE: |
| Signature: |  (Supervisor) | DATE: |

**FOR CONTRACTS WITH EXTERNAL SUPERVISORS:**

| Signature: |  (Supervisee’s Manager) (RDaSH) | DATE: |
| Signature: |  (Supervisor’s Manager) | DATE: |

Name of external supervisor’s organisation:

Copy to be sent to supervisee’s Line Manager
Guidelines for Safeguarding Supervision Children and Adults

Safeguarding supervision is required for those staff working at level 2 and above as outlined in the intercollegiate document for children or the intercollegiate document for adults.

The Purpose, Principles and Components of Supervision

Supervision is an interaction which should enable the service to:

- maintain the quality and efficiency of services
- ensure its commitment to the ongoing support, training and development of staff
- provide a supportive environment, sensitive to equal opportunities, which encourages the professional development of supervisors and supervisees

Supervision is guided by four principles:

- Sensitive to equal opportunities issues of the supervisee and supervisor.
- Managed in a professional way.
- Undertaken with mutual respect between the supervisor and the supervisee.
- Regular assurance that it is fit for purpose

Supervision has four key components:

- **Functional (Normative)** - the promotion and maintenance of good standards of work, co-ordination of practice with policies of administration, and the assurance of an efficient and smooth-running service.
- **Reflective (Formative)** - the facilitation of thoughtful and considered review of personal action in meeting organisational and professional objectives.
- **Educational (Formative)** - the intellectual and emotional development of each individual member of staff so as to enable them to reach their full potential.
- **Supportive (Restorative)** - attention to the development and maintenance of emotional and intellectual capacity of the individual for personal well-being and good working relationships.

Safeguarding Supervision is designed to:

- ensure that the multi-agency practice is discussed and remains child focused/focused on making safeguarding personal
- ensure that practice remains in line with legislation and procedures.
- ensure that practitioners fully understand their roles, responsibilities and the scope of their professional discretion and authority.
• identify practice/management issues which could have an impact on safety and wellbeing of children and young people and discuss with managers as appropriate.
• explore the impact of any potential emotionally harmful environments on the child and agree the course of action.
• provide emotional support due to sensitivity of cases discussed.
• identify the training and development needs of practitioners, so that each has the skills to provide an effective service.
• review other areas of safeguarding management issues which could have an impact on professional workload and safe practice.

Consideration also needs to be given to safeguarding issues and impact on children and adults at risk, particularly where:

• parents/ carers/ member of the family living in the household have poor mental health
• parents/carers are violent/abusive/highly resistant or hard to reach individuals.
• families are experiencing domestic abuse,
• parents/ carers have a learning disability
• parents/ carers have a substance misuse issue

It is important to consider whether there is any impact on their ability or capacity to parent/ care and assessments and analysis of risk should be discussed and an action plan agreed. It is also necessary to consider who is and/or should be involved in plans of support and appropriate information sharing.

Safeguarding supervision can be delivered via the following methods:

1) One to one supervision by an individual trained in delivering safeguarding supervision
2) Multi agency supervision
3) Group Supervision facilitated by an individual trained in delivering safeguarding supervision

It is good practice in safeguarding supervision that both the supervisor and supervisee draw up a contract of supervision.

Responsibilities of supervisors include:

• Receiving regular supervision
• Facilitating and protecting the availability of time for supervision
• Recording supervision using the portal
• Ensuring that the diverse needs of the person being supervised are considered in relation to the process
• adhering to the principles of this supervision policy
• maintaining an environment conducive to achieving the aims of supervision
• aiming to develop a supportive relationship to facilitate reflection and exploration
• fulfilling responsibilities in relation to agreed action plans within the process of supervision.
• attempting to identify and resolve any areas of potential conflict that may arise within the process of supervision.
• Seeking advice from a Safeguarding Named Nurse or line manager, where conflicts remain unresolved.

Responsibilities of supervisees include:

• prioritising and attend supervision
• discussing with and choosing an appropriate model of supervision
• bringing issues of risk, health and safety to the attention of the manager
• identifying learning/development and training needs that may be required in partnership with the supervisor
• actively identifying agenda items
• maintaining personal portfolio

1:1 supervision
Face to face, video conferencing or over the telephone.

Multi agency Supervision
Access to multi agency supervision is recommended in ‘What about the Children’ (Ofsted March 2013). Staff requesting multi agency supervision will discuss this with their manager, safeguarding supervisor, named nurse, or lead professional, who will help to make arrangements with partner agency counterparts. Once completed, the manager is responsible for recording the staff member’s attendance at supervision on the staff portal.

Group Supervision
This is a process where practitioners come together to reflect on their work by pooling their skills, experience and knowledge. Group supervision can be case specific or based around a topic. It can be used to support a service team or include members of different teams who are working with the same family.

Safeguarding Supervisors
Safeguarding supervisors must have attended safeguarding supervision training to be able to facilitate a safeguarding supervision sessions.

Safeguarding supervisors are practitioners who have received training to Level 3 in safeguarding children or adults, who have also completed an additional half day Safeguarding Supervisors and Practice Leaders’ course. They act as a link between the Safeguarding Children and Adult team and their own clinical teams, offering day to day advice and support on safeguarding issues. They are also ideally placed to cascade safeguarding information to colleagues.
What safeguarding supervisors can expect from the Safeguarding Team

- Training in Safeguarding Supervision
- A support visit to their clinical area one month after the course
- Invitations to quarterly learning forums
- Invitations to supervisors group supervision sessions
- Receipt of any safeguarding information for their own use and to cascade to teams
- Day to day support with individual cases as requested

What is expected of Safeguarding Supervisors?

- Keep up to date with safeguarding training to level three
- Attendance at Safeguarding Supervisor training
- Attendance at quarterly supervisors supervision sessions and learning forums where appropriate
- Delivery of individual and group supervision within clinical their team
- Recording of supervision sessions using the portal
- Provision of day to day advice on safeguarding issues to clinical team
- Cascade safeguarding updates and information sent out by Safeguarding Team to colleagues

The Safeguarding Supervisors’ Forum

Safeguarding Supervisors’ Forums take place on a regular basis in each of the geographical areas where RDaSH services are provided, co-terminus with the Safeguarding Children Partnerships and Safeguarding Adult Boards.

Forums are split into two halves, the first part of the session focusing upon dissemination and discussion of local safeguarding developments, national and local research and guidance, and sharing good practice, listening to guest speakers. The second part of the session considers anonymised cases/ scenarios provided reflective safeguarding supervision for those present. The Safeguarding Nurse will record attendance on the Portal.

In order to remain compliant with safeguarding supervision, safeguarding supervisors are expected to have supervision 3 monthly by a named nurse/ lead professional or attend Supervisors Forums.

Named nurses/ lead professionals have the following responsibilities in respect of the Safeguarding Supervisors Forums:

- offer supervision to safeguarding supervisors
- coordinate and facilitate supervisors’ forums in each geographical area.
- record attendance of supervisors at supervision with named nurses or supervisors’ forums
- retain a list of trained supervisors via the Safeguarding team administrators
- communicate with supervisors who had not had supervision or have not attended a forum in a 3 month period to explore where they are getting their support
**Named Nurse/ Lead Professional Supervision**

Named nurses and Lead Professionals receive regular supervision from the Nurse Consultant for Safeguarding.

Supervision with a named nurse/ lead professional is available on request. Supervisor and supervisees can contact the Safeguarding Team to request one to one supervision which can be conducted face to face, via Skype or over the telephone.

Where a named nurse/ lead professional conducts a supervision session they will record it on the staff portal.