Clinical Supervision Policy V2.0

Document reference code: GEN/002/24

This is a joint policy between Cornwall Partnership NHS Foundation Trust and Royal Cornwall Hospitals NHS Trust.

Purpose: To set the standards for clinical supervision undertaken by health care professionals and other clinical staff across Cornwall Partnership NHS Foundation Trust and Royal Cornwall Hospitals NHS Trust. To clearly articulate the need and process by which staff receive supervision.
All clinical staff should review this policy for full details of how it affects them.
Target audience: This policy is applicable to all healthcare staff working at Cornwall Partnership NHS Foundation Trust and Royal Cornwall Hospitals NHS Trust.
Document author and role: Alan Jervis, Head of Education.
Document authors contact details: 01208 834494.
Document definition: Policy.
Supporting committee and chairperson: Jane Abraham, People, and Culture Committee.
Executive director responsible for the policy: Kim O'Keeffe, Dual Chief Nursing Officer / Deputy CEO RCHT.

Freedom of information: Can be released under the Freedom of Information Act 2000.
CFT Document section: Corporate, generic.

Audience:
☒ Cornwall Partnership NHS Foundation Trust.
☒ Royal Cornwall Hospitals NHS Trust.

Key words: Clinical, Supervision, Coaching, Mentoring, HARP.

Approval process

Approved at: Strategic Education Group and People, and Culture Committee.
Date approved: 12 April 2024
Executive approval: Dual Chief Nursing Officer / Deputy CEO RCHT.
Date approved by: 27 April 2024
RCHT General manager confirming approval processes: RCHT Director of Nursing.
RCHT Governance lead confirming approval process: Associate Clinical Professor / Consultant Nurse.
Review date: October 2026 (6 months prior to the expiry date).

Expiry date: April 2027 (normally 3 years after ratification unless there are changes in legislation, NICE guidance or national standards or the document should only be valid for a specified period).

Publication location:

☒ Internet and intranet ☐ Intranet only

RCHT Document Library folder or sub-folder: Clinical / Corporate Clinical.

Version control

Version	Date	Author and/or reviewer	Section	Changes (key points)
V1.0	October 2020	**RCHT:** Frazer Underwood, Associate Clinical Professor **CFT:** Alan Jervis, Head of Education and Training		New integrated Trust policy.
V2.0	February 2024	Alan Jervis, Head of Education and Training		Inclusion of all front-line clinical staff (excluding medical staff). Updated definitions and responsibilities.

This document replaces: Clinical Supervision Policy V1.0

Summary

The purpose of this policy is to provide a framework for the delivery of comprehensive, consistent, and good quality clinical supervision for all healthcare professionals. The policy explains the difference between clinical supervision, managerial supervision, caseload, and children's safeguarding supervision.

This policy sets out the minimum requirements for clinical supervision and is not intended to limit any arrangements that go beyond these. Some specialist areas or professions may have further requirements that are over and above these minimum standards. In this situation locally agreed procedures may be put in place but should not deviate from the core principles of this policy. Colleagues should also refer to their own professional bodies for further guidance.

Contents

Data Protection Act 2018 (UK General Data Protection Regulation Legislation

The Trusts have a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out; it must be opted in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679, contact the Information Governance team.

- Cornwall Partnership NHS Foundation Trust: Email cpn-tr.infogov@nhs.net
- Royal Cornwall Hospitals NHS Trust: Email rch-tr.infogov@nhs.net

1. Introduction

1.1. Both Cornwall Partnership NHS Foundation Trust (CFT) and the Royal Cornwall Hospitals NHS Trust (RCHT) are committed to ensuring clinical supervision supports individuals and teams in clinical practice by establishing, maintaining, and promoting the development of professional skills and standards in practice.

1.2. There are many definitions and models relating to clinical supervision. The following definition from the Nursing and Midwifery Council (2006) is useful in health care settings:

‘A formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations’ (NMC 2006 p6).

1.3. Butterworth (2022) expands on this by suggesting clinical supervision is the protected time for reflective scenario based situational learning and is a collaborative dynamic process with the intention of learning, developing practice and providing high quality, safe care to patients. By participating in clinical supervision, clinicians are actively demonstrating their individual responsibility under clinical governance (Butterworth and Woods (1998), as they are contracted to undertake clinical supervision to support their practice. Some professional groups have particular supervision requirements as specified by their professional or regulatory bodies and the CQC have identified that care professionals should have access to supervision that meets these requirements.

1.4. The value of effective supervision is recognised by other health associated bodies such as Chartered Society of Physiotherapists, Health and Care Professions Council etc. In addition, the document ‘Supporting effective clinical supervision’ (Care Quality Commission, 2013) explains the value of clinical supervision:

- It can help staff manage the personal and professional demands created by the nature of their work. This is particularly important for those who work with people who have complex and challenging needs – clinical supervision provides an environment in which they can explore their own personal and emotional reactions to their work.
- It can allow staff to reflect on and challenge their own practice in a safe and confidential environment.
- It can be one part of their professional development, and also help to identify developmental needs.
- Clinical supervision can help ensure that people using services receive high quality care at all times from staff that are able to manage the personal and emotional impact of their practice.
- Clinical supervision should be valued within the context of the culture of the organisation, which is crucial in setting the tone, values and behaviours expected of individuals. It should sit alongside good practices in recruitment, induction, and training to ensure that staff have the right skills, attitudes, and support to provide high quality services.

1.5. Coaching and mentoring are also recognised as an effective means of supporting individuals to develop both personally and professionally. Coaching and mentoring can be defined as ‘learning relationships which help people to take charge of their own development, to release their potential and to achieve results which they value’ (Connor and Pokora 2007 p11).

1.6. Whilst coaching and mentoring can be viewed as complementary and have many similarities, such as facilitating insight, learning and change through a one-to-one relationship, there are some more distinct differences between the two approaches. Mentoring is often undertaken by a more senior person who has experience or achieved success within the same field as the ‘mentee’ and may include a level of professional guidance direction and support. Coaching can be undertaken by an individual who does not have experience within the same field as the coachee and is more focused on facilitating the coachee to find their own solutions and fulfil potential.

1.7. Clearly, coaching and mentoring can be used to support individuals within any work setting whereas clinical supervision is aimed specifically at staff working in clinical settings. However, many of the principles and outcomes are similar to that being achieved through supervision. Consequently, whilst accepting the differences between coaching, mentoring and clinical supervision, CFT/RCHT acknowledge that all these processes ultimately fulfil the requirements of staff for supervision and development. Therefore, for the purpose of this document, the term ‘supervision’ and ‘supervisee’ are utilised. These are used as inclusive terms and could equally refer to coaching and mentoring processes.

1.8. This policy sets out the minimum requirements for clinical supervision and is not intended to limit any arrangements that go beyond these. Some specialist areas or professions may have further requirements that are over and above these minimum standards. In this situation locally agreed procedures may be put in place but should not deviate from the core principles of this Policy. Colleagues should also refer to their own professional bodies for further guidance.

1.9. The purpose of this policy is to provide a framework for the delivery of comprehensive, consistent, and good quality clinical supervision for all healthcare professionals. The policy explains the difference between clinical supervision, managerial supervision, caseload, and children’s safeguarding supervision.

1.10. This policy does not advocate a single model of clinical supervision. No single model can be used in every clinical setting. Flexibility is important to enable staff to choose a model or adapt an approach to suit their individual learning and development needs. Proctors model of supervision has been provided as an example. (Appendix 2) This model can be used to support other forms of supervision but is used in the context of this policy to support clinical supervision.

1.11. It is recognised that clinical supervision takes place both formally and informally; both provide valuable support to individual practitioners. This policy addresses formal clinical supervision conducted either on a one-to-one basis or in a group setting.

2. Scope

This policy applies to all clinical staff with a face-to-face clinical role throughout the Trust (including block booked agency staff) with the exception of Medical staff. Medical Staff have a set process of supervision which may vary depending on their role and function. The areas set out below broadly cover their requirements.

2.1. **Career grade psychiatrists:**

Psychiatrists meet in peer groups to support continuing professional development. These groups occur regularly, and attendance is an expectation of employment at CFT. Attendance is recorded and notes taken where appropriate. This is the primary source of supervision in this occupational group. Managerial/Line management supervision occurs through medical management via Clinical Directors as required. Compliance is monitored through appraisal and revalidation processes.

2.2. **Doctors in training:**

Supervision for trainees occurs as clinical/psychiatric supervision and educational supervision for 1 protected hour per week, directed by the Gold Guide for doctors in training. The relevant postgraduate curricula also provide detailed guidance as to the content and focus of supervision time. Monitoring occurs through training programme portfolio development. Compliance is evidenced through Health Education England's Quality Matrix.

2.3. **GPs:**

Peer group education and learning meetings are held regularly. (Acute GPs – Monthly, Help for Homeless – Weekly, Musculoskeletal – Quarterly) Attendance at these meetings supports CPD and attendance is monitored by review of minutes. Managerial supervision occurs through medical management via Clinical Directors and the Director of Primary Care. Adequate arrangements for clinical supervision are monitored through the revalidation process.

2.4. **Consultants:**

Peer group education and learning meetings are held regularly. (Audit, Morbidity and Mortality, Care Group Governance meetings, Grand Rounds etc) Attendance at these meetings supports CPD and attendance is monitored by review of minutes.

Managerial supervision occurs through medical management via Clinical Directors and the Medical Directors Office. Adequate arrangements for clinical supervision are monitored through the appraisal and revalidation process.

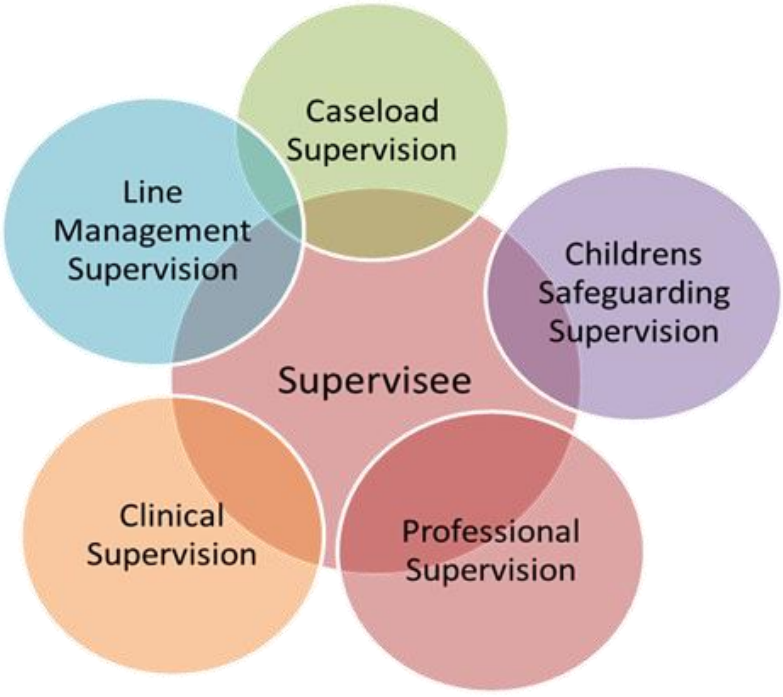
3. Definitions and glossary

3.1. There are several types of formal supervision – the most commonly referred to are:

- Clinical.
- Professional.
- Managerial.
- Caseload.
- Safeguarding.

3.2. The terms used in this area may sometimes overlap and in practical terms, it may be difficult to separate them from each other with several grey areas and blurred boundaries. Diagram 1 demonstrates how complex this area can be for some professionals. This policy will provide clarity for supervisors and supervisees to ensure core expectations are achieved in relation to clinical supervision and also direct staff to other guidance and areas of support related to other forms of supervision.

Diagram 1: Supervision Processes:



3.3. Clinical supervision provides regular protected time in a safe and confidential environment for staff to reflect on and discuss their work including their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice.

3.4. Differing terms may be used for this type of supervision depending on the professional group or approach being taken, for example the term reflective practice is commonly used. For recording purposes and clarity all such methods will be recorded as clinical supervision.

3.5. At CFT and RCHT clinical supervision is offered in a variety of ways:

- 1:1 supervision with a supervisor from your own practice.
- 1:1 supervision with a supervisor from a different practice.
- Debriefing.
- Learning from experience.
- Round tables.
- Reflective practice – Reflection is an integral part of the nursing revalidation process and also a key component to any effective episode of clinical supervision.
- Group supervision (Max 1:8 ratio) – Supervision in a group setting offers the added benefit of learning from the experience and insights of fellow practitioners. However greater consideration needs to be made to the establishment of ground rules at the start of the process and there should be a common purpose between the group members. Numbers should be limited to 8 as larger numbers will inhibit levels of interaction.
- Action learning sets – these are usually undertaken as part of a formal development programme e.g. preceptorship.

3.6. It is expected that all clinical staff receive formal clinical supervision at least once every 3 months. In addition, all clinical staff will take every opportunity to participate in informal clinical supervision on an ad-hoc and opportunistic basis.

3.7. All staff involved in a serious incident should access clinical supervision within 72 hours of the event. Further guidance can be found on the Intranet in the document Policy and Help guide for supporting staff involved, reporting, or witnessing an incident or stressful event.

3.8. **Line Management Supervision**

3.8.1. The purpose of line management supervision is to ensure staff recognise and understand their role and contribution to the delivery of the Trust's objectives through effective personal objective setting, appraisal, and performance review for individual staff. Further guidance can be obtained by referring to the Trust's Appraisal guidance available on the document library.

3.8.2. If during an appraisal or line management supervision, there have been 'reflective clinical discussions' then this may be considered as clinical supervision. Reflection and development are core components of an effective episode of supervision.

3.9. **Caseload Supervision**

3.9.1. Caseload supervision is likely to form part of management supervision. This is a requirement for all staff that have an allocated clinical caseload.

- Where supervision includes reviewing specific patients, both supervisor and supervisee should independently select patients for discussion.
- Caseload supervision is essential for all staff that carries an individual case load, either in the community or in an inpatient setting. This includes unregistered practitioners who act as a key worker.
- A primary function of caseload supervision is to monitor the size and complexity of the caseload to ensure that the workload allocated to the practitioner is achievable.

- Caseload supervision ensures the effectiveness and safety of services delivered to service users and families. This includes assuring that all relevant aspects of the Care Planning, Risk Management and Safeguarding are being implemented and recorded dependant on the professional involved and the service they are working within.
- Caseload supervision also ensures that the processes to deliver safe and effective care under CPA and Safeguarding are being adhered to through the monitoring of the clinical records.
- It is a minimum standard that staff should receive no less than one hour of case load management supervision every 6 weeks. It is recognised and recommended that caseload supervision sessions may need to take place with a higher degree of frequency if the supervisee is dealing with a very complex or challenging issue, for which they and their supervisor have identified the need for more supervision. Caseload supervision may take place in a group setting where clinically appropriate.
- Caseload supervision should include the following:
  - Review of record keeping quality.
  - Frequency of contact.
  - Access to appropriate treatment.
  - Any cases currently subject to or may be referred to Adult Safeguarding.
  - Any Child Safeguarding concerns.
  - Use of Routine Enquiry.
  - Non-attendance and subsequent management of cases.
  - Self-neglect.
  - Complex Cases with multiple services engaged.
  - Practice related to any case where the person lacks capacity to consent and the legal frameworks in place to support this.

3.10. **Children's Safeguarding Supervision**

3.10.1. Children's Safeguarding supervision is mandatory for all staff that work directly with children and have child protection responsibilities. The Trust is committed to the national approaches of "Think Adult Think Child" and "Think Child, Think Parent, Think Family" as a result child protection supervision is

available to staff who work with adults whose children are on a child protection plan and should be accessed through the Trust safeguarding children team. Further guidance can be found in the Trust's Safeguarding Policy available on the document library. Further information can be found in the Safeguarding Supervision Policy.

3.10.2. Purpose:

- To ensure that practice is focused on the safety and wellbeing of children and young people.
- To provide support to staff working with complex and challenging situations and allowing the opportunity to reflect on practice.
- To ensure that information is shared with appropriate agencies in order to reduce risks to vulnerable individuals and underpin effective partnership working.
- To ensure that Child Protection Plans or Child In Need Plans are reviewed and progressed appropriately.

3.11. Professional Supervision

This form of supervision is required when a health care professional works in a team isolated from other members of their professional body.

3.12. HARP (Healthcare Appraisal and Revalidation Tool)

The HARP system is a web application enabling health care professionals to record and manage a portfolio for revalidation purposes. It also supports the recording of clinical supervision the outcomes of which can be included in individual portfolios. All clinical staff will be required to record episodes of clinical supervision on this system. User guides can be found on the Intranet and support can be obtained from cft.educationandtraining@nhs.net or rcht.landdadmin@nhs.net

Other Forms of Support

3.13. Restorative Supervision

3.13.1. Restorative clinical supervision (RCS) addresses the emotional needs of staff. It provides ‘thinking space’, which, as highlighted in this guidance, reduces stress and burnout and in turn improves staff retention. Those providing restorative supervision must complete an approved Professional Nurse Advocate (PNA) training programme.

3.13.2. The restorative approach “promotes reflection of personal emotions and practice, has a positive impact on emotional wellbeing, provides a strategy to mitigate workplace stress, enhances retention and assists with the management of personal and professional demands.

3.14. Schwartz Rounds

Whilst not seen as clinical supervision the use of Schwartz Rounds also provides a good opportunity to gain emotional and psychological support. CFT/RCHT offer access to these rounds on a regular basis staff should access Schwartz Rounds via the intranet.

3.15. Coaching

Staff can access a qualified Coach through the systems coaching pool. Staff can be directed to this support by contacting cft.educationandtraining@nhs.net or rcht.landdadmin@nhs.net.

3.16. Health and Wellbeing Team

CFT and RCHT are committed to supporting the health and wellbeing of its employees. Support with Health and Wellbeing can be accessed via the intranet.

4. Ownership and responsibilities

4.1. Lead executive

- The Joint Director of Nursing and Allied Health Professionals is responsible for the development, monitoring, and support of this policy.

4.2. Responsible reporting group

- The Strategic Education Group (CFT) is responsible for the creation, implementation, and monitoring of this policy. This group reports to the People and Culture Committee which is a subgroup of the Trusts Board.

4.3. Employees

- All Trust employees are personally and/or professionally responsible for ensuring they access and engage in the supervision required for their role and maintain procedures to assure compliance with this policy.
- They must maintain accurate records of their supervision using the HARP system.

4.4. Directors, Clinical Directors, Associate Directors

- Are responsible for implementation and monitoring of this policy in their areas of responsibility; ensuring the implementation systems and processes are in place to ensure compliance with this policy.

4.5. Professional Leads/Matrons

- Each relevant professional lead/Matron has the responsibility to ensure that there are supervision systems and processes in the organisation to meet professional governance requirements.
- They should ensure that all professionals have access to the supervision they require to meet their professional standards.

4.6. Team/Service Managers/Ward Managers

- Each manager has the responsibility for ensuring their staff have access to and are participating in the appropriate supervision for their role.

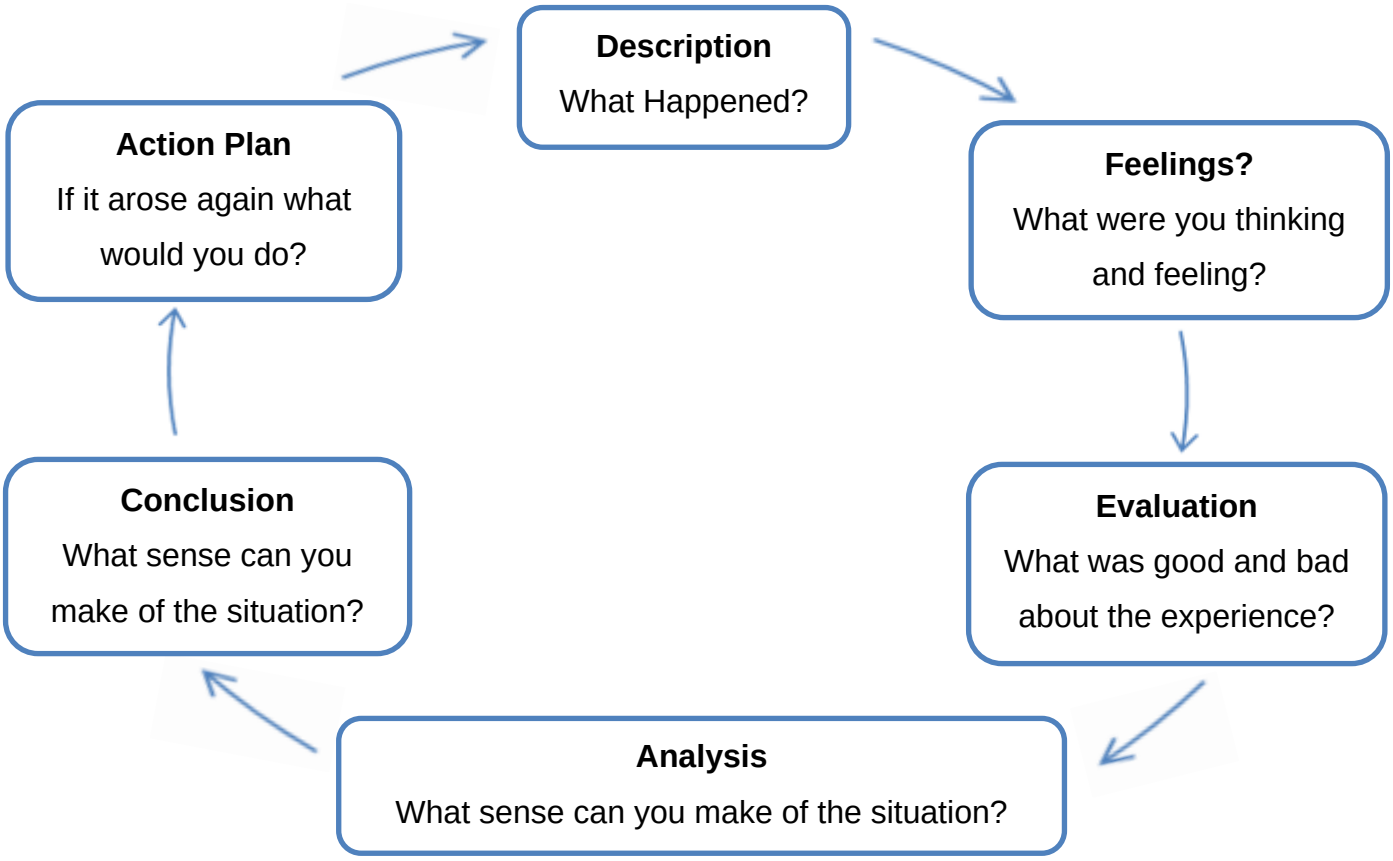
- They should have documentary evidence for all employees they have responsibility for. They also have responsibility for the maintenance and monitoring of compliance with this policy within their area of responsibility and for feedback through the management and governance systems.
- During appraisals is an opportunity to ensure appropriate arrangements for supervision are in place.

4.7. Clinical supervisors

Key responsibilities of the clinical supervisor are detailed below:

- To set out the supervision arrangements with the supervisee including ground rules. Clinical supervision contracts are recommended in order to provide a basis for creating a collaborative supervision process. Where it is thought to be useful a template to be used for the supervision contracting is shown in Appendix 4.
- Provide an environment in which the supervisee feels safe to explore potentially difficult situations, behaviours, and attitudes.
- Encourage reflection of practice. Gibb's model (Diagram 2) can be utilised to support the reflective process however there are a number of other models.
- Ensure they focus on the developmental needs of the supervisee and maintain a non-judgemental approach.
- Utilise appropriate skills to ensure that supervision sessions are effective and purposeful.
- Access appropriate supervisor training as required to maintain relevant skills.
- Commitment.
- Manage own time.

Diagram 2: Gibbs Model of Reflection, 1988



4.8. Clinical supervisees

Key responsibilities of the supervisee are detailed below:

- Clinical supervision is supervisee led therefore the supervisee must take responsibility for organising, engaging with, and recording all episodes of clinical supervision.
- Select an appropriate supervisor that would normally be separate from existing line management arrangements.
- Will actively engage in clinical supervision activities in accordance with the requirements from their professional body and this policy.
- Will reflect on their practice with their supervisor. Gibb's model (Diagram 2) can be utilised to support the reflective process however there are a number of other models.
- Will ensure that the content of clinical supervision remains practice focussed.
- Will ensure that they adhere to the agreed supervision arrangements and ground rules.
- Supervisees must prepare for clinical supervision by identifying relevant issues to discuss during supervision.

- Supervisees should be open to constructive feedback.
- To design and commit to action plans that has arisen from reflection during clinical supervision.
- Will feedback any personal development requests originating from clinical supervision through their line manager/appraisal processes.
- Record all episodes of clinical supervision utilising the HARP System. (Excluding medical staff) User guides can be obtained from the Intranet and support is available from CFT Education and Training Team (cft.educationandtraining@nhs.net) or from RCHT Learning and Development team (rcht.landdadmin@nhs.net).

5. Standards and practice

5.1. Confidentiality

The content of clinical supervision sessions will be kept confidential. It is important to discuss confidentiality at the outset of the clinical supervision session and for both parties to recognise that dependent upon the disclosures made, there may be circumstances where the clinical supervisor has a duty of care to break confidentiality. Examples may include:

- The clinical supervisor has genuine concerns for the well-being of the supervisee.
- Unsafe or unethical practice is revealed during the clinical supervision session.
- Illegal activity is revealed during the clinical supervision session.
- A request for action to be taken outside of the clinical supervision session which has been requested by or agreed with the supervisee.
- The supervisee repeatedly fails to attend sessions or attends but does not engage in reflection of practice.

Table 1: Supervision Summary Table

Type of Supervision	Relevant Staff Group (within scope of this policy)	Minimum Frequency	Recommended Duration	Format
Line Management	All Staff	Every 3 months	1 hour	1:1 or Group as appropriate

Type of Supervision	Relevant Staff Group (within scope of this policy)	Minimum Frequency	Recommended Duration	Format
Caseload	Clinical staff carrying a caseload.	Every 6 weeks	1 hour	1:1 or Group as appropriate.
Clinical	All clinical staff.	Every 3 months	1 hour	1:1 or Group as appropriate, Action learning set, Learning from experience, debriefing.
Children's Safeguarding	Identified Groups within Children's Service.	Every 3 months	Variable	Group.

6. Related legislation, national and local guidance

Clinical supervision models for registered professionals: https://www.nhsemployers.org/articles/clinical-supervision-models-registered-professionals.

The Code: Standards of conduct, performance and ethics for nurses and midwives Health and Care Professions Council (HCPC) Supervision, leadership, and culture: https://www.hcpc-uk.org/standards/meeting-our-standards/supervision-leadership-and-culture/supervision/

Professional nurse advocate A-EQUIP model: a model of clinical supervision for nurses. Version 2, September 2023: https://www.england.nhs.uk/long-read/pna-equip-model-a-model-of-clinical-supervision-for-nurses.

7. Training requirements

Training is available for supervisors to ensure effective clinical supervision is delivered. This will be made available and advertised through the Education and Training service. E-Learning is also available to support both supervisors and supervisees.
Training is also available to support the development of coaching skills and in the facilitation of action learning sets.

Support relating to the recording of supervision using the HARP system is available monthly via CFTs learning management system. One to one support can also be arranged by contacting cft.supervision@nhs.net and rcht.landdadmin@nhs.net.

8. Implementation

The document is available on the document library. Significant updates will be communicated via Trust wide communications and direct email to all supervisees and supervisors.

Implementation of the policy will be via Trust wide communication and supported by appropriate training for the relevant members of staff as described above.

9. Document Monitoring arrangements

All staff receiving supervision will utilise the HARP system to record supervision activity, specific guidance on how to do this is provided on the Intranet. Clinical staff working within operational services will have compliance reported monthly through the education and training team with monthly reports to management teams, professional and quality leads.

Compliance data will be reported to the trusts Strategic Education Group (monthly) and the trusts People and Culture Committee (bi-monthly). Responsibilities for generating reports are held with the Education and Training Team.

Information category	Detail of process and methodology for monitoring compliance
Element to be monitored	Compliance with the policy – monitoring through HARP (Healthcare professionals Appraisal and Revalidation support Portal).
Lead	Head of Education (CFT) Learning and Development Leads (RCHT).
Tool	Adherence will be monitored as part of the ongoing audit process within the department on a Word or Excel template specific to the topic.
Frequency	Quarterly report from HARP to Clinical Cabinet, monthly reporting to operational leads, bi-monthly reporting to strategic education group and People and Culture Committee (CFT).
Reporting arrangements	Head of Education/Learning and Development Leads to present compliance reports to Clinical Cabinet each quarter.
Acting on recommendations and lead(s)	Clinical Cabinet will act on reports presented if required.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned. A lead member of Clinical Cabinet will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

10. Updating and review

This policy will be reviewed no less than every three years.

11. Equality and diversity

This document complies with the Cornwall Partnership NHS Foundation Trust and Royal Cornwall Hospitals NHS Trust equality and diversity statements. The statements can be found in the RCHT Equality Diversity And Inclusion Policy and CFT Equality, Diversity and Inclusion Statement.

The initial equality impact assessment screening form is at appendix 1.

12. Appendix 1: Equality Impact assessment Form

Title of policy or document for assessment: Clinical Supervision Policy V2.0

Document library section: Corprostae Governance

Is this a new or existing document? Existing

Date of assessment: 2 January 2024

Person responsible for the assessment: CFT: Alan Jervis, Head of Education and Training

What is the main purpose of the document?

To provide a framework for supervisory activity to support safe and effective professional practice.

Who is affected by the document?

☒ Staff ☐ Patients ☐ Visitors ☐ Carers ☐ Other ☐ All

The document aims to improve access, experience and outcomes for all groups protected by the Equality Act 2010.

Concerns

Are there concerns that the procedural document could have a differential impact on the following areas?

If a negative impact has been identified, please complete a full EIA by contacting the Equality, Diversity, and Inclusion Team. For RCHT please contact rcht.inclusion@nhs.net and for CFT please contact cft.inclusion@nhs.net

Concern area	Response	If yes, what existing evidence (either presumed or otherwise) do you have for this?
Age	☐ Yes ☒ No	
Disability	☐ Yes ☒ No	
Sex	☐ Yes ☒ No	
Gender reassignment	☐ Yes ☒ No	
Pregnancy and maternity	☐ Yes ☒ No	
Race	☐ Yes ☒ No	
Religion and belief	☐ Yes ☒ No	
Sexual orientation	☐ Yes ☒ No	
Marriage and civil partnership	☐ Yes ☒ No	
Groups at risk of stigma or social exclusion such as offenders or homeless people	☐ Yes ☒ No	
Human rights	☐ Yes ☒ No	

Are there any associated objectives of the document? If yes, what existing evidence (either presumed or otherwise) do you have for this?

No.

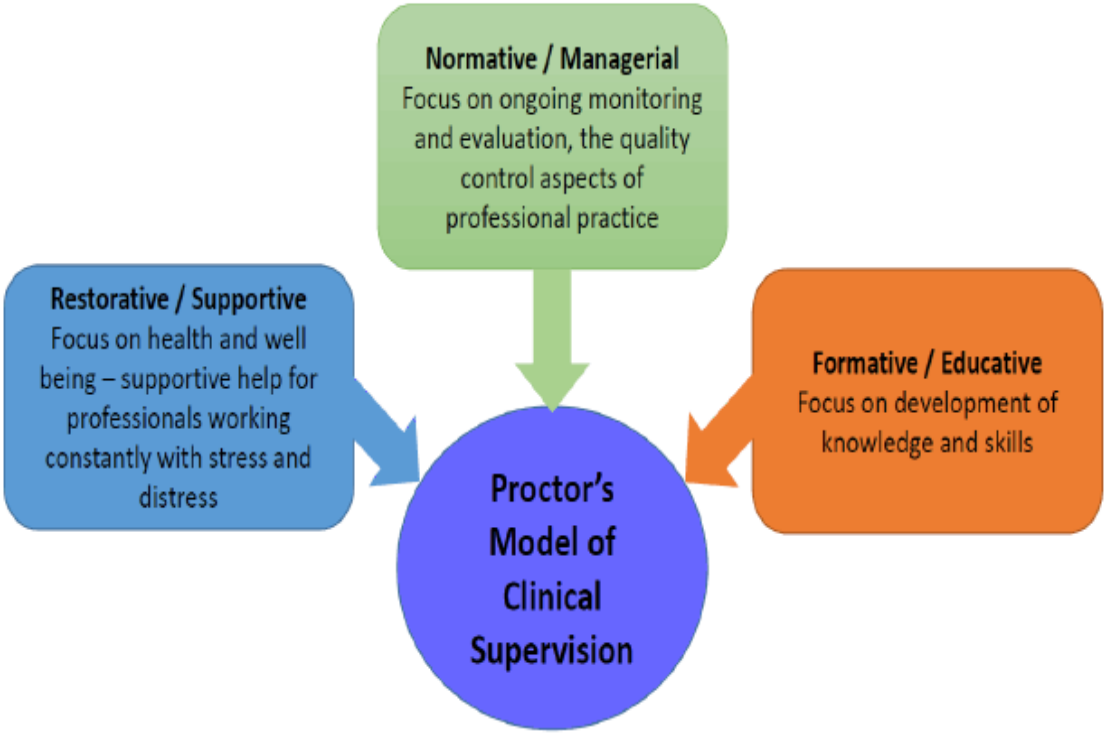
Signature of person completing the equality impact assessment:

Name: Alan Jervis, Head of Education

Date: 2 January 2024

13. Appendix 2. Proctors Model of Supervision (1998)

1. Normative Support.
2. Restorative Support.
3. Formative Support.



Proctor (1998) Supervision a co-operative exercise in accountability in Marken M and Payne M (1998) Enabling and ensuring supervision in practice national youth bureau for education Community Work: Leicester.

14. Appendix 3. Supervision Record Template

Supervisee Name:	
Supervisor Name:	
Date:	

Summary of Discussion	
Actions Agreed (SMART)	
Summary of Learning	

Supervisee Signature: _____

Supervisor Signature: _____

15. Appendix 4. Clinical Supervision Agreement Contract

As Supervisee and Supervisor, we agree to the following:

- That we will meet on a regular basis as agreed (insert agreed timescales).
- Sessions will be supported, guided, and recorded in line with Trust policy.
- Privacy will be ensured, and there will be no interruptions.
- That the aims of the session will enable us to reflect in depth on issues affecting practice, in order to develop personally and professionally towards achieving, sustaining, and developing high quality practice.
- The content of the clinical supervision session will be to:
  - ✓ Review /reflect on clinical practice.
  - ✓ Discuss current issues or concerns.
  - ✓ Discuss issues related to professional development.
- We will work in the spirit of learning about how to use clinical supervision, both of us being open to feedback on how we handle the session.
- The boundaries of confidentiality within clinical supervision do not include anything that is illegal, contrary to the code of professional conduct, or contravenes the policy of the Trust.
- We both agree that clinical supervision is a commitment and should be cancelled only in the event of an illness or crisis. Notice will be given by the person who cancels, and it will be their responsibility to rearrange the session.
- Both parties will participate in evaluation of supervisory meetings after the first 6 months and then annually thereafter.
- In the event of the supervisory partnership being ineffective or difficulties arising, either party can choose to terminate the contract after discussion and without recourse. The supervisee should then seek support from their line manager to identify a new supervisor.
- To challenge any breach of this agreement.

As supervisee, I agree to:

- Prepare for the sessions and be responsible for the agenda. Take responsibility for making effective use of time.
- To identify and action any learning or developmental needs.

- To identify practice issues for exploring and to be open to feedback and explore alternative interventions/ possible solutions.
- Record completion of Supervision on the HARP system.
- To take responsibility for the outcomes and actions I take as a result of clinical supervision.

As supervisor I agree to:

- To provide a safe environment to explore and clarify thinking, give clear feedback, share information experiences and skills.
- Offer support and supportive challenge (skills, decisions, behaviour and values) regarding situations that the supervisee talks about.
- Provide Information, advice and sign posting to enable reflection on issues affecting professional practice.

Supervisor Name (PRINT)	
Supervisee Name (PRINT)	
Frequency	
Duration of sessions	
Contract Review Date	

Signed Supervisor		**Date**	
Signed Supervisee		**Date**	