HPFT

# Supervision Policy

HPFT Policy

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| Version | 5 |
| Executive Lead | Executive Director of Quality and Safety |
| Lead Author | Head of Recovery and Psychological Services |
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## Document on a Page

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| **Title of document** | Supervision Policy | | |
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| **Version** | **Issue Date** | **Review Date** | **Lead Author** |
| 5 | 08/02/2019 | 08/02/2022 | Head of Recovery and Psychological Services |
| **Staff need to know about this policy because (complete in 50 words)** | All HPFT staff need to be conversant with this policy because it describes and defines one of the most important aspects of their roles in HPFT. Clinical, Managerial and Professional Supervision should be organised according to the principles of this policy. | | |
| **Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:** | 1. A record of all kinds of supervision should be made, stored appropriately and shared with the staff concerned.<br>2. Supervision arrangements should be supported by a contract, including arrangements for external supervision which should always be agreed with the line manager and professional lead.<br>3. Training in the provision of supervision is available through Learning and Development. | | |
| **Summary of significant changes from previous version are:** | 1. Guidance on Supervision Contracts has been strengthened.<br>2. New guidance on External Supervision has been added.<br>3. New guidance on the selection of Supervisors has been added,<br>4. New guidance on the relationship between different forms of supervision has been added.<br>5. New guidance on the Supervision of trainees and students has been added.<br>6. New guidance on the inclusion of Safeguarding processes in Clinical Supervision has been added.<br>7. Safeguarding process has been added.<br>8. Various additional guidance pertaining to the different disciplines has been added in the appendices. | | |

## Contents Page

## PART 1 – Preliminary Issues:

### 1. Introduction

Hertfordshire Partnership University NHS Foundation Trust (HPFT) is committed to ensuring that all staff, including trainees, have access to regular, good quality supervision.

Good quality, effective supervision enhances job satisfaction, personal development and the provision of a high quality service. Supervision is a key opportunity for staff to receive guidance, feedback and support. The key benefits of supervision are detailed in appendix 1.

This policy describes the minimum expectations of supervision across HPFT. Detailed guidance on clinical (reflective) supervision for professional roles can be found in the appendices. Unless otherwise stated in the policy, the term supervision refers to management, clinical and professional supervision

The policy incorporates the performance indicators required by the National Health Litigation Authority Risk Management Standards

“This policy does not apply to medical staff, for whom a separate Policy for Supervision of Medical Staff” applies.

### 2. Purpose

The policy describes what supervision means and responsibilities regarding supervision. It describes the types of supervision staff will receive. Detail is given regarding supervision standards and the relationships between different types of supervision.

### 3. Definitions

Supervision is an accountable process which supports, assures and develops the knowledge, skills and values of an individual, group or team. The purpose is to improve the quality of their work to achieve agreed objectives and outcomes.

## PART 2

## 4. Duties and Responsibilities

### 4.1 Management supervision

Management supervision is task orientated with a formal service-led agenda. It takes place in a regular meeting with the line manager (or other nominated manager) in order to discuss issues including:

- Operational and management issues relating to the staff member (supervisee)'s role
- Operational issues relating to the achievement of Trust objectives
- Agreed objectives and progress towards these
- Delegation and workload management
- Accountability for practice and required performance standards
- Managerial support
- Personal development

### 4.2 Clinical (Reflective) supervision

Clinical (Reflective) supervision provides the opportunity for health and social care staff to:

- Discuss individual cases in depth, including reviewing the aims and expected outcomes of intervention
- Reflect on and review their clinical practice to further develop clinical effectiveness and demonstrate required competencies to practice
- Identify concerns such as safeguarding issues
- Change or modify their practice
- Give constructive feedback to change or modify their practice if necessary or to identify good practice to share with others
- Develop clinical skills and use opportunities for wider learning
- Review professional standards and how any changes impact on practice
- Discuss key clinical or organisational issues that are impacting on practice

### 4.3 Professional supervision

Professional supervision is delivered by a supervisor who has the same professional registration as the supervisee. This may be required by some professional groups in addition to management and clinical supervision, according to the requirements of their professional body. Advice regarding this can be sought from the relevant professional head / lead

Staff in professional lead roles will require professional supervision from the relevant head of profession to support their leadership roles**.**

Further information on types of supervision can be found in appendix 2.

### 4.4. Relationship between the different forms of supervision

It is possible, with the agreement of both parties, for a member of staff to receive different forms of supervision from the same colleague. However, it is also sometimes the case that a supervisee or a supervisor may prefer to have these functions separated. Any potential arrangement where multiple supervisory functions may be served should be sensibly weighed and an arrangement made which suits both parties.

It is more likely that Professional, Clinical and Managerial supervision will be organised separately and be provided by different supervisors. In cases such as these care should be taken to establish regular communication as is appropriate and for all supervisors to contribute to the supervisee's PDP.

## 5. Expectations

**5.1** All staff within the Trust must receive line management supervision. This is part of the contract of employment within HPFT and is a mandatory requirement of employment. All staff engaged in direct clinical care must receive clinical supervision which is also a mandatory requirement of employment. Professional supervision will be provided where appropriate.

5.2 Regular management supervision must include the monitoring of individual objectives, which should flow from local and trust-wide objectives. Regular feedback during supervision will ensure that the staff member (supervisee) knows what is expected and required of them in order to provide a high quality service.

5.3 Supervision must be a regular, planned meeting with an appropriate supervisor. Clinical supervision should be clearly distinguished and kept separate, where possible, from management supervision.

5.4 Supervision should be carried out in a supportive manner, ensuring that quality standards are met and that objectives are outcome focussed and there are opportunities for learning. Supervision should be carried out in line with Trust values.

5.5 Supervisors must keep clear, accurate and up-to-date records using an appropriate record form. (See section 6.4)

5.6 Both parties should retain a copy of the record form.

5.7 Supervisors and supervisees should avoid other personal or dual relationships which could affect the integrity and objectivity of the relationship involved.

## 6. Responsibilities

Every employee has responsibility for participation in supervision and the implementation of this policy, **(appendix 3).**

Directors, Senior Managers and Professional Leads have key responsibility for the implementation of this policy. Senior managers should lead by example with good quality supervision and processes.

Line managers are responsible for ensuring that appropriate supervision arrangements are made for each member of staff. Being a supervisor is a significant responsibility and should be taken seriously. Where two or more people provide supervision to one individual, the line manager is responsible for coordinating the process and ensuring adequate provision is made. Line managers may seek advice from heads of professions when agreeing supervision arrangements for an individual.

Team Leaders must ensure that a record is kept of planned supervision, where sessions have been cancelled and the reasons for this. A template is available on Trustspace if required.

Line managers should refer to the Performance and Development Review Policy and Procedure in relation to performance issues and seek the support of their Human Resources Manager (HRM).

Managers have a responsibility to ensure appropriate supervision takes place whilst individual staff has a responsibility to engage and participate fully in the process. Every effort should be made to ensure that supervision takes place and is only cancelled when absolutely necessary. In these instances the cancelled session should be rescheduled as soon as is feasibly possible.

Managers and supervisors are responsible for ensuring that adequate time and opportunity are made for the supervision meeting, during work time and planned in advance.

Clinical team managers are responsible for checking record keeping standards and data quality by using electronic reports and also at supervision.

More detailed responsibilities of supervisors and supervisees are detailed in the appendices.

## 7. Supervision Standards

### 7.1 Selection of Supervisors

Decisions regarding the selection of supervisors should be mutually agreed with the staff member, line manager, professional lead / head and supervisee.

Usually Professional and Line Management supervision will be provided by a more senior member of professional or operational staff.

Clinical or Reflective Supervision should be provided by a more experienced member of the supervisee's profession. However, there will be situations where a supervisee is providing a clinical intervention (e.g. a psychological therapy) and will require regular

clinical supervision from a practitioner skilled in that approach. This arrangement may not replace the core clinical supervision which the supervisee requires.
The following additional factors may require consideration in making arrangements for any kind of supervision:

- Performance issues
- The supervisee's experience and competence
- Personal development
- Workload / Caseload issues
- Geographical location of both staff

## 7.2 Frequency and Duration

Management supervision should usually take place at a frequency of once every 4-6 weeks with a maximum interval of 8 weeks. The session should usually last between one and two hours. Optimal frequency will depend on the experience of the staff member, length of time in the job (usually more often during the induction period), the complexity of the role and the individual's needs. Recommendations may be made at service or professional level.

All staff engaged in direct clinical care will receive clinical (reflective) supervision. The frequency of clinical (reflective) professional supervision will depend on the context and requirements of the role and any minimum requirements of professional bodies. Frequency levels should be agreed by supervisee, line manager and clinical and professional supervisor but it is likely that this will be no less than monthly.

## 7.2 Confidentiality

Supervision will be confidential in line with professional Codes of Practice and Trust policies which describe the limited circumstances in which it is appropriate to act upon information disclosed in supervision. All supervision must take place in a quiet and confidential place without unnecessary interruptions.

Supervision records made within all types of supervision should be properly and promptly recorded with notes copied to the supervisee and a copy saved on a secure network drive with arrangements made for appropriate third-party access in situations where the supervisor is unavailable. .

Supervision records must respect confidentiality of information relating to service users. Any record should avoid personal identification of service users or third parties.. When it is necessary to record discussion of a particular service user initials should be used and not the individuals full name.

Clinical Supervisors have a clear responsibility to liaise directly with the supervisee's line manager if there are issues of concern arising from clinical supervision. Although the clinical supervisor has clear responsibilities to the Trust and the practitioner, the primary responsibility of the supervisor remains the welfare of the client.

Supervision records may be released on request for monitoring purposes or used as documentation in disciplinary or legal proceedings.

Supervision notes are also disclosable if the staff member makes a Data Protection Act subject access request.

## 7.3 Contracts

All staff will have a Supervision Contract specifying the nature, purpose, frequency and scope of supervision and defining the responsibilities of the supervisor and the supervisee. An example supervision contract can be found in appendix 4. Contracts for clinical and professional supervision should follow the ratified guidance for the appropriate professional group.

## 7.4 Recording

It is the responsibility of the supervisor whether management clinical or professional supervision to keep clear, accurate and up-to-date records of all discussion using an appropriate record form. The record should not be passed to a third party to write up unless both parties agree to this. The supervisor is responsible for providing the supervisee with a copy and the two parties should agree the content and sign.

Arrangements for recording group or peer, professional and/or clinical supervision will be agreed as part of the Terms of Reference when the group is started.

Appendices 4 - 13 are examples of record forms. These forms do not have to be used but if alternative forms are used they must reflect the content required to be covered in each type of supervision.

If supervision records are made and held electronically the supervisor must seek permission from the supervisee. The supervision record must be kept in a secure network drive belonging to the supervisor (with an explicit delegated access arrangement in the supervisor's absence).

## 7.5 Agenda

There should be an agenda which the supervisee has the opportunity to contribute to. Areas of work to achieve organisational and personal objectives should be the focus, while also set in a context which encourages reflective practice.

The agenda for all types of supervision should jointly be set between the supervisee and the supervisor and both will have opportunity to contribute to the discussion and decisions and have equal responsibility for constructive discussion.

Examples of agenda topics are included in the profession specific guidance contained within the appendices. Safeguarding issues must be a regular agenda item in all supervision and the outcome of any such discussions must be recorded in the electronic patient record. A flow chart describing interventions needed when such issues are identified is attached at **(appendix 14).**

## 7.6 Anti-discriminatory practice

Supervision should provide supportive time and space whereby an individual staff member feels enabled to share any issues or concerns. The session should be non-judgemental, anti-discriminatory and encourage reflection in order to enhance practice.

# 8.0 External Supervision

### 8.1 Usual and preferred practice

It is the clear expectation of the Trust that all types of supervision will be primarily provided within HPFT by staff directly employed by HPFT. Staff are not permitted to develop their own arrangements for any type of supervision, professional, managerial, nor clinical, without the express and written permission from their line manager.

Some clinical staff will in the course of their professional activities outside of the Trust have supervisory arrangements with non-HPFT staff; they should not discuss their work in HPFT in these contexts.

### 8.2 Formalised external supervision arrangements

In appropriate circumstances the Trust will make formal arrangements for HPFT staff to receive supervision from a non-HPFT practitioner. This will usually be where the service being provided is particularly specialised to the point where an experienced HPFT supervisor is not available. The external supervisor, especially where a clinical role is being provided, will satisfy the requirements of the Professional Body under which the HPFT staff member is registered / accredited etc.

Where an arrangement is put in place for external supervision this will be done in writing by the line manager and be accompanied by a contract which will be signed by the line manager, the staff member and the external supervisor. This contract will fulfil the same role and be constituted in the same way as the contracts used within the Trust. It is especially important that the external supervisor is aware of, and agrees to being in contact with the line manager where concerns of any kind arise in the course of the supervision. Guidance for developing this kind of contract is available in Appendix 13.

## 9. Training/Awareness –

| Course | For | Renewal Period | Delivery Mode | Contact Information |
|---|---|---|---|---|
| **Supervision Skills** (Incorporates Clinical Supervision) | Managers & Supervisors new to the role | Once | Taught course (1 day) | For taught courses, contact the Learning & Development Team: Learning@hpft.nhs.uk You can check for future dates here, and request a specific date. |

All staff responsible for supervising others can access the Trust's Supervision Skills Training as a baseline.

However for advice and support the HR Manager, Professional Head or Learning and Development lead should be contacted in the first instance. Staff delivering clinical supervision can access other development opportunities relevant to their profession **(see Appendix 13)**. The need for this training should be identified in an individual's personal development plan. Supervisors are also encouraged to access coaching and mentoring opportunities.

## 10. Trainees

As a University Trust HPFT provides training opportunities for staff from a wide range of professional backgrounds, including: Nurses, Social Workers, AHPs, and Psychological Therapists etc. The supervision of these students / trainees must of course be organised and delivered in close conjunction with the training body providing the academic aspect of the training. Further, all supervision provided to trainees must comply with HPFT's Student / Trainee Placement and Mentorship Policy.

All HPFT Supervisors offering training placements must do so in a way which allows oversight from an HPFT Practice Education Facilitator (PEF). Additionally all requests for training placements must be agreed in liaison with the PEF.

Supervision arrangements for trainees / students from different professional backgrounds will vary somewhat but in all cases liaison with the training body will be necessary. More detailed guidance is available in the appendix.

## 11. Embedding a culture of Equality & RESPECT

The Trust promotes fairness and RESPECT in relation to the treatment, care & support of service users, carers and staff.

RESPECT means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

| | |
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| **Service user,** | Staff access and reasonable adjustments should be addressed when |

| | |
|---|---|
| **carer and/or staff access needs** (including disability) | making supervision arrangements that should be stipulated in the supervision contract and regularly reviewed via contractual agreements.<br><br>Any actions required to implement adjustments should be documented in supervision records and the PDR |
| **Involvement** | The implementation of the values and behaviours framework allows staff to include comments and experiences about their work in supervision. The policy clearly states that all staff should be given the opportunity to plan, prepare and participate in supervision which by its very nature is a two way process |
| **Relationships & Sexual Orientation** | The statement of equality relevant to all protected characteristics is embedded in the supervision policy and documentation |
| **Culture & Ethnicity** | The supervision policy anticipates that in a majority of cases the supervisor and supervisee will have an existing relationship and will therefore be aware of any culturally driven factors that might influence, for example at the beginning of the supervision arrangements, via the supervision contract and throughout the supervision process. |
| **Spirituality** | Supervision arrangements assume a relationship between the supervisor and supervisee exists in relation to their role and responsibilities within the organisation and service. These arrangements will be sensitive to individual needs and the nature of the process should prevent any system bias. All supervisors will attend supervision skills training and mandatory equality training that will prevent discriminatory practice |
| **Age** | All staff are required to participate in supervision. The supervisory arrangements and supervision contract will be tailored to meet the needs of the individual based on skills, ability and the requirements of their role which should not be impacted on by the individuals age and makes no age related assumptions |
| **Gender & Gender Reassignment** | Supervision arrangements assume a relationship between the supervisor and supervisee exists in relation to their role and responsibilities within the organisation and service. These arrangements will be sensitive to individual needs and the nature of the process should prevent any system bias. All supervisors will attend supervision skills training and mandatory equality training that will prevent discriminatory practice |
| **Advancing equality of opportunity** | The supervision arrangements are made by mutual agreement by the supervisor and supervisee. The supervision contract, process and records encourage an individual approach that is personalised to the staff member, their skills, role and responsibilities. Supervision provides an opportunity for reflection, skills development and the setting of future objectives that enhances the personal development of the individual and enables equal involvement and participation in the process. The PDR is reviewed and monitored via the supervision process. |

## 12. Process for monitoring compliance with this document:

The organisation's objective is to demonstrate monitoring as a minimum in relation to:

- Ensuring all staff receive management supervision
- Ensuring all staff with direct contact with service users receive clinical supervision
- Where appropriate staff also receive professional supervision.

Line managers must check that supervision arrangements are cascaded through their line of responsibility through their direct reports.

Heads of professional groups are responsible for checking that clinical supervision arrangements described in the relevant appendices attached, take place.

The Trust will include supervision audits as agreed in the Annual Audit Plan. The Reports will be reviewed by the Practice Audit Implementation Group (PAIG) and then reported on to the Quality and Risk Management Committee.

| Action: | Lead | Method | Frequency | Report to: |
|---|---|---|---|---|
| Audit implementation of policy | Heads of Services<br>P G Leads | PACE Audit | Annual | PAIG<br>Quality and Risk Management Committee |
| Supervision records are checked at annual review | Manager | Audit | Annually | HR |

## PART 3 – Associated Issues

### 12. Version Control

| Version | Date of Issue | Author | Status | Comment |
|---|---|---|---|---|
| V3 | September 2011 | Head of Organisational Development and Learning | Superseded | Archived |
| V4 | 27th May 2014 | Head of Nursing & Patient Safety | Superseded | Updated |
| V4.1 | 27th May 2014 | Head of Nursing & Patient Safety | Superseded | Updated |
| V5 | 8th February 2019 | Head of Recovery and Psychological Services | Current | |

### 13. Archiving Arrangements

All policy documents when no longer in use must be retained for a period of 10 years from the date the document is superseded as set out in the Trust Business and Corporate (Non-Health) Records Retention Schedule available on the Trust Intranet

A database of archived policies is kept as an electronic archive administered by the Compliance and Risk Facilitator. This archive is held on a central server and copies of these archived documents can be obtained from the Compliance and Risk Facilitator on request.

### 14. Associated Documents

This procedural document should be used in conjunction with the following HPFT policies all of which are available on the HPFT staff website

- Care Records Policy – Policy and Procedure on the Management of Care Records
- Information Governance Strategy & Policy
- Performance Review & Development Policy
- Grievance Policy
- Policy for Registration of Professional Health/Social Care Staff
- Performance Development and Review Policy
- Student / Trainee Placement and Mentoring Policy

### 15. Supporting References


- Association for Family Therapy and Systemic Practice in the UK, Code of Ethics and Practice for Supervisors
- British Psychological Society “New Ways of Working for Applied Psychologists in Health and Social Care – Organising, Managing, and Leading Psychological Services”
- British Psychological Society “Generic Professional Practice Guidelines” 2nd Edition Feb 2008
- British Psychological Society – Division of Clinical Psychology, Continued Supervision policy document, July 2006
- Department of Health “From values to action: The Chief Nursing Officer’s review of mental health nursing”

- College of Occupational Therapists. Professional Standards for Occupational Therapy Practice. Standard Statements 2007
- Royal college of Speech and Language Therapists “Communication quality 3”
- Royal college of Psychiatrists PDP forms recommended by the College
- UK council for Psychotherapy. Continuing Professional Development
- British association of Dramatherapists. Standards of Ethical Practice for Registered Supervisors of Dramatherapy
- British association of Arts Therapists supervision guidance
- Association of Professional Music therapists supervision guidance
- Skills for Care and the Children’s Workforce Development Council ‘Providing Effective Supervision’ (2007)

16. **Comments and Feedback –** List people/ groups involved in developing the Policy.

**Example list of people/groups involved in the consultation.**

| | |
|---|---|
| Head of Nursing and Patient Safety | |
| Head of Allied Health Professionals | |
| Head of Recovery and Psychological Therapies | |
| Head of Social Care & Safeguarding | |
| Senior Nurses and Modern Matrons | |
| Head of Nursing | |
| PACE Team | |
| Consultant Social Worker | |
| Senior Psychological Therapists | |

## APPENDICES

## Benefits of Supervision

Robust supervision arrangements have a positive outcome on the performance of organisations. The benefits are described below

**Benefits for the Service User**
They should receive an effective service because supervision should lead to: increased employee motivation, job satisfaction, clarity about job role and early resolution of any problems

**Benefits for the employee**

- They have space away from their work in a private one to one setting
- The manager gives time and focus to the individual worker
- Potential problems can be discussed
- Areas of their work that need improvement can be identified at an early stage
- Training and development needs can be identified
- They can receive feedback about their work
- They may have increased feeling of being valued by the service
- A relationship can be developed with their supervisor
- They can develop clarity about their work role
- Their motivation and job satisfaction may be increased
- Communication may be improved between the employee, supervisor and employer
- Supervision enables staff to reflect on how they carry out activities within their role to provide a high quality service to service users and carers.
- Employees can learn continuously from experiences at work to develop their skills.

**Benefits for the manager**

- A positive relationship can be developed with the employee
- Communication may be improved between the employee, supervisor and employer
- Values, behaviours and the vision of the team can be clarified and monitored
- The employees objectives, KSF and personal development plans can be clarified and monitored
- Staff retention rates may be increased
- There may be improvements in staff performance
- Problems can be identified, and dealt with, at the earliest opportunity
- There may be a decrease in complaints about the service

## Types of Supervision

A range of supervision arrangements may be suitable for individuals across and within care groups and professions. The type of supervision an individual accesses must be agreed by the individual, their line manager and where appropriate a profession lead. Further description of the types of supervision is given below. When individuals are engaged in group supervision they should be given some access to individual sessions at some points in the year

**Individual supervision**
This is a meeting between supervisor and one supervisee and can take place for management, clinical and professional supervision. Most clinical supervision takes place within a 1:1 setting though this need not be exclusively so.

**Peer supervision**
Peer supervision in pairs or groups must be formalized and occur on a regular basis. It should involve meeting with a colleague or group of colleagues of the same grade and with the same level of responsibility. Supervision tasks should be shared equally. In Peer Group supervision, each member of the group will fill responsibilities as a supervisee and act as a supervisor. The task is not to line manage but to challenge thinking and encourage reflective practice.

**Group Supervision**

- Group supervision for professional and/or clinical issues will take place where it is appropriate to the members, where permissible by relevant professional bodies and where supportable by the Trust.
- Group size should be 6–8 maximum. Groups can be uni-disciplinary or multi-disciplinary.
- Groups will use standard agenda, contract and supervision record documentation. Copies of which will be kept on each participants personal file.
- The group and its effectiveness should be reviewed on an annual basis. Most groups will need to disband and reconfigure after 5 years maximum.
- New staff can be referred to group via the supervisor and it is the supervisor's responsibility to ensure that the group is effective and members are treated equitably, whatever their length of membership.
- The supervisor will be responsible for determining and upholding the ground rules for the group.

**Relationship between different types of supervision**

All staff with involvement in some aspect of direct clinical care will require more than just managerial supervision. Arrangements will vary across and within professions depending on

for example: experience, complexity of caseload, team context and professional and regulatory body requirements.

- Each professional group will have their own standards for clinical supervision. These standards will include details regarding: choosing supervisors, content and relationship with line managers.

As described in above, line managers are responsible for ensuring that appropriate supervision arrangements are made for each member of their staff. The table in appendix gives examples but is not an exclusive list of the types of discussions required during supervision and demonstrates how some points will overlap into all areas of supervision.

Supervision forms part of the annual performance review cycle, therefore all types of supervision should have a relationship to each other and should not be seen as operating exclusively without connection to each other. Line managers should ensure that arrangements are in place which allow for information from clinical and professional supervision to be used as part of the annual performance review. These arrangements should be described in the supervision contract see section 9.3 below.

## Responsibilities of supervisors

Supervisors are responsible for negotiating the supervision contract and preparing adequately before each supervision session.

Supervisors are responsible for making and maintaining supervision records The supervisor is responsible for providing the supervisee with a copy and the two parties should agree the content and sign.

Supervisors are responsible for challenging the supervisee if they feel a service user, staff or the organisation could be at risk.

Supervisors should both challenge and support the supervisee. Their role is to assist the supervisee in critical reflection of their work.

Managers and professional leads are expected to be up to date with the EPR system and supplementary reporting procedures and use them to support clinical supervision.

Supervisors and supervisees in clinical supervision settings are both responsible for reviewing any current Safeguarding processes in every supervision session.

## Responsibilities of supervisee

Supervisees are responsible for sharing with their line manager any issues which may have an impact on the service user, other employees and the organisation. This includes issues which may arise during clinical and professional supervision.

The supervisee is responsible for their own actions and how these actions impact on a service user and the organisation.

The supervisee should prepare for each supervision meeting by reviewing notes from the previous meeting and thinking about the areas to raise and discuss.

The supervisee should be open to feedback regarding performance and improving the service provided to service users and carers. Any development needs or actions should be addressed promptly as agreed with your line manager and the organisation.

Supervisees and supervisors in clinical supervision settings are both responsible for reviewing any current Safeguarding processes in every supervision session.

## Supervision Contract

| **Management/clinical/professional supervision arrangements** |
|---|
| Name of Supervisee |
| Name of Supervisor |
| Frequency<br>Duration of supervision<br>Method by which the session will be cancelled by either party: |
| Location of supervision (this should be an appropriate place with no interruptions or distractions) |
| AGENDA for supervision (refer to prompts for management supervision and profession specific clinical and Professional supervision) |
| Where appropriate, are arrangements for Clinical and/or Professional in place? If yes add detail. |
| Confidentiality will be maintained in accordance with the Trust Supervision Policy and appropriate professional Codes of Practice |
| **As a Supervisee I agree to:-**<br>Take responsibility for making effective use of the time made available for supervision and for acting upon decisions made within it.<br>Be willing to learn and change, and to receive support and challenges to help professional and personal development, and to ensure service provision to agreed standards.<br><br>Signed (Staff Member)……. |
| **As Supervisor I agree to:**<br>Offer you support, constructive feedback, information and advice to enable you to reflect in depth on issues affecting your practice and to develop professionally and personally. I agree to help you to make decisions about your work where required, to take decisions about issues that you bring to my attention that are outside your remit and to assist you in prioritising work in accordance with the needs of the service, service users and carers.<br><br>Signed (Supervisor)…… |
| **Date:** |
| **Date of contract review:** |

# Hertfordshire Partnership University NHS Foundation Trust

## Professional/Clinical/ Management Supervision

| | |
|---|---|
| **Attendees:** | |
| **Date:** | |
| **Venue:** | |
| **Signatures:** | |
| **Agenda:** | |
| **Follow up from last meeting:** | |
| **Date of next meeting:** | |
| **Issues to follow up:** | |
| **Notes of discussion:** | **Actions/ Outcomes** |
| | |

# Supervision Record Continuation Sheet

| Notes of discussion | Actions/outcomes |
|---|---|
| | |

**Hertfordshire Partnership University NHS Foundation Trust**

**Clinical (reflective) Supervision Guidelines for Nursing Staff**

## 1 Introduction

Clinical (reflective) supervision is an essential ingredient of all nursing practice in the provision of high quality care.

It is a process where nurses are supported to improve practice and manage the demands, conflicts and stresses which are intrinsic within the roles and responsibilities of care providers.

Reflective supervision provides nurses with the opportunity to discuss and reflect on their work in a "supportive yet challenging environment" facilitating the development of skills and competence.

It is a method of providing professional support and learning that should not be compromised.

Reflective supervision is a requirement for all nurses working in the organisation and should be adopted as routine in day to day practice.

It is a formal process that should be prioritised and not deferred due to other work pressures. It requires dedicated time and resources.

Hertfordshire Partnership University NHS Foundation Trust are committed to ensuring that all nurses are enabled to participate in reflective supervision in order to improve best practice and learn from reflective practice. Best practice and lesson learning is shared across the organisation to improve the overall quality of care delivery in line with the Trusts vision to be the best mental health care provider, benefiting service users, carers, and staff.

## 2 Definition

**2.1 Reflective learning** can be defined as "a process which involves dialogue with others for improvement or transformation whilst recognising the emotional, social and political context of the learner (Brocbank et al 2002). It is the process of internally examining and exploring a critical incident or experience which creates and clarifies meaning in terms of self and which results in changed conceptual perspective, Boyd and Fales 1983" (cited by Torbay and Southern Devon Care Trust TCT)

### 2.2 Reflective Practice

"The process of reflection and of supervision intersects at the point of wanting to intentionally learn something based on personal experience (learning by doing). In clinical supervision, it is the intention of the supervisee to learn something by sharing their experience of clinical practice. In summary not all reflective practice is clinical supervision but potentially all good supervision is reflective practice" (TCT)

## 2.3 Clinical Supervision

Clinical supervision acts as a vehicle to facilitate protected time and provides the opportunity for health and social care staff to;

- Discuss individual cases in depth, including reviewing the aims and expected outcomes of intervention
- Review current issues of Safeguarding
- Reflect on and review their clinical practice
- Change or modify their practice
- Develop clinical skills
- Review legislation, professional standards and codes of conduct and how any changes impact on practice
- Explore key clinical issues that are impacting on practice

Through the process of reflection the practitioner is enabled to build on their skills and knowledge, enhancing their professional practice and in so doing improves the quality of care delivery (NMC 2008)

## 2.4 Reflective Supervision

Within the organisation the nursing service have adopted the term **Reflective Supervision** to incorporate the three elements described above emphasising the requirement for all nurse's active participation in a reflective learning, reflective practice, supervision process

Reflective Supervision should provide an opportunity for practitioners to;-

- Discuss and review their individual clinical caseload exploring the purpose and anticipated outcomes of their practice.
- Recognise areas of risk or concern i.e. safeguarding, infection control.
- Assess and evaluate their clinical practice in relations to its effectiveness and outcomes.
- Identify areas of good practice to share with others.
- Learn, develop and enhance their knowledge and skills.
- Examine clinical issues developing competence and exploring wider opportunities for learning.
- Provides a forum for "critical debate" related to individual and team practice.
- Consider the application of professional standards and best practice guidelines on their practice.

## 3 Purpose & Benefits of Reflective Supervision

## 3.1 To the nurse practitioner

- Supports the development of knowledge and skills and identifies areas for professional development and personal training objectives
- Improves skills of self reflection
- Enables practice to be goal and outcome focussed based on the Trusts principles of Recovery
- Provides a forum to explore and address challenges
- Is a component of the individuals stress management mechanisms
- Helps the nurse to be self-aware of their role and responsibilities,
- Promotes good interpersonal and team interrelationships through skills development
- Encourages the identification and sharing of good practice

### 3.2 To the service & organisation

Supports the development of the individual in practice leading to the employment and retention of a skilled and competent workforce

Significantly contributes to the establishment of excellent leadership within the organisation

It is the role and responsibilities of any good employer to provide robust supervision framework and maintains the good reputation of the organisation

Ensures high quality care delivery

## 4 Key principles

4.1 All nursing staff will have a designated supervisor and will be expected to actively participate in reflective supervision. This includes reporting any failure to provide/or poor experience of supervision to an appropriate senior member of staff in the Trust.

4.2 Line managers are expected to support reflective supervision arrangements and they should be built into the work plan for all staff.

4.3 The responsibility for accessing reflective supervision lies with the individual practitioner.

4.4 All nurses will be able to demonstrate that they have a model of reflective practice/supervision in place.

4.5 The adoption of a particular model of reflective practice i.e. Gibbs (see Diagram 1), should be mutually agreed by both supervisee and supervisor.

4.6 The Trust will provide regular uninterrupted quality time for supervision and the responsibility of this lies with the line manager, supervisor and supervisee.

4.7 The Trust is committed to the provision of training that enables the provision on good quality reflective supervision and all supervisors will have a undertaken an agreed level of training.

4.8 The requirement of nurses to actively engage in all supervision including reflective supervision is endorsed in job descriptions.

4.9 An Introduction to the supervision policy and its implementation is embedded in the induction process for all staff.

4.10 A register of supervisors/supervisees is actively managed by Service Business Units.

4.11 Supervisee and supervisor should prepare and plan in advance utilising previous records and reflection to inform this preparation, Actions should be taken as agreed.

## 5 Who acts as a reflective supervisor?

5.1 It is not a requirement that the supervisee and supervisor are from the same professional background unless this is stipulated by the professional body. However it is recommended that both parties are from the same professional background and a registered nurse is the preferred option within the Trust.

5.2 There is recognition that in reflective supervision a choice of supervisor is desirable. However the constraints of the services/organisation's structure is likely to limit the opportunity for wide choice although reasonable efforts will be made to support individual preference.

5.3 Nursing staff may receive reflective supervision from their Line Manager if this person is a nurse.

5.4 Nursing staff should normally be supervised by a registered nurse who is more experienced than them.

5.5 Reflective supervision arrangements should be reviewed at least annually and changes made when required. Supervisees can ask for a review of arrangements at any time.

5.6 The following factors should be considered in the decision making process. This is not an exhaustive list.

- New to the team
- Individual supervisee circumstances e.g. working with a complex service user(s)
- Personal issues which may impact on performance
- Performance issues
- Clinical expertise/competence
- Personal development
- Workload/caseload issues
- Location
- Hours worked for the Trust

5.7 There may be times where supervision by another expert in a specialist field of knowledge may be accessed in addition to the usual supervision arrangements

## 6 Reflective Supervision Contracts (see 6.3 Supervision Policy and Appendix 7 C)

Those involved in the process of reflective supervision should formulate a written agreement between supervisor and supervisee that sets out the purpose, goals and boundaries of the supervisions. This contract should include the following details:

- Expectations and goals
- Roles and responsibilities of supervisor and supervisee
- Confidentiality and rights
- Model of reflective practice
- Record keeping
- Evaluation and review process
- Boundaries and Actions including those related to unsafe practice issues or professional practice concerns

## 7 Record Keeping Standards

7.1 An accurate record should be made of each supervision session that is documented at the time on agreed template (see Appendix A and B template).

7.2 Each record should be signed and dated by Supervisee and Supervisor.

7.3 Both the Supervisee and Supervisor should retain a copy.

7.4 The Supervisor has responsibility for ensuring the secure storage of records.

## 8 Frequency

8.1 All nurses will be able to access supervision at regular intervals ideally monthly but a minimum requirement of 8 weekly for between 1 – 2 hours as agreed in the contract and with the line manager (See Supervision Policy 4.1).

8.2 Reflective supervision should not be confused with operational/management supervision.

8.3 There should be opportunity for joint reflective and operational supervision at review and PDP. At least 6 monthly and annually to review progress and support professional development and objective setting.

## 9 Confidentiality

9.1 The supervisee should experience supervision as a confidential space in which to develop confidence and trust in their supervisor. Supervision should therefore be seen as a confidential space but do note 9.2 below.

9.2 Poor practice, safeguarding issues and concerns about the individual's health and well-being will be disclosed according to the Trusts policies and procedures and should be specified in the supervision contract

## 10 Where

Protected time in a quiet, private environment away from the clinical area

## 11 Content of Reflective Supervision

- Review of previous supervision and actions
- Reflective practice using agreed model of reflection

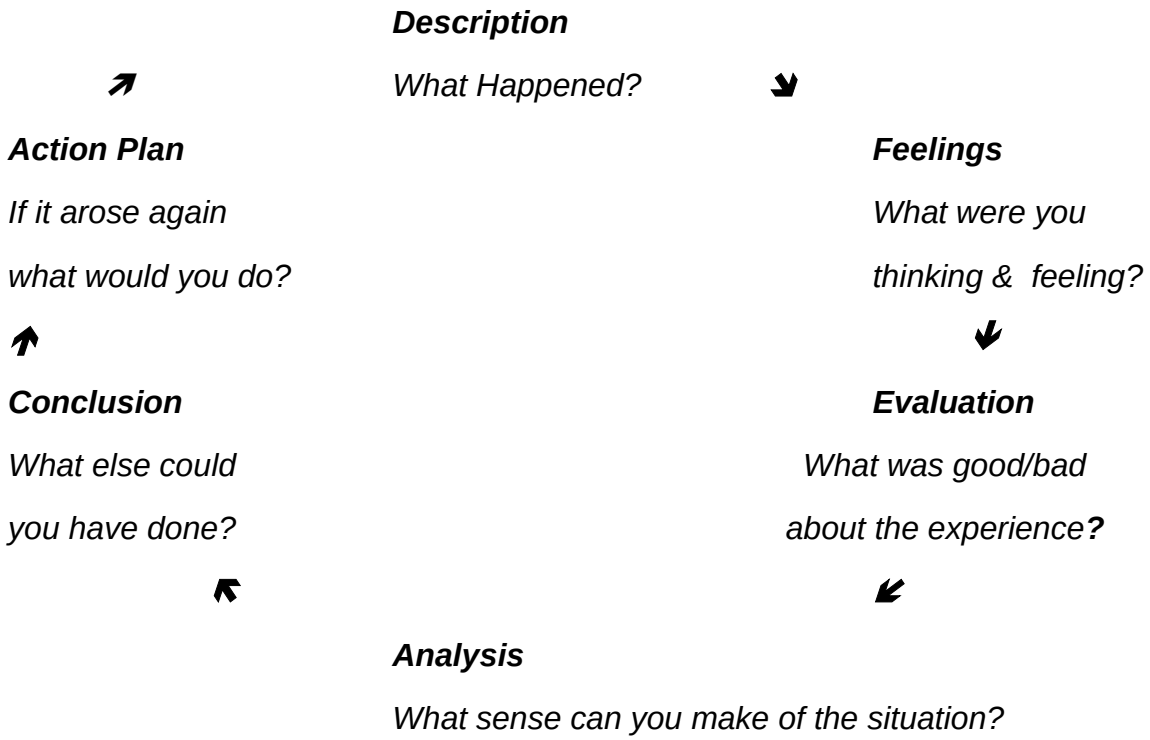
- Safeguarding & Safety
- Clinical Caseload;- purpose, goals, care plans and outcomes
- Complex practice issues /concerns
- Workload priorities
- Skills, knowledge, competence and training needs
- Report writing
- Clinical notes
- Risks and Risk Assessments/management
- Investigations
- Medication Management

## 12 Supervision Model

Various models of reflective supervision are available and the use of a particular model should be mutually agreed during the drafting of the supervision contract (see 6.3 and Appendix 4 template).

The following model is suggested as a guide for use

**Diagram 1 Reflective Cycle Gibbs 1968**




## 13 Types of Supervision

### 13.1 Individual supervision

All nursing staff should have individual supervision the frequency of this will depend on whether peer supervision is also accessed

### 13.2 Peer Supervision

Peer supervision can be an extremely valuable form of supervision and the Trust supports nursing staff accessing this type of reflective supervision. Peer supervision must be recorded and a template can be found as Appendix B.

### 13.3 Group Supervision

Group supervision can also be an extremely valuable form of supervision that is also supported by the Trust.

## 14 Monitoring

Nurses Supervisors should ensure that a:

- Local system for planning supervision is in place
- Visible supervision structure is in place so that all team members are aware of their supervisor or supervisee (See **Appendix 7E**)
- Monitoring system that is visible to all staff, indicating the names of staff in the team, the name of their supervisor and date of when supervision has taken place (**See Appendix 7D6**). This should enable all team members and their managers to see at a glance, supervision uptake within their area of responsibility and to address compliance if it falls below expected standards.

# Hertfordshire Partnership University NHS Foundation Trust

## Reflective Supervision Template

**Name of Supervisee** **Date**

**Name of Supervisor**

**Standard Agenda Items**

Safeguarding, Clinical Caseload, Care Plans/Pathways, Outcomes, Complex Practice Issues, Risks, Critical Incidents/investigations

| **Discussion/Reflections**<br><br>**High Risk Service User/Practice Issues** | **Agreed Action** | **By Whom/when** |
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| Professional Development Education & Training | Agreed Action | By Who/when |
|---|---|---|
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**Signature (Supervisee)** **Date**

**Signature (Supervisor)**

## Nursing Staff Reflective Supervision Form

□ **Peer**

□ **Group**

□ **Specialist**

**Date:**

**Note taker:**

| Attended | Did not Attend |
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| Key issues discussed |
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**Action points**

# Hertfordshire Partnership University NHS Foundation Trust

## Clinical Supervision Contract – Nursing Staff

| |
|---|
| Name of Supervisee |
| Name of Supervisor |
| Frequency<br><br>Duration of supervision |
| Location of supervision (this should be an appropriate place with no interruptions or distractions) |
| Confidentiality will be maintained in accordance with the Trust Supervision Policy and appropriate professional Codes of Practice |
| **As a Supervisee I agree to:-**<br><br>Take responsibility for making effective use of the time made available for supervision and for acting upon decisions made within it.<br><br>Be willing to learn and change, and to receive support and challenges to help professional and personal development, and to ensure service provision to agreed standards.<br><br>Signed (Staff Member)……. |
| **As Supervisor I agree to:**<br><br>Offer you support, constructive feedback, information and advice to enable you to reflect in depth on issues affecting your practice and to develop professionally and personally. I agree to help you to make decisions about your work where required, to take decisions about issues that you bring to my attention that are outside your remit and to assist you in prioritising work in accordance with the needs of the service, service users and carers.<br><br>Signed (Supervisor)…… |
| **Date:** |
| **Date of contract review:** |

Appendix 7D

# Hertfordshire Partnership University NHS Foundation Trust

**Supervision Monitoring Form Year..... Ward/Team Name…….**

| Supervisor | Supervisee | Jan | Feb | March | April | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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Please this form to record dates of when supervision has taken place.

# Clinical Supervision Guidelines for Occupational Therapists (OT)

## 1. Introduction

It is intended that these guidelines are used by Line Managers and Occupational Therapists alongside the trusts Supervision Policy. The guidelines are designed to help managers and clinicians with the decision making pathway regarding the provision of clinical supervision and give detail regarding the content of clinical supervision. We have tried not to be prescriptive but help those involved in making informed, equitable and open decisions.

## 2. Definitions

The definitions of supervision are given in section 3 of the policy. Further information regarding how these apply to OT is given in section 4 below.

### 2.1 Management supervision

Management supervision is task oriented, with a formal service led agenda. Management supervision is a regular meeting with the line manager (or other nominated manager) in order to discuss

- operational and management issues relating to the supervisee's role including prioritising work
- main tasks
- required performance standards
- training needs
- personal development

### 2.2 Clinical supervision

Clinical supervision provides the opportunity for health and social care staff to:

- Discuss individual cases in depth, including reviewing the aims and expected outcomes of intervention
- Reflect on and review their clinical practice
- Review current issues of Safeguarding
- change or modify their practice
- Develop clinical skills
- Review professional standards and how any changes impact on practice
- key clinical issues that are impacting on practice

### 2.3 Professional supervision

OTs do not require professional supervision as described by the trust policy.

## 3. Relationship between the different types of supervision

This refers to section 7 of the Trust policy. Supervisors providing clinical supervision to an individual would be expected to contribute to the individual's appraisal and the setting and reviewing of objectives. This also supports the need for clear communication pathways between line manager, supervisor and supervisee.

## 4. Supervision Standards

### 4.1 Selection of supervisors

Decisions regarding clinical supervision for OTs should be made in partnership between: line manager, professional lead, current clinical supervisor if appropriate and the supervisee. Line managers should make the final decision subject to on-going review of arrangements.

**4.1.1** OTs can be receive clinical supervision from their line manager if this person is an OT.

**4.1.2** Clinical supervision must be provided by an OT.

**4.1.3** OTs would usually be clinically supervised by someone more experienced than them who may be of the same band or higher.

**4.1.4** Clinical supervision arrangements should be reviewed at least annually and changes made when required. Supervisees can ask for a review of arrangements at any time.

**4.1.5** The following factors should be considered in the decision making process. This is not an exhaustive list:

- new to the team and/or specialist area
- individual supervisee circumstances e.g. working with a complex service user(s), personal issues which may impact on performance
- performance issues
- clinical expertise/competence
- personal development
- workload/caseload issues
- location

**4.1.6** Where OTs have undertaken additional training, for example CBT, then additional supervision arrangements should be made for this additional skill. Supervision for this additional area would be in addition to and not instead of clinical supervision for the OT role.

### 4.2 Frequency

The frequency of clinical supervision should comply with trusts standards described in section 7.2 of the policy. The factors shown in 4.1.5 above can also be used to inform decisions regarding frequency.

### 4.3 Agenda

The following areas are suitable for discussion within clinical supervision. These are suggestions and is not an exhaustive list. Appendix 1.a can be used as a stand-alone prompt sheet at each supervision session

- Caseload
    - Aims
    - Outcomes
    - Intervention plans
- Safeguarding issues
- Prioritising work from caseload
- Individual clinical competence e.g. training required, developing action plan to acquire skills
- Performance issues as agreed with line manager
- Report writing
- Clinical notes
- Clinical risk assessments
- CPD, checking areas required by HPC are being covered
- Developing clinical confidence
- Reflecting on practice

**4.4 Contracts**
A sample contract can be found below in appendix 1.b

**4.5 Record forms**
Example record forms for use in OT clinical supervision can be found at the end of this document. Appendix 1.c and 1.d

**4.6 Types of Supervision**

**4.6.1** Individual supervision
All OTs should have individual supervision the frequency of this will depend on whether peer supervision is also accessed.

**4.6.2** Peer supervision
Peer supervision can be an extremely valuable form of supervision and we support OTs accessing this type of clinical supervision. It is suitable for all bands of OT staff including OT support staff. Peer supervision must be recorded and an example form can be found at the end of this document. Evidence of peer supervision must be checked within line manager supervision and included in the CPD file required by HPC.

**4.6.3** Group supervision
Group supervision is not frequently used for this staff group. Case discussion is likely to take place at team meetings, uni-professional and multidisciplinary, but does not meet the needs of full clinical supervision. Discussions of this nature can and should be recorded as taking place within the CPD portfolio.

## Occupational Therapy Clinical Supervision

## Agenda Prompts

The following prompts are designed to help supervisee and supervisor plan the agenda for each supervision session. They are prompts and not a definitive list. It is not expected that all areas are covered at every session but there to help all involved cover a wide range of agenda items over a period of time.

- Caseload. E.g.
    - Aims
    - Outcomes
    - intervention plans

- Prioritising work from caseload
- Current Safeguarding issues
- Individual clinical competence e.g. training required, developing action plan to acquire skills
- Performance issues as agreed with line manager
- Report writing
- Clinical notes
- Clinical risk assessments
- CPD, checking areas required by HPC are being covered
- Developing clinical confidence
- Reflecting on practice
- Reviewing clinical objectives
- Areas of difficulty/conflict

## Clinical Supervision Contract – Occupational Therapists

| |
|---|
| Name of Supervisee |
| Name of Supervisor |
| Frequency<br><br>Duration of supervision<br><br>Method by which the session will be cancelled by either party: |
| Location of supervision (this should be an appropriate place with no interruptions or distractions) |
| Communication with line manager. Describe how/when/where information will be shared between line manager, supervisee and clinical supervisor. |
| Confidentiality will be maintained in accordance with the Trust Supervision Policy and appropriate professional Codes of Practice |
| **As a Supervisee I agree to:-**<br>Take responsibility for making effective use of the time made available for supervision and for acting upon decisions made within it.<br>Be willing to learn and change, and to receive support and challenges to help professional and personal development, and to ensure service provision to agreed standards.<br><br>Signed (Staff Member)…… |
| **As Supervisor I agree to:**<br>Offer you support, constructive feedback, information and advice to enable you to reflect in depth on issues affecting your practice and to develop professionally and personally. I agree to help you to make decisions about your work where required, to take decisions about issues that you bring to my attention that are outside your remit and to assist you in prioritising work in accordance with the needs of the service, service users and carers.<br><br>Signed (Supervisor)…… |
| **Date:** |
| **Date of contract review:** |

## Occupational Therapy Clinical Supervision Form

**Supervisee's name:**

**Supervisor's name:**

**Date of session:**

| **Agenda for today's session. Use prompt sheet to aid agenda setting** | |
|---|---|
| **Follow up from previous supervision** | |
| **Discussions** | **Actions Outcomes** |
| | |

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| **Areas of learning** | |
| **Issues to follow up next time** | |
| **Date of next session** | |

**Signature of supervisee**_____

**Signature of supervisor**_____

# Occupational Therapy Peer Supervision Form

**Date:**

**Note taker:**

| Attended | Did not Attend |
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| Key issues discussed |
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# Clinical Supervision Guidelines for Speech and Language Therapists (SLT)

## 1. Introduction

It is intended that these guidelines are used by Line Managers and Speech and Language Therapists alongside the trusts Supervision Policy. The guidelines are designed to help managers and clinicians with the decision making pathway regarding the provision of clinical supervision and give detail regarding the content of clinical supervision. We have tried not to be prescriptive but help those involved in making informed, equitable and open decisions.

## 2. Definitions

The definitions of supervision are given in section 4 of the policy. Further information regarding how these apply to SLT is given in section 4 below.

### 2.1 Management supervision

Management supervision is task oriented, with a formal service led agenda. Management supervision is a regular meeting with the line manager (or other nominated manager) in order to discuss

- operational and management issues relating to the supervisee's role including prioritising work
- main tasks
- required performance standards
- training needs
- personal development

### 2.1 Clinical supervision

Clinical supervision provides the opportunity for health and social care staff to:

- Discuss individual cases in depth, including reviewing the aims and expected outcomes of intervention]
- Current Safeguarding issues
- Reflect on and review their clinical practice
- change or modify their practice
- Develop clinical skills
- Review professional standards and how any changes impact on practice
- key clinical issues that are impacting on practice

### 2.2 Professional supervision

SLTs do not require professional supervision as described by the trust policy.

## 3. Relationship between the different types of supervision

This refers to section 4of the Trust policy. Supervisors providing clinical supervision to an individual would be expected to contribute to the individual's appraisal and the setting and reviewing of objectives. This also supports the need for clear communication pathways between line manager, supervisor and supervisee.

## 4. Supervision Standards

Decisions regarding clinical supervision for SLTs should be made in partnership between: line manager, professional lead, current clinical supervisor if appropriate and the supervisee. Line managers should make the final decision subject to on-going review of arrangements. SLTs may require clinical supervision for both communication and dysphagia clinical work this may be from more than one supervisor.

### 4.1 Selection of supervisors

The following factors should contribute to the process for agreement of clinical supervision arrangements

**4.1.1** SLTs can receive clinical supervision from their line manager if this person is an SLT

**4.1.2** Clinical supervision must be provided by an SLT

**4.1.3** SLTs would usually be clinically supervised by someone more experienced than them who may be of the same band or higher

**4.1.4** Clinical supervision arrangements should be reviewed at least annually and changes made when required. Supervisees can ask for a review of arrangements at any time.

**4.1.5** The following factors should be considered in the decision making process. This is not an exhaustive list

- new to the team and/or specialist area
- individual supervisee circumstances e.g. working with a complex service user(s), personal issues which may impact on performance
- performance issues
- clinical expertise/competence
- personal development
- workload/caseload issues
- location
- proportional time spent on communication and dysphagia
- hours worked for the trust

### 4.2 Frequency

The frequency of clinical supervision should comply with trusts standards described in section 9.1 of the policy. The factors shown in 4.1.5 above can also be used to inform decisions regarding frequency.

### 4.3 Agenda

The following areas are suitable for discussion within clinical supervision. These are suggestions and is not an exhaustive list. If separate arrangements are in place for communication and dysphagia supervision then it should be made clear in the contract and agenda where certain discussions will take place. Appendix 2.a can be used as a stand-alone prompt sheet at each supervision session

- Caseload
    - Aims
    - Outcomes
    - Treatment plans
- Prioritising work from caseload
- Current Safeguarding Issues
- Individual clinical competence e.g. training required, developing action plan to acquire skills
- Performance issues as agreed with line manager
- Report writing
- Clinical notes
- Clinical risk assessments
- CPD, checking areas required by HPC are being covered
- Developing clinical confidence
- Reflecting on practice

### 4.4 Contracts

A sample contract can be found below.

### 4.5 Record forms

Example record forms for use in SLT clinical supervision can be found at the end of this document.

### 4.6 Types of Supervision

**4.6.1** Individual supervision

All SLTs should have individual supervision the frequency of this will depend on whether peer supervision is also accessed.

**4.6.2** Peer supervision

Peer supervision can be an extremely valuable form of supervision and we support SLTs accessing this type of clinical supervision. It is suitable for all bands of SLT staff. Peer supervision must be recorded and an example form can be found at the end of this document. Evidence of peer supervision must be checked within line management supervision and included in the CPD file required by HPC.

**4.6.3** Group supervision

Group supervision is not frequently used for this staff group. Case discussion is likely to take place at team meetings, uni-professional and multidisciplinary, but does not meet the needs of full clinical supervision. Discussions of this nature can and should be recorded as taking place within the CPD portfolio.

**Clinical Supervision Contract – Speech and Language Therapists**

| |
|---|
| Name of Supervisee |
| Name of Supervisor |
| Frequency<br><br>Duration of supervision<br><br>Method by which the session will be cancelled by either party: |
| Location of supervision (this should be an appropriate place with no interruptions or distractions) |
| Communication with line manager. Describe how/when/where information will be shared between line manager, supervisee and clinical supervisor. |
| Confidentiality will be maintained in accordance with the Trust Supervision Policy and appropriate professional Codes of Practice |
| **As a Supervisee I agree to:-**<br>Take responsibility for making effective use of the time made available for supervision and for acting upon decisions made within it.<br>Be willing to learn and change, and to receive support and challenges to help professional and personal development, and to ensure service provision to agreed standards.<br><br>Signed (Staff Member)……. |
| **As Supervisor I agree to:**<br>Offer you support, constructive feedback, information and advice to enable you to reflect in depth on issues affecting your practice and to develop professionally and personally. I agree to help you to make decisions about your work where required, to take decisions about issues that you bring to my attention that are outside your remit and to assist you in prioritising work in accordance with the needs of the service, service users and carers.<br><br>Signed (Supervisor)…… |
| **Date:** |
| **Date of contract review:** |

**Speech and Language Therapy**
**Clinical Supervision Form**

**Supervisee's name:**

**Supervisor's name:**

**Date of session:**

| **Agenda for today's session. Use prompt sheet to aid agenda setting** | |
|---|---|
| **Follow up from previous supervision** | |
| **Discussions** | **Actions Outcomes** |
| | |

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| | |
| **Areas of learning** | |
| **Issues to follow up next time** | |
| **Date of next session** | |

**Signature of supervisee**_____

**Signature of supervisor**_____

# Speech and Language Therapy Peer Supervision Form

**Date:**

**Note taker:**

| Attended | Did not Attend |
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| Key issues discussed |
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| Action points |
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## Clinical Supervision Guidelines for Assistant Therapy Practitioners (ATPs)

### 1. Introduction

It is intended that these guidelines are used by Line Managers and ATPs alongside the trusts Supervision Policy. The guidelines are designed to help managers and ATPs with the decision making pathway regarding the provision of clinical supervision and give detail regarding the content of clinical supervision. We have tried not to be prescriptive but help those involved in making informed, equitable and open decisions.

### 2. Definitions

The definitions of supervision are given in section 4 of the policy. Further information regarding how these apply to ATPs is given in section 4 below.

#### 2.1 Management supervision

Management supervision is task oriented, with a formal service led agenda. Management supervision is a regular meeting with the line manager (or other nominated manager) in order to discuss

- operational and management issues relating to the supervisee's role including prioritising work
- main tasks
- required performance standards
- training needs
- personal development

#### 2.1 Clinical supervision

Clinical supervision provides the opportunity for health and social care staff to:

- Discuss individual cases in depth, including reviewing the aims and expected outcomes of intervention
- Current Safeguarding issues
- Reflect on and review their clinical practice
- change or modify their practice
- Develop clinical skills
- Review professional standards and how any changes impact on practice
- key clinical issues that are impacting on practice

#### 2.2 Professional supervision

ATPs do not require professional supervision as described by the trust policy.

### 3. Relationship between the different types of supervision

This refers to section 4of the Trust policy. Supervisors providing clinical supervision to an individual would be expected to contribute to the individual's appraisal and the setting and reviewing of objectives. This also supports the need for clear communication pathways between line manager, supervisor and supervisee.

## 4. Supervision Standards

### 4.1 Selection of supervisors

Decisions regarding clinical supervision for ATPs should be made in partnership between: line manager, current clinical supervisor if appropriate and the supervisee. Line managers should make the final decision subject to on-going review of arrangements. ATPs may require clinical supervision from more than one supervisor depending on the nature of the clinical speciality.

**4.1.1** ATPs can receive clinical supervision from their line manager.

**4.1.2** Clinical supervision should be provided by the most appropriate AHP more than one supervisor may be involved.

**4.1.3** ATPS should be clinically supervised by a qualified AHP

**4.1.4** Clinical supervision arrangements should be reviewed at least annually and changes made when required. Supervisees can ask for a review of arrangements at any time.

**4.1.5** The following factors should be considered in the decision making process. This is not an exhaustive list

- new to the team and/or specialist area
- individual supervisee circumstances e.g. working with a complex service user(s), personal issues which may impact on performance
- performance issues
- clinical expertise/competence
- personal development
- workload/caseload issues
- location
- proportional time spent on different clinical speciality
- hours worked for the trust

### 4.2 Frequency

The frequency of clinical supervision should comply with trusts standards described in section 9.1 of the policy. The factors shown in 4.1.5 above can also be used to inform decisions regarding frequency.

### 4.3 Agenda

The following areas are suitable for discussion within clinical supervision. These are suggestions and is not an exhaustive list. Appendix 3.a can be used as a stand-alone prompt sheet at each supervision session

- Caseload
    - Aims
    - Outcomes
    - Treatment plans
- Prioritising work from caseload
- Current Safeguarding issues
- Individual clinical competence e.g. training required, developing action plan to acquire skills
- Performance issues as agreed with line manager
- Report writing
- Clinical notes
- Clinical risk assessments
- Developing clinical confidence
- Reflecting on practice

**4.4 Contracts**
A sample contract can be found below in appendix 3.b

**4.5 Record forms**
Example record forms for use in ATP clinical supervision can be found at the end of this document.
.
**4.6 Types of Supervision**

**4.6.1** Individual supervision
All ATPs should have individual supervision the frequency of this will depend on whether peer supervision is also accessed.

**4.6.2** Peer supervision
Peer supervision can be an extremely valuable form of supervision and we support ATPs accessing this type of clinical supervision. It is suitable for all bands of ATP staff. Peer supervision must be recorded and an example form can be found at the end of this document. Evidence of peer supervision must be checked within line management supervision.

**4.6.3** Group supervision
Group supervision is not frequently used for this staff group. Case discussion is likely to take place at team meetings, uni-professional and multidisciplinary, but does not meet the needs of full clinical supervision. Discussions of this nature can and should be recorded as taking place within the CPD portfolio.

## Assistant Therapy Practitioners Clinical Supervision

### Agenda Prompts

The following prompts are designed to help supervisee and supervisor plan the agenda for each supervision session. They are prompts and not a definitive list. It is not expected that all areas are covered at every session but there to help all involved cover a wide range of agenda items over a period of time.

- Caseload. E.g.
    - Aims
    - Outcomes
    - intervention plans

- Prioritising work from caseload
- Current Safeguarding issues
- Individual clinical competence e.g. training required, developing action plan to acquire skills
- Performance issues as agreed with line manager
- Report writing
- Clinical notes
- Clinical risk assessments
- CPD
- Developing clinical confidence
- Reflecting on practice
- Reviewing clinical objectives
- Areas of difficulty/conflict

Clinical Supervision Contract – Assistant Therapy Practitioner

| |
|---|
| Name of Supervisee |
| Name of Supervisor |
| Frequency<br><br>Duration of supervision<br><br>Method by which the session will be cancelled by either party: |
| Location of supervision (this should be an appropriate place with no interruptions or distractions) |
| Communication with line manager. Describe how/when/where information will be shared between line manager, supervisee and clinical supervisor. |
| Confidentiality will be maintained in accordance with the Trust Supervision Policy and appropriate professional Codes of Practice |
| **As a Supervisee I agree to:-**<br>Take responsibility for making effective use of the time made available for supervision and for acting upon decisions made within it.<br>Be willing to learn and change, and to receive support and challenges to help professional and personal development, and to ensure service provision to agreed standards.<br><br>Signed (Staff Member)……. |
| **As Supervisor I agree to:**<br>Offer you support, constructive feedback, information and advice to enable you to reflect in depth on issues affecting your practice and to develop professionally and personally. I agree to help you to make decisions about your work where required, to take decisions about issues that you bring to my attention that are outside your remit and to assist you in prioritising work in accordance with the needs of the service, service users and carers.<br><br>Signed (Supervisor)…… |
| **Date:** |
| **Date of contract review:** |

**Assistant Therapy Practitioner**
**Clinical Supervision Form**

**Supervisee's name:**

**Supervisor's name:**

**Date of session:**

| **Agenda for today's session. Use prompt sheet to aid agenda setting** | |
|---|---|
| **Follow up from previous supervision** | |
| **Discussions** | **Actions Outcomes** |
| | |

| | |
|---|---|
| | |
| **Areas of learning** | |
| **Issues to follow up next time** | |
| **Date of next session** | |

**Signature of supervisee**_____

**Signature of supervisor**_____

**Assistant Therapy Practitioner**
**Peer Supervision Form**

**Date:**

**Note taker:**

| Attended | Did not Attend |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| Key issues discussed |
|---|
| |

| Action points |
|---|
| |

## Issues relevant to the supervision of Social Workers

### 11.1 Implementing the recommendations of the Social Work Task force with regard to Supervision

One of the recommendations for Social Work reform from the Social Work Task Force (2010) was to implement national standards for supervision. These were due to be rolled out from April 2011.

However the Task Force advised that it would expect frequency of supervision to be normally weekly during the first six weeks of employment, then fortnightly for the rest of the first six months. After six months in post, this would move to a minimum of monthly supervision, with each session at least an hour and a half of uninterrupted time. They also said that, where the line manager is not a social worker, professional support should be provided by an experienced supervisor.

*Providing effective supervision* gives guidance to employers and social workers in adult and children's services about the quality and content of effective supervision. Graduate Social Workers are able to access enhanced supervision via the Newly Qualified Social Worker Programme (NQSW) Protected time for supervision – and support for supervisors – is an important part of the NQSW pilot programmes. CWDC has developed further guidance specifically for supervisors of social workers on its NQSW and Early Professional Development programmes. This underpins training that is offered to everyone acting as a supervisor on these programmes. Skills for Care offers action learning sets for managers of NQSWs in adult services.

### 11.2 Supervision Agendas

Supervision Agendas

The following areas are important points to be discussed within reflective (clinical) and professional supervision. The supervision template in Appendix 2 can be used as a prompt sheet at each supervision session.

- Caseload: aims, objectives, interventions and outcomes
- Prioritising caseload work
- Individual practice competence: training required, skills development
- Any performance issues (as agreed with line manager)
- Practice reflection
- Continuing professional development and learning needs
- Safeguarding issues/cases (See Section {insert} for further guidance)

In cases where reflective (clinical), professional and line management supervision are provided by the same supervisor, the following line management supervision requirements should also form part of the agenda:

- Operational and management issues relating to the Social Worker's role, including the prioritisation of work
- Main tasks of the role

- Required performance standards, including monitoring of Key Performance Indicators (KPIs) and review of the Caseload Management Tool.
- Mandatory training requirements
- Performance and capability issues (where appropriate)

Social Workers should take responsibility for preparing their own agenda for discussion at their supervision sessions. Supervisors may also wish to add their own items to the agenda.

## 11.3 Student Social Worker Supervision Arrangements

11.3.1 Student Social Workers on placement with the Trust will normally be supervised by their designated Practice Educator. However, there may be occasions where this function is delegated to another member of the team (during periods of annual leave etc.) Should supervision arrangements be delegated for a period of time to another member of the team, this should ensure that the Student Social Worker Continues to be supervision by a Registered Social Worker.

11.3.2 The frequency and duration of Student Social Worker's supervision will be guided by the University at which the student is completing their training by way of the Practice Learning Agreement.

11.3.3 The supervision of Student Social Workers should be recorded in a format agreed by the Practice Assessor, Student and University. Records of supervision should also be retained by the Practice Assessor on behalf of the Trust as these may incorporate case discussions and clinical decision making.

11.3.4 Student Social Workers should be encouraged to access group supervision forums available to them whilst on placement to enhance their learning experience.

11.3.5 Practice and performance issues arising in relation to Student Social Workers on placement with the Trust should be raised by the Practice Educator to the University. Team Managers should be kept informed of all practice concerns in relation to Student Social Workers on placement in their area.

## 11.4 Social Workers completing their Assessed and Supported Year in Employment (ASYE)

11.4.1 Definitions

The Assessed and Supported Year in Employment (ASYE) flows from the 15 Recommendations of the Social Work Task Force and the subsequent work of the Social Work Reform Board. It has been designed to help newly qualified Social Workers to develop their skills, knowledge and capability and strengthen their professional confidence. The ASYE has been aligned with the Professional Capabilities Framework (PCF), The HCPC Standards of Proficiency and the Knowledge and Skills Statement for Social Workers (KSS).

The Trust has chosen to implement the ASYE in order to provide excellent support and development in the first year of a newly qualified Social Worker's practice.

Further information on the ASYE can be found in the ASYE Information Pack which is downloadable via the Social Work Trustspace site.

11.4.2 Supervision Arrangements

All newly qualified Social Workers completing the ASYE will receive management and reflective (clinical) supervision throughout the duration of the programme. This must be carried out by a Registered Social Worker.

Following appointment of a newly qualified Social Worker who is completing the ASYE, supervision sessions must take place:

- Weekly, for the first six weeks;
- Fortnightly, from week 7 to six months;
- Monthly, thereafter

Reflective supervision sessions for newly qualified Social Workers can take a variety of forms, including one to one or group forums, however, newly qualified Social Workers should continue to retain the minimum one to one supervision requirements as set out in this policy.

**11.5 Additional Support Forums**

In addition to the provision of supervision provided by the Trust to newly qualified Social Workers, those completing the ASYE will also have access to additional support forums as part of the programme. This may include:

- Additional peer led forums arranged by individual ASYE groups
- Action Learning Sets
- ASYE training and development days

The additional forums described are organised by the Learning and Development at Hertfordshire County Council.

11.6 Social Workers who are Approved Mental Health Professionals

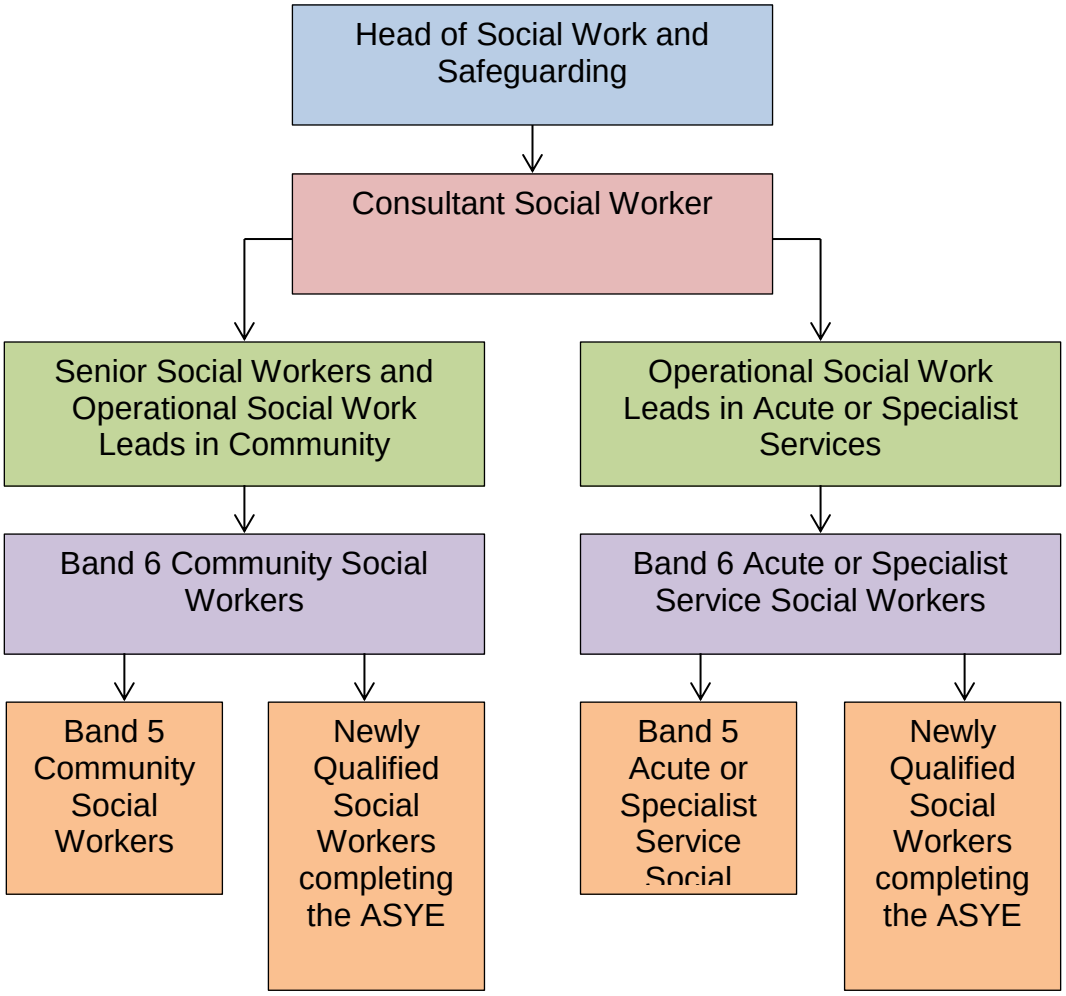
11.6.1 It is essential that Social Workers who also practice as Approved Mental Health Professionals receive supervision in relation to their AMHP role.

11.6.2 Where an Approved Mental Health Professional is already line managed by an Approved Mental Health Professional, this would form part of their usual supervision.

11.6.3 Approved Mental Health Professionals who are not line managed or otherwise supervised by an Approved Mental Health Professional may wish to seek Professional Supervision from a qualified AMHP.

11.6.4 Approved Mental Health Professionals may alternatively seek supervision in relation to this role via group AMHP supervision forums.

## 11.7 Supervision Structure for Social Workers



## 11.8 Template Supervision Record for Social Workers

**Supervision Record**

| | |
|---|---|
| **Supervisee:** | |
| **Supervisor:** | |
| **Date of Supervision:** | |
| **Agenda** | |
| 1. | |
| **Agenda item:** | **Discussion & Agreed Actions:** |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |
| 9. | |
| 10. | |
| **Date of next supervision:** | |
| **Signed (supervisee)** | |
| **Signed (supervisor)** | |

## Supervision contract

### 1. Time commitment

We agree to meet for supervision sessions fortnightly for up to two hours.
We each agree to make a commitment to our meetings, agreeing to cancel only if an emergency arises, or in case of illness. If either person has to cancel, we will reschedule on the same day a further time to meet.

### 2. Recording

We agree that we will make notes together of the relevant discussion and action points on the Supervision Record during supervision. Supervisor will send a copy to Supervisee, and we will both sign it at the next session. A copy of the Supervision Record will be forwarded to both parties.

### 3. Confidentiality

We agree that any information shared during our meetings will be shared with each other. Information will be shared also with the line manager / Head of Service if there is any professional misconduct or areas of concern regarding practice or concerns about progression within the placement.

### 4. Respect

We agree to treat each other with respect. In practice this means listening carefully to each other's point of view, and communicating with openness and honesty.
We both aim to create a space where problems can be aired by Supervisee without him being afraid of being judged or blamed.
Both of us agree to be open with each other about any problems we are experiencing in the context of supervision. If we are unable to resolve a conflict, we will ask a Tutor to become involved.

### 5. Differences / power imbalance

We acknowledge our differences and aim to understand and value these, and not to allow these to feed into misunderstandings or discrimination.
We aim to foster an open, safe atmosphere of equality and two-way communication, where we communicate with honesty.

### 6. Support

Supervisor to offer Supervisee support through formal supervision sessions, and she is happy to be contacted by phone or e mail between sessions. If there is an urgent matter to discuss, Tutor will expect Supervisee to contact her.

Supervisee agrees to inform Supervisor/other team leads and/or Tutor of any incidents that occur during his work. Supervisee is also responsible for informing us if his workload is

unmanageable or if he is having problems fulfilling any duties so that we can work together to resolve the issue. Supervisor agrees that any concerns raised by Supervisee will be acted upon by her if this is what we agree.

## 7. Structure

A standing agenda has been drawn up which includes a review of agreed action points from last meeting, general wellbeing, workload & capacity, interactions within the team, cases/group work, self-assessment and feedback, PCF, learning needs, progress made, evidence file, and any other business.

The agenda to be agreed by us at the beginning of each session, allowing for priorities to be identified.

## 8. Review

The supervision contract can be reviewed at any time at the request of either party.

**Supervisee**
Signature: Date:

**Supervisor**
Signature: Date:

## Issues relevant to the supervision of Psychological Therapists

**11.1** The guidance provided in the body of this policy is a sufficient description of issues relevant to the supervision of Psychological Therapists. However, there are several issues which sometimes require particular consideration, these are described below.

**11.2** The larger part of the body of Psychological Therapists is made up of Clinical and Counselling Psychologists. These staff are trained and accredited to provide multi-modal therapies and as a result require clinical supervision from within their own professions (from either applied tradition).

**11.3** A significant part of the body of Psychological Therapists is made up of staff who are trained and accredited to provide a single mode of therapy. These staff require clinical supervision from a member of staff who is qualified to provide this therapy.

**11.4** Staff providing clinical supervision should have training in supervision.

## External Supervision Contract

**12.1** Prior to agreeing a supervision contract the potential supervisor will provide a CV with the following details, which if the arrangement is formalised, will appear on an external supervision contract which will be an official document on HPFT Letterhead:

Name and Address of Supervisor

Relevant Qualifications of Supervisor

Relevant Accreditation(s) of Supervisor

Clinical experience of the Supervisor

Address at which Supervision will take place

Address for correspondence (if different)

Contact details for Supervisor (email, mobile phone, landline)

Frequency of Supervision, length of Supervision sessions

Cost of Supervision

**12.2** The contract will contain the following sections:

*The Supervisor will hold appropriate professional registration / accreditation to provide clinical supervision. This will be agreed as sufficient by the supervisee's professional lead.*

*The supervisor will maintain this professional registration / accreditation and inform HPFT of any circumstances where the validity of this registration / accreditation is called into question or lapses.*

*Supervisor and supervisee agree to keep all client-based and sensitive service information discussed confidential.*

*Supervisor and supervisee agree that clinical responsibility for practice remains with the supervisee and HPFT.*

*Supervisor and supervisee will be alert to safeguarding and practice governance issues and any concerns about the wellbeing of service users, their children or the supervisee will be raised as appropriate with the supervisee, their line manager (insert name and contact details), and their professional lead (insert name and contact details).*

*This arrangement, between (staff member), supervisor (insert name) and HPFT will be reviewed every 6 – 12 months to ensure that it is fulfilling its purpose. This will take the form of a written communication between the line manager and the supervisor which the supervisee will have sight of. This report will be stored in the staff member's personnel file.*

**12.3** The contract will be signed by the supervisee, the supervisor and the line manager and a copy will be kept by each party.

Relationship between different types of supervision: Examples of where discussion should take place

| Examples | Management supervision | Clinical supervision | Professional supervision |
|---|---|---|---|
| Workload management | * | * | * |
| Prioritising work | * | * | * |
| Identify CPD needs | * | * | * |
| Mandatory training | * | | |
| Profession specific training | * | * | * |
| Personal development | * | * | * |
| Annual leave | * | | |
| Performance | * | * | * |
| Monitoring objectives | * | * | * |
| Case discussion | * | * | * |
| Aims/outcomes of intervention | * | * | * |
| Reflect on practice | * | * | * |
| Modifying practice | * | * | * |
| Professional issues | * | * | * |
| Evidence based practice | * | * | * |
| Risk issues | * | * | * |
| Record keeping | * | * | * |

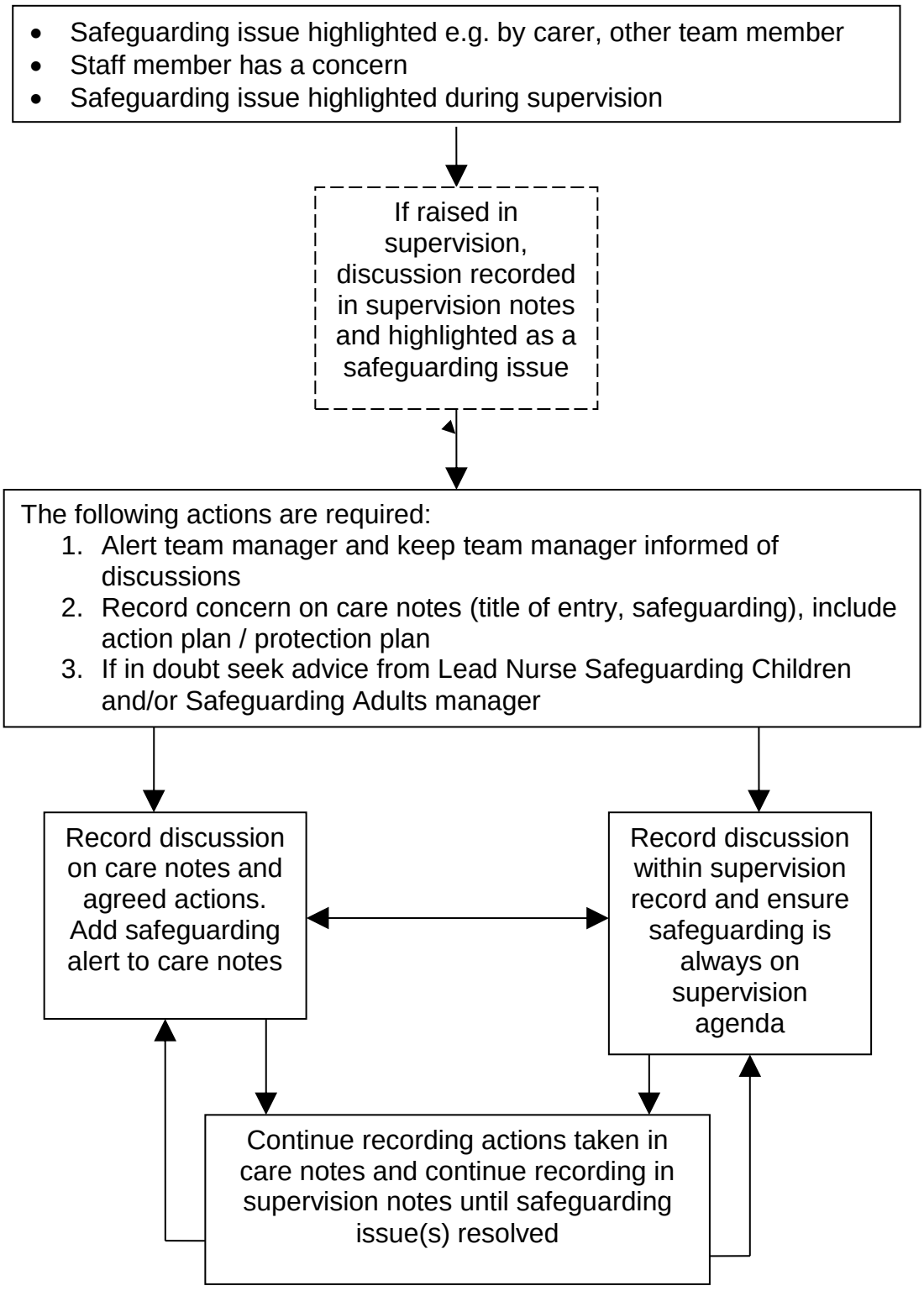
**Training Needs Analysis**

| Level of Training | Service | Staff group | Training package and/or provider | Frequency |
|---|---|---|---|---|
| Short course | All teams | All staff responsible for giving supervision | In – house introductory course | As identified in individuals PDP |
| Short course | All direct care teams | AHPs | Courses offered by universities to support placements of their students e.g. UCL Speech Sciences | As identified in individuals PDP |
| Short course | All direct care teams | AHPs | Courses offered by professional bodies | As identified in individuals PDP |
| Short courses | All direct care teams | Nursing | Courses offered by Universities to support placements of their students and to also support newly registered nurses (Mentorship & Preceptorship) | As identified in individuals PDP and also based on service need |
| Short courses | All direct care teams | Nursing | In house training provided for all nursing staff who provide supervision, co-ordinated by the Lead Nurses | As identified in individuals PDP |
| Short | All direct care teams | Medical staff | By academic and professional body | As identified in individuals PDP |
| Short courses | All direct care teams | Social care | Courses offered by professional body | As identified in individuals PDP |
| Short courses | All direct care teams | Social care | Courses offered by universities to support placements of their | As identified in individuals |

| | | | | |
|---|---|---|---|---|
| | | | students | PDP |
| Short courses | All direct care teams | Psychological therapies | Courses offered by Doctorate Clinical Training courses at UH, UCL and other courses from where trainees are taken.<br><br>CBT Supervision Training<br><br>Other supervision courses applicable to Professional Bodies | As identified in individuals PDP |
| Longer courses | All direct care teams | Psychological therapies | By academic and professional bodies to enhance supervision in particular therapeutic approaches or models. | As identified in individuals PDP |

Hertfordshire Partnership University NHS Foundation Trust

## Safeguarding Adults Supervision Flow Diagram



Safeguarding Children Flowchart

Guidelines for Arts Therapies Clinical Supervision

## 1. Summary

Clinical Supervision is an integral part of arts therapies practice and is recognised by the HCPC, the regulating body, to be essential in assuring high standards of proficiency and standards of practice.

**"Registrant arts therapist must understand the role and value of ongoing clinical supervision in an arts therapy context". HCPC Standards of Proficiency for arts therapists 2013, 11.3.**

Hertfordshire Partnership University NHS Foundation Trust (HPFT) is committed to ensuring that all staffs have access to management, professional ***and*** clinical supervision. The Trust fully supports the need for Arts Therapists to receive clinical supervision as laid down by the relevant professional bodies.

It is intended that these guidelines are used by managers and therapists alongside the Trust's Supervision Policy. The guidelines are designed to help managers and clinicians with the decision making pathway regarding the provision of clinical supervision. These guidelines are not intended to be prescriptive but help those involved in making informed, equitable and transparent decisions.

It is recognized that an Arts Therapist's clinical supervision needs may change over time and it is intended that these guidelines can be used at any time to help staff re-consider their clinical supervision arrangements in partnership with their line manager and professional lead.

## 2. Definitions

This section defines the different types of supervision as they apply to arts therapists in HPFT. More in depth definitions of clinical supervision are given in section 3 of the policy.

### 2.1 Management supervision

Management supervision is task oriented, with a formal service led agenda. Management supervision is a regular meeting with the line manager (or other nominated manager) in order to discuss

- operational and management issues relating to the supervisee's role including prioritising work
- main tasks
- required performance standards
- training needs
- personal development

### 2.2 Professional supervision

Professional supervision is given by the professional lead. Frequency is determined by need but all arts therapists in HPFT should receive professional supervision from an arts therapist lead at least quarterly. Where this is also the line manager, professional and line management supervision may be combined. The role of professional lead is designed to ensure that staff are delivering appropriate, evidenced based interventions. Where clinical supervision explores the specifics of the therapy, professional supervision addresses the wider picture.

Areas that might be discussed in professional supervision are:

- professional development
- service development and innovation
- professional standards and registration requirements
- pathways
- research
- case load including activity level and throughput
- outcomes

### 2.3 Clinical supervision

Clinical supervision provides the opportunity for arts therapists to
discuss individual cases in depth with the aim of providing effective and safe interventions. This will include reviewing the aims and expected outcomes of interventions, the techniques to apply to the therapy, the therapeutic relationship, and the therapist's feelings in order to understand possible transference.

### 3. Professional association guidance on clinical supervision

*'The principle aims of supervision are to protect service user safety and to reflect on and develop the clinician's practice. The supervisee remains responsible and accountable for their clinical work. The role of the supervisor is to support the clinician to develop their clinical practice and to ensure the welfare of the client through the supervision process'. (BAMT March 2008, updated 2012)*

The British Association for Drama Therapists (BADth), the British Association for Music Therapy(BAMT) and the British Association of Art Therapists (BAAT) have all produced advice regarding supervision. They introduce the rationale for clinical supervision in the following ways.

**BADth**
*"Clinical Supervision is a formal, collaborative process in which two or more professionals meet to discuss the clinical content and process of the Supervisee's work and is an important and integral part of Dramatherapy practice. It is intended to help Supervisees maintain ethical and professional standards of practice and to enhance critical reflection and creativity. It should take into account the setting in which Supervisees practise and its frequency will vary according to the volume of clinical work, the experience of Supervisees and their work setting."*

**BAMT**
*"Music therapy supervision provides a forum for support and an objective perspective on clinical work. It provides a channel for learning and expanding clinical techniques and theoretical structures and for examining issues of professional practice. It brings new perspectives to bear upon engrained patterns of working and thinking in certain clinical situations, and seeks to increase the effectiveness of music therapy practice, while also ensuring that this is in line with current legislation and procedures."*

**BAAT**
*"Supervision is required for good clinical practice, to ensure the continuing working development (CPD) of the Art therapist and for the protection and welfare of patients/clients."*

The three separate associations (BAAT, BAMT, and BADth) give similar guidance regarding clinical supervision, which can be summarised by the following:

- To look at ingrained patterns of practice and challenge them where relevant
- To expand clinical techniques and theoretical structures
- To examine the therapeutic relationship in-depth between therapist and service user and the way in which this impacts on the progress of the therapy (transference/counter transference)
- To endeavor compliance with the supervisee's code of professional practice and the delivery of a safe service to clients
- To analyse the clinical material and its expression through the particular art form.
- Periodically to review the original aims of the therapy and discuss time scales of the intervention
- To mark turning points within the therapeutic relationship
- To provide a framework for understanding the unspoken process and agendas. (State Registered Art Therapist Guidelines for Supervision 2011)

### 3.1 Content of clinical supervision:
*"Clinical Supervision may include discussion and analyses of the dramatic, verbal and behavioural material, the emotional and psychological world of the client including conscious and unconscious processes, the relationship between the client and the therapist and the impact of this on the therapy, and areas of resistance / difficulty."* (BADth 2014)

## 4. Types of Clinical Supervision

These guidelines focus on individual clinical supervision; however it is recognized that at times and where appropriate group supervision may also be applicable. Individual clinical supervision and group clinical supervision can be defined as follows:

**Individual supervision**
One to one clinical supervision with an experienced supervisor. This is usually the primary form of supervision and is conducted on a face-to-face basis. Sessions are usually 50-60 minutes. Alternative arrangements may be considered in exceptional circumstances (e.g. telephone supervision, Skype) but must be discussed with the professional lead before arrangements are agreed to.

**Group Supervision**
Group supervision refers to a process where two or more practitioners take turns in presenting their work for discussion. Such group supervision is led by a designated supervisor. Session length would usually be a minimum of 30 minutes per supervisee.

**Peer Supervision**
Peer supervision may sometimes be a helpful addition to clinical supervision. It is not a replacement and is not an appropriate structure to meet the content and aims of Clinical Supervision.

## 5. Finding a Clinical Supervisor

The decision making process should involve where appropriate the line manager, the professional lead and therapist concerned. The professional lead together with the therapist will establish the most appropriate options for discussion.

The following factors need to be considered when making decisions around the provision of appropriate clinical supervision:

- The Therapist's role;
- Preference for clinical approach and profession of supervisee and supervisor;
- Service User group and Service Specifications;
- Previous experience and competency of supervisee;
- The range of complex needs in therapist's clinical caseload;
- Time for attendance at clinical supervision sessions and travel to location;
- Experience of clinical supervisor which may include obtaining evidence, e.g. CV

### 5.1 Internal supervision

Heads of Service and/or Professional Leads will make every attempt to find an internal supervisor where appropriate. To support this, managers within the Trust, must be willing to enable professional leads to make arrangements across different teams within the Trust. It would be advised that internal supervisors discuss this within their PDP/job plan to ensure it meets the expectations of their role. If the supervisor identified is not seen as appropriate by the member of staff they must present clear evidence of why they require an alternative supervisor. Members of staff would need to consider the guidance given in this document to help them with this task.

Clinical supervision should not be given by an individual's operational line manager as this is not recommended as good practice.

Clinical supervisors would usually be from within the same profession however in some circumstances the clinical supervisor may be from a different clinical background as long as they use a similar clinical approach such as another arts therapies profession or a psychotherapist.

If a suitable internal arrangement is not possible then reasonable funding for the provision of external supervision will be provided.

### 5.2. The Provision of an External Supervisor

When an internal supervisor cannot be found then the Trust will cover reasonable costs of external clinical supervision. This will be calculated on an individual basis. Costs of external supervision vary greatly and must be agreed with the appropriate manager, and the budget holder should this be different. Any increases in costs must also be agreed. Should the increase in costs seem unreasonable, it may be necessary to review the clinical supervision agreement. A contract with the external supervisor must be agreed with the line manager as per appendix 1.

The professional lead will be required to check the competency of supervisors.

**5.3. Grade of Therapist and Supervisor**

A therapist would normally be expected to be supervised by someone on a higher grade and with more experience than themselves with the relevant Service User group. At all times, the competency of the supervisor and the needs of the supervisee must be closely matched, for example where specialist knowledge of clinical areas is required.

It is not recommended that a therapist is offered clinical supervision from a therapist of the same grading when working within the same service and/or department. This may be acceptable if the supervisee and supervisor do not work alongside one another on a day-to-day basis and are based within different service areas of the Trust.

**6. Frequency of Clinical Supervision**

Full time staff with a full case load should receive clinical supervision twice monthly. Access to clinical supervision for part time staff will be calculated on a pro-rata basis with a minimum of once a month.

BADth recommends that all dramatherapists in clinical practice receive no less than one and a half hours per month of individual Clinical Supervision, or group equivalent. For part time staff this could include clinical supervision they receive for work outside the trust, with monthly still being the minimum for work within the trust.

**7. Attendance at clinical supervision sessions**

Supervision should take place within contracted hours. If this is not possible therapists will be given time in lieu (including reasonable travel time) and appropriate travel costs will be paid.
Therapists are encouraged to arrange clinical supervision so as to cause least impact on service delivery e.g. if the clinical supervisor lives near the therapists home then sessions at the beginning or end of the day would be most suitable.

**8. Contract agreements**

The Professional Lead, Line Manager and individual therapists have responsibilities regarding clinical supervision.

Internal clinical supervisors are expected to use the Trust clinical supervision contract and follow the Trust supervision policy. External supervisors would be expected to agree to the contract in appendix 17. These contracts are designed to improve communication between manager, therapist and clinical supervisor. These contracts are supported by professional body advice regarding supervision contracts. Managers within the Trust are required to ensure that the clinical work carried out by arts therapists is of a high standard and therefore need this assurance from the external supervisor.

Contracts and arrangements should be reviewed annually by the therapist and Professional Lead.

| **Clinical supervision contract with external supervisor** |
|---|
| Name of Supervisee |
| Name of supervisor |
| Supervisors contact details |
| Arrangements for three way contact between management supervisor, supervisee and clinical supervisor, e.g. email |
| Supervision details e.g. agreed levels of funding, frequency |
| Aims of supervision session (refer to professional codes of practice) |
| Confidentiality will be maintained in accordance with the trust supervision policy and appropriate professional codes of practice. External supervisors must not record any information about a service user which would make the service user identifiable |
| As a supervisee I agree to :<br>Take responsibility for making effective use of the time made available for supervision and for acting upon decisions made within it.<br>Be willing to learn and change to receive support and challenges to help professional and personal development and to ensure service provision to agreed standards<br><br>Signed:<br>Date: |
| As supervisor I agree to:,<br>Offer you support, constructive feedback, information and expert advice to enable you to reflect in depth on issues affecting your practice and to develop professionally and personally<br><br>Signed:<br>Date: |
| Management supervisor<br>I agree to support the contact as agreed above<br><br>Signed:<br>Date: |
| Professional Lead<br><br>Signed:<br>Date: |

## Our vision

**‘to be the leading provider of mental health and specialist learning disability services in the country’**

To be a leading provider, we must offer high quality care with excellent treatment outcomes, within a safe environment which meets the needs of service users.

Our vision is underpinned by eight goals which inform our entire strategy.

- To deliver high quality integrated health and social care services in accordance with recovery principles
- To be the provider of choice for service users, carers, the community and commissioners
- To work in partnership with the community to promote the wellbeing of others, whilst making a positive contribution to the environment
- To be the employer of choice where staff are highly valued, well supported and rewarded
- To create a dynamic and flexible working environment where staff are motivated and committed to providing high quality care
- To embed a learning culture where staff develop their full potential and deliver excellent care
- To ensure a sustainable future through income growth and efficient use of resources
- To be an innovative and learning organisation that embraces new and modern approaches to health and social care