Policy: C16
Clinical Supervision for Nurses

| Version:       | C16/06                  |
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| Target audience: | All nursing staff and clinical managers |
| Disclosure Status: | B Can be disclosed to patients and the public |

EIA / Sustainability

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<td>140211 (BL) Sustainable Development.doc</td>
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This is current version C16/06 June 15
## Equality & Diversity statement

The Trust strives to ensure its policies are accessible, appropriate and inclusive for all. Therefore all appropriate policies will be required to undergo an Equality Impact Assessment and will only be approved once this process has been completed.

## Sustainable Development Statement

The Trust aims to ensure its policies consider and minimise the sustainable development impacts of its activities. All relevant policies are therefore required to undergo a Sustainable Development Impact Assessment to ensure that the financial, environmental and social implications have been considered. Policies will only be approved once this process has been completed.
## C16 – Clinical Supervision for Nurses

### Version Control Sheet

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<td>C16/01</td>
<td>June 2003</td>
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<td>New policy issued</td>
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<td>C16/03</td>
<td>17&lt;sup&gt;th&lt;/sup&gt; November 2010</td>
<td>Deputy Director of Nursing</td>
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<td>Revised policy issued</td>
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<td>C16/05</td>
<td>July 2013</td>
<td>Deputy Director of Nursing</td>
<td>Revised policy</td>
<td>Partial review and update due to full review of process by external consultants Presented to TMT, approved, review date Oct 2014</td>
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<td>C16/06</td>
<td>Oct 2014</td>
<td>Deputy Director of Nursing</td>
<td>Revised Policy</td>
<td>Comprehensive review following completion of Trust wide Clinical Supervision development programme Trustwide consultation ending 01.05.15</td>
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1. Flowchart

New member of staff (new starter or transfer from another ward/team) joins team.

Ward/Team manager allocates supervisor with 7 days.

Supervisee and supervisor sign contract and agree date for monthly clinical supervision session.

Supervisor records attendance and session summary via exchange. Date of next session agreed and diarised.

Supervisee attends 1:1 clinical supervision session (40-60 minutes duration).

Supervisee attends group (max 8) clinical supervision session (40 - 60 minutes duration).

OR

Ward/Team manager allocates supervisor with 7 days.

All supervisees complete an annual clinical supervision evaluation survey at time of PDR final review.

Monthly uptake trends and actions reviewed in CSU Nursing governance meeting.

Uptake and quality assurance report received by Trust-wide nursing Governance forum.

Clinical supervision data feedback to Ward/team manager by operational manager. Maintenance and improvement actions agreed.

Annual evaluation report and recommendations prepared by CSU Nursing governance forum.

Annual clinical supervision uptake and quality report and recommendations to QAC, TMT. Subsequently to CSU SMTs and Nursing Governance forums for action.
2. **Introduction**

2.1 The West London Mental Health NHS Trust [WLMHT] is one of the largest and most diverse mental health services in the United Kingdom. It provides treatment and care for around 20,000 people each year and serves a local population of about 700,000 residents.

2.2 WLMHT employs around 3000 staff and serves a diverse community across three London boroughs. This includes local mental health services for adults, older people and children in the Boroughs of Ealing, Hammersmith & Fulham and Hounslow. The high secure services at Broadmoor Hospital, together with the West London Forensic Service, makes the Trust one of the leading national providers of secure and specialist mental healthcare.

3. **Scope**

3.1 The West London Mental Health NHS Trust is committed to the practice of Clinical Supervision [CS], a formally structured arrangement to support staff in human service agencies, which has a long and established history in many healthcare professions.

3.2 The WLMHT has given public expression to such a commitment through this Policy document, which was first issued in June 2003, the contents of which seek to ensure that each employed nurse and healthcare assistant [HCA] has access to, and receives, appropriate and effective Clinical Supervision.

3.3 Through regular and frequent Clinical Supervision, it is expected that these staff groups will be assisted to develop a deeper understanding of their respective roles as reflective and accountable practitioners. It will help support them to develop and maintain complex relationships in a modern mental health service.

3.4 At the level of individual, Clinical Supervision will encourage the process of lifelong learning and will help in the development of the clinical leaders of the future. At the level of the organisation, Clinical supervision will help to identify and address matters of professional interest and concern to a relevant Trust-wide clinical governance agenda. In particular, CS can make a contribution to the process of clinical risk management and to a safe environment in which care is delivered.

4. **Definitions and models**

4.1 Operational definitions of Clinical Supervision, together with the preferred models of practice, frameworks for implementation and the strategies for systematic evaluation, all vary within and between professional groups and practice settings (Sloan and Watson 2002; Milne 2007). The essential parameters of Clinical Supervision, however, have now been established. Clinical Supervision is usually distinguished from case review, personal performance review and therapy,
although there is little doubt that when Clinical Supervision is provided to an efficacious standard it is likely to be therapeutic (Spence 2001).

4.2 Within the WLMHT, it is likely that nurses will become exposed to examples of five main forms of local supervision:

- 'clinical supervision',
- 'managerial supervision',
- 'caseload management',
- 'reflective practice groups' and
- 'modality specific supervision'.

Managerial supervision is usually facilitated by the line manager and focuses on performance and associated tasks; it may provide support and feedback and tends to conclude with further actions and tasks to be completed within an agreed timescale. Reflective practice groups are usually organised around the work of the clinical team and are an opportunity to reflect on specific case work and generation of hypothesis for improvement to be tested out. This form of supervision may also examine ways to improve the system in which individual Supervisees and teams work. The 'modality specific supervision' usually involves supervision in a discrete psychological therapy, to help ensure the development and fidelity of that approach. Nurses will experience some or all of these types of supervision and these together with case reviews, clinical incident reviews and case discussions with other professional colleagues provide continuous opportunities for reflection on practice. The WLMHT Nursing Directorate will work with colleagues to identify guidance to record these additional opportunities for reflection in order to further support nurses in practice and in their preparation for NMC revalidation (NMC 2015).

4.3 This Policy document, however, relates specifically to Clinical Supervision for nurses. For the majority employed by WLMHT, CS sessions are currently arranged on a one-to-one basis [so-called dyads], in which a Senior Nurse in the management line will assume the role of Supervisor. The content of such CS sessions are distinct from Performance Development Review [PDR], however, and the present Policy readily acknowledges the potential sensitivity of the current arrangement, which will remain under constant review (see The Trust Process at section 7 below).

5. Background

5.1 The main historical threads of the development of nursing Clinical Supervision in Britain are now well rehearsed in the public literature [White and Winstanley, 2014]. Most publications agree that the main accelerator was caused by findings from the Allitt Inquiry (1991) and by recommendations of the subsequent Clothier
Report [Department of Health, 1994]. General concerns were raised about the standards of supervision and training for nurses.

5.2 In the wake of these accounts, Faugier & Butterworth (1994) argued that Clinical Supervision should be considered a necessary part of the clinical governance agenda for safer nursing care in Britain. This position was later publicly endorsed by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC 1996) and later by the Department of Health (2000), London and, by 2002; the successor regulatory authority [Nursing & Midwifery Council] had issued guidelines on Clinical Supervision.

5.3 In 2008, the Nursing & Midwifery Council updated its publicly available CS guidelines. In 2012, however, the N&MC reviewed its advice sheets and moved to a new structure of providing a range of regulatory information to support implementation of standards and guidance. A decision was taken by the N&MC to remove the information on Clinical Supervision which was not only because it was out-dated, but also because it was no longer regarded appropriate for a Regulator to provide guidance on an issue that should be part of local training, development and governance frameworks.

5.4 Throughout, the WLMHT has been mindful of several internal Serious Untoward Incident and Critical Incident Review inquiries, which reinforced the need for good quality Clinical Supervision to be included as an important area for development in Clinical Governance forward plans and key performance indicators.

6. Previous internal reviews of WLMHT Clinical Supervision Policy for Nurses

6.1 Three years after it was introduced, this Policy was reviewed in 2006 by a selection of Senior Nurses working within the West London Mental Health NHS Trust. It included a full consultation exercise with all Senior Nurses, via the nursing governance structures. It also included feedback from a series of Focus Groups held for Band 5, 6 and 7 nurses in Local and Forensic Services, the results of which were built into a revised policy document. In 2010, the policy was again reviewed by WLMHT Heads of Nursing. Findings revealed that Clinical Supervision offered an opportunity to:

- examine practice openly, safely and honestly
- identify examples of good practices
- consider future development needs
- help improve the delivery of nursing care to patients
- feel professionally supported and minimise any sense of professional isolation
6.2 It was agreed that Clinical Supervision should not be regarded as a channel for disciplinary procedures; nor a route to make complaints; an opportunity to reprimand poor performance or to criticise other team members; a time to arrange off duty and shifts or hours of work, nor 'time out' to chat about things in general, or gossip.

6.3 The current policy revision is the product of a comprehensive Trust wide Clinical Supervision Development Programme concluded in 2014. It recommended the review of this policy to reflect contemporary evidence and best practice.

7. **International evidence base for Clinical Supervision**

7.1 A number of contemporary reviews of the international CS outcomes literature have examined the evidence base of Clinical Supervision (Watkins 2011, White and Winstanley 2011) and a commonality of expert opinion has begun to emerge from the findings, some of which were highlighted during the WLMHT policy review process referred to at 6.3 above. For example, there is little doubt that effective CS has a causal effect on lowering the stress levels of individual Supervisees, when carefully measured by research instruments with established psychometric properties.

7.2 A current research agenda exists to unequivocally establish a causal relationship between this reduction and [say] staff sick leave and staff retention rates. There are also growing indications that Clinical Supervision may also be positively associated with an improvement in the quality of clinical care and, where this can be demonstrated, improved outcomes for mental health service users may also be detected( Bambling et al 2006; Bradshaw et al 2007; White and Winstanley, 2010).

7.3 In order that CS may be successfully implemented and sustained, the best and clearest directions currently available (White and Winstanley 2010) suggest that a number of environmental conditions should be met:

   I. Clinical Supervision should be universally considered part of the core business of contemporary professional mental health nursing practice.

   II. Positive support for Clinical Supervision should be evident at all levels of service management and accepted as a dominant feature of the organisational culture.

   III. The mainstream status of Clinical Supervision should be written into all workforce policies, as a positive expectation for all staff to engage

   IV. Explicit protocols should be in place to confirm the arrangements for the sustainable implementation across all services [size, 1:1 or 6-8 in groups; frequency, not less than monthly; duration, between 40-60 minutes; ground rules about confidentiality and so on], together with a dedicated
information management system to continuously monitor these are given full effect.

V. Supervisees should retain the option to identify an additional Clinical Supervisor for modality specific clinic work, where this is practicable. This should be an appropriately trained and experienced practitioner, who does not hold operational or managerial responsibility for the Supervisee

VI. Individuals identified by local criteria to become Supervisors should be appropriately prepared for their role through the provision of appropriate training.

VII. Upon appointment, all staff should be assisted to become fully orientated to local Clinical Supervision arrangements, including new registrants and others transferring into the mental health workforce.

VIII. Managers who hold individual responsibility for the staff roster and budget should to be provided with the support necessary to ensure a smooth CS operation, without deleterious effect on clinical contact time.

IX. A Programme of continuous evaluation in discrete clinical locations and across the entire service should be in place to ensure that the quality and efficacy of local Clinical Supervision arrangements are able to be demonstrated and regularly reported.

X. In the face of compelling evaluation outcomes, necessary adjustments should be made to maximise potential benefits arising from Clinical Supervision.

XI. Suitable administrative records (Recording of sessions, reporting uptake and evaluation of effectiveness) should be maintained.

8. Duties

8.1 Chief Executive

8.1.1 The Chief Executive is responsible for ensuring that the Trust has policies in place and complies with its legal and regulatory obligations.

8.2 Accountable Director (Executive Director of Nursing & Patient Experience)

8.2.1 The accountable director is responsible for the development of relevant policies and to ensure they comply with NHSLA standards and criteria where applicable. They must also contain all the relevant details and processes as per policy P3. They are also responsible for trust wide implementation and compliance with the policy.
8.2.1.1 It is the responsibility of the Executive Director of Nursing & Patient experience and Deputy Directors of Nursing to ensure that a contemporary policy, appropriate training and a system of audit is in place for Clinical Supervision.

8.2.2 It is the responsibility of Service Directors to implement the Clinical Supervision Policy through the cascade mechanisms in each CSU.

8.3 **Managers**

8.3.1 Managers are responsible for ensuring policies are communicated to their teams/staff. They are responsible for ensuring staff attend relevant training and adhere to the policy detail. They are also responsible for ensuring policies applicable to their services are implemented.

8.3.2 It will be the responsibility of the ward or team manager to confirm that all nurses who provide supervision have the skills to do so.

8.4 **Policy Author**

8.4.1 Policy Author is responsible for the development or review of a policy as well as ensuring the implementation and monitoring is communicated effectively throughout the Trust via CSU/Directorate leads and that monitoring arrangements are robust.

8.5 **Local Policy Leads**

8.5.1 Local policy leads are responsible for ensuring policies are communicated and implemented within their CSU/Directorate as well as co-ordinating and systematically filing monitoring reports. Areas of poor performance should be raised at the CSU/Directorate SMT meetings with agreed actions to address.

8.6 **Service Director**

8.6.1 Service Directors responsible for implementing the policy and monitoring compliance with policy.

8.7 **All Staff**

8.7.1 It is an expectation that all staff will engage in supervision with the aim of learning and improving practice.

9. **Systems and Recording**

9.1 Where recorded: A record of every clinical supervision session (1:1 and group) will be recorded via the exchange.

9.2 When recorded: As soon after the clinical supervision session as possible.
9.3 Recorded by who: The supervisor is responsible for recording that the session has taken place.

10. West London Mental Health NHS Trust Process

10.1 West London Mental Health NHS Trust expects that individual Clinical Supervision will be provided to all nursing employee’s using a cascade model, in which Senior Nurses will supervise junior nurses within their CSU Team/Ward or Department. In the majority of instances Senior Nurses/Nurse Consultant at Band 8b to 8a will supervise the Ward/Team Managers and other Senior Nurses at Band 7. The Ward/Team Managers will supervise their Clinical Team Leaders [Band 6]; the Team Leaders supervise Band 5 Nurses. Band 5 Nurses (not undergoing preceptorship) will be expected to provide clinical supervision for Preceptorship Band 5 Nurses and Healthcare Assistants within each ward and department. Each supervisor will record (via the exchange) each supervision session to ensure an appropriate level of monitoring, a local register should be maintained by the ward manager (Appendix 8).

10.2 This arrangement for the delivery of Clinical Supervision not only recognises the size and complexity of the Trust, but also offers a structure to enable some options for the individual, in recognition of the need to manage the workload effectively. The cascade structure fulfils the Trust’s responsibility to ensure that every member of nursing staff receives Clinical Supervision within their individual work context. In some cases, experienced nurses of the same banding e.g. band 6 may supervise another inexperienced band 6 nurse with the agreement of the Line Manager of the Supervisee.

10.3 Only in exceptional circumstances will individuals be allowed to choose their supervisor. Supervisors will normally be assigned by the ward/team Manager within 7 days of a nurse joining the team (New starter or transfer from another area).

10.4 If individuals wish to seek supervision from an additional supervisor (internal or external), they will be required to negotiate the development of this relationship through their Line Manager in addition to the Clinical Supervision arrangements outlined in this document.

10.5 In some instances Clinical Supervision may be offered by someone other than a nurse; however, this should only be in addition to supervision from a nurse. A nurse may also supervise another registered professional.

10.6 In addition to offering individual Clinical Supervision, every Directorate, Ward, Team or Department where nurses are employed should consider establishing group clinical supervision.

10.7 A signed copy of a Clinical Supervision contract should be held by both parties (appendix 1 & 2).
10.8 A record of each Clinical Supervision session attendance (1:1 or group) together with a session summary is made via the exchange by the clinical supervisor; both practitioners should have access to this record. It is the responsibility of individual supervisees to keep a record of their Clinical Supervision, including topics discussed and actions agreed.

10.9 Appendices 3 to 7 provide example templates to support the administration and process of clinical supervision including; supervision record and Clinical Supervision session agendas for band 3 to band 7 nursing staff.

10.10 Written records of supervisory sessions are confidential and should only be disclosed with the consent of the supervisee. Trust Audits of clinical supervision uptake will simply ensure that the clinical supervision session has been recorded.

10.11 Every ward/team Manager should maintain a staff supervision register which both parties sign after every session [example template at Appendix 8] to provide assurance that

10.12 A requirement to participating in, and (where appropriate) provide, Clinical Supervision will appear in all Job Descriptions.

10.13 The ratio of supervisees held by any one Supervisor should be considered locally. Ideally, no more than 6 staff should be assigned to each Supervisor.

10.14 Supervisors must be appropriately trained for their role. Training programmes and refresher opportunities are available within the Trust and these will be revised and extended to reflect this Policy.

10.15 The Trust’s Higher Education providers have incorporated the principles of Clinical Supervision into pre-and post-registration programmes.

10.16 Information resulting from clinical audit should be made available to all staff in a feedback loop, to enhance the quality of Clinical Supervision sessions, within wards, teams and areas.

10.17 Teams and Wards must be audited (via data provided by performance departments) by their Service Manager/Senior Clinical Manager or Senior Nurse to ensure all nursing staff have access to, and experience of, Clinical Supervision. This forms an important and integral part of the nursing governance arrangements, as outlined in the WLMHT ‘Strategy for Nursing 2014-16 (October 2014)

11. Implementation and Monitoring

11.1 Strategically, WLMHT provides a policy framework for Clinical Supervision which nurses are expected to follow. This framework is provided to ensure that all nurses employed in the Trust receive frequent and regular Clinical Supervision. This policy is agreed through the Trust Clinical Governance processes and implemented by operational managers in each Clinical Service Unit (CSU).
11.2 Operational Implementation

11.2.1 It is the responsibility of the Executive Director of Nursing & Patient experience and Deputy Directors of Nursing to ensure that a contemporary policy, appropriate training and a system of audit is in place for Clinical Supervision.

11.2.2 It is the responsibility of Service Directors to implement the Clinical Supervision Policy through the cascade mechanisms in each CSU.

11.2.3 The provision of Clinical Supervision is a performance objective for nurses at bands 5 – 8b. Progress against this objective will be assessed within annual and periodic personal development reviews (PDRs).

11.2.4 It is the duty of Ward managers/Clinical Nurse Manager’s [or senior nurse in the community] to ensure that Clinical Supervision arrangements are in place for all nursing staff. They are accountable for ensuring that monthly Clinical Supervision is available for all staff in their Team/Ward/Department.

11.3 Monitoring of Clinical Supervision:

11.3.1 Standardised templates which are to be used by all those who manage WLMHT-employed Nurses, are found as Appendices of this policy. Each clinical supervision session must be recorded via the Trust exchange platform.

11.3.2 It is the duty of the Service Director in each CSU to monitor that the Clinical Supervision standard has been met. The uptake of Clinical Supervision for nurses in each CSU will be audited through performance management processes.

11.3.3 The CSU Director carries overall responsibility for ensuring that the Clinical Supervision is delivered in the clinical setting and that evidence of this is available to the Deputy Director of Nursing and Executive Director of Nursing and Patient Experience.

11.3.4 The Service Director(s) in each CSU may delegate the monitoring and reporting of Clinical Supervision to a senior nurse in the Directorate; however, the Service Director will retain overall responsibility.

11.3.5 Ward managers/Clinical Nurse Manager’s Nurse Managers [or senior nurse in the community] will hold a register of all Clinical Supervision held in their ward/team. This record should include the name of the nurse, the name of their Supervisor, and the date that it took place. This record must be signed by both parties and kept for audit purposes.

11.3.6 Deputy Directors of Nursing, have a responsibility to ensure that the clinical supervision system outlined in this policy is in place within their CSU. They will provide assurance to the Trust Nursing Governance forum on a minimum of a six monthly basis using uptake data and audits of clinical supervision quality.
12. Supervision skills development:

12.1 Clinical supervision is integral to nursing practice and it is generally accepted that the skill is learnt by experience (i.e. through receiving good quality clinical supervision). It is the responsibility of the most seniors nurses in the CSU to set the clear standards. It will be the responsibility of the ward or team manager to confirm that all nurses who provide supervision have the skills to do so. Where there is a skills gap an individual skills development plan will be put in place, which will include the receipt of high quality clinical supervision to learn from.

13. Policy review

13.1 This Policy should be reviewed annually. The responsibility for the review will rest with the Executive Director of Nursing and Patient Experience, who will also take the lead role.

13.2 Any deficits in compliance with, and/or departures from, the Policy should be raised with the Executive Director of Nursing and Patient Experience, or deputies.

14. Fraud statement

14.1 Not applicable to all policies (N/A)

15. Supporting documents

This policy should be read in conjunction with: West London Mental Health NHS Trust Strategy for Nursing 2014-16 (2014)

16. Glossary of terms

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<td>CS</td>
<td>Clinical Supervision</td>
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<tr>
<td>NMC</td>
<td>Nursing &amp; Midwifery Council</td>
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<td>KSF</td>
<td>Knowledge &amp; Skills Framework</td>
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<td>PDR</td>
<td>Performance Development Review</td>
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<td>CSU</td>
<td>Clinical Service Unit</td>
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<tr>
<td>WM</td>
<td>Ward Managers</td>
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<tr>
<td>SN</td>
<td>Senior Nurses</td>
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17. References


White, E., & Winstanley, J (2014) *Clinical Supervision and the Helping Professions: An Interpretation of History*. The Clinical Supervisor, 33:1, 3-25

### 18. Appendices

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<th>Clinical Supervision contract (Line Manager – responsible for PDR)</th>
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<td>Clinical Supervision contract (Alternative suggested for use by non-line Manager - not responsible for PDR)</td>
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<td>Appendix 3</td>
<td>Example Supervision record</td>
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<tr>
<td>Appendix 4</td>
<td>Example Clinical Supervision agenda – band 3</td>
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Appendix 1

Clinical Supervision contract
(Line Manager – responsible for PDR)

Supervisee Name_____________________

As supervisee and clinical supervisor we agree to the following:

- To work together to facilitate reflection on issues affecting practice, in order to both personally and professionally develop a high level of practice expertise.
- To meet once per calendar month for 40-60 minutes.
- To protect the time and space for clinical supervision, by keeping to agreed appointments and time boundaries. Privacy will be respected and interruptions avoided.
- To keep a record of our supervision, showing the time and date of the meeting. This record may include notes, practice objectives and plans for future sessions.
- We understand that there may be circumstances (e.g. CIR, SUI’s, disciplinary investigations) when supervision records may be required and reviewed by Trust and Directorate managers.

As a supervisee I agree to:

- Prepare for the sessions, for example by having an agenda and bringing pertinent practice issues to supervision.
- Take responsibility for making effective use of the time.
- Be willing to learn, to develop practice skills and be open to receiving support and challenge.

As a supervisor I agree to:

- Keep all information you reveal in the clinical supervision confidential, except for these exceptions: Should you describe any unsafe, unethical or illegal practice that you are unwilling to go through the appropriate procedures to address or you repeatedly fail to attend sessions. In the event of an exception arising I will discuss the issue with you and if I remain concerned then I will inform you that I will need to discuss this issue with a suitable manager.
- Offer you advice, support, and supportive challenge to enable you to reflect in depth on issues affecting your practice.
- Be committed to continually developing myself as a practicing professional
- Use my own clinical supervision to support and develop my skills as a clinical supervisor and practitioner.
Any other issues?

__________________________________________________________________________

__________________________________________________________________________

Frequency of meetings ____________________________

Venue ____________________________

Review date ____________________________

Signed (Supervisee) ____________________________

Signed (Supervisor) ____________________________

Date contract signed ____________________________
Appendix 2

Clinical Supervision contract
(Alternative suggested for use by non line Manager - not responsible for PDR)

Supervisee: ____________________________________________

Supervisor: ____________________________________________

Line Manager: __________________________________________

EXPECTATIONS –TO BE AGREED

The purpose of supervision sessions:

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Particular priority areas to be discussed regularly:

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Documentation:

__________________________________________________________________
__________________________________________________________________
Limits of Confidentiality:

________________________________________________________________
________________________________________________________________

How conflicts/problems in the supervision relationship will be dealt with:

________________________________________________________________
________________________________________________________________

Informal contact between sessions:

________________________________________________________________
________________________________________________________________

Role of the Line Manager:

________________________________________________________________

<table>
<thead>
<tr>
<th>Frequency of Sessions:</th>
<th></th>
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<tbody>
<tr>
<td>Duration:</td>
<td></td>
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<tr>
<td>Usual Venue:</td>
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<tr>
<td>Responsibility for Initiating Sessions:</td>
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<tr>
<td>Responsibility for Agenda Setting and Preparing for Sessions:</td>
<td></td>
</tr>
<tr>
<td>Structure of Sessions:</td>
<td></td>
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</tbody>
</table>

Annual Review Date: ____________________________________________

Signed: ____________________________ Supervisee

Signed: ____________________________ Supervisor

Signed: ____________________________ Line Manager

Date: ____________________________
Appendix 3

Example Supervision Record

Supervisee/Band: ____________________________  
Ward/Dept: ____________

Supervisor/Band: ____________________________  
Date: ____________

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Discussion notes</th>
<th>Action points – by whom/when</th>
</tr>
</thead>
</table>

Date of next meeting: ______________

Supervisee sign: ________________  
Supervisor sign: ___________________
Appendix 4

Example Clinical Supervision agenda

Band 3 - Health Care Assistant

1. Supervisees issues

2. Review actions agreed at last meeting and explore current issues in practice

3. NHS KSF Core dimensions (see post outline for appropriate ‘level’ required for this post)
   - Communication
   - Personal & people development
   - Health, safety & security
   - Service improvement
   - Quality
   - Equality and diversity

4. Mandatory training/other training

5. Supervisory responsibilities

6. Practice
   - Role
   - Attitude
   - Quality of engagement with service users
   - Record keeping (including reporting of incidents)
   - Working with others
   - Safeguarding

7. Date next meeting
Appendix 5

Example Clinical Supervision Agenda

Band 5 - Staff nurse

1. Supervisees issues

2. Review actions agreed at last meeting and explore current issues in practice

3. NHS KSF Core dimensions (see post outline for appropriate ‘level’ required for this post)
   - Communication
   - Personal & people development
   - Health, safety & security
   - Service improvement
   - Quality
   - Equality and diversity

4. Mandatory training/other training

5. Supervisory/preceptor/mentor responsibilities

6. Practice
   - Role – Primary/associate nurse, care co-ordinator
   - Attitude
   - Shift co-ordination
   - Quality of engagement with service users
   - Record keeping (including incident reporting)
   - Working with others
   - Case load
   - Assessment/care plans/interventions/evaluation
   - 1:1 weekly meetings with patient
   - CTM/CPA attendance
   - Safeguarding

7. Date next meeting
Appendix 6
Example Clinical Supervision Agenda

Band 6 - Team leader

1. Supervisees issues

2. Review actions agreed at last meeting and explore current issues in practice

3. NHS KSF Core dimensions (see post outline for appropriate ‘level’ required for this post)
   - Communication
   - Personal & people development
   - Health, safety & security
   - Service improvement
   - Quality
   - Equality and diversity

4. Mandatory training/other training

5. Supervisory/preceptor/mentor responsibilities

6. Practice – assure own and the practice of others:
   - Role (Including Primary/associate nurse, care co-ordinator)
   - Attitude
   - Quality of engagement with service users
   - Record keeping (including incident reporting)
   - Working with others
   - Case load
   - Assessment/care plans/interventions/evaluation
   - 1:1 weekly meetings with patient
   - CTM/CPA attendance
   - Safeguarding

7. Leadership/management:
   - Visible facilitation, support & guidance
   - Assure practice standards and systems are understood and met
   - Assure clinical systems (e.g. primary nursing, CPA, record keeping, reporting, security, supervision, mandatory training) are maintained.

8. Date next meeting
Appendix 7

Example Clinical Supervision Agenda

Band 7 - Clinical nurse manager

1. Supervisees issues

2. Review actions agreed at last meeting and explore current issues in practice

3. NHS KSF Core dimensions (see post outline for appropriate ‘level’ required for this post)
   - Communication
   - Personal & people development
   - Health, safety & security
   - Service improvement
   - Quality
   - Equality and diversity

4. Mandatory training/other training

5. Supervisory/preceptor/mentor responsibilities

6. Practice- ensure standards
   - Role – (including care co-ordinator)
   - Attitude
   - Quality of engagement with service users
   - Record keeping (including incident reporting)
   - Working with others
   - Case load
   - Assessment/care plans/interventions/evaluation
   - 1:1 weekly meetings with patient
   - CTM/CPA attendance
   - Safeguarding

7. Leadership/ward management
   - Facilitation and support
   - Visibility
   - Ensure practice standards are understood and met
   - Ensure clinical systems (e.g. primary nursing, CPA, record keeping, reporting, security, supervision, mandatory training) are maintained.

8. Date next meeting
Appendix 8
Staff Supervision Register

Team/Ward/Department______________________________
Month_________________________________________

<table>
<thead>
<tr>
<th>Name/band</th>
<th>Supervisee sign</th>
<th>Supervisor sign</th>
<th>Date*</th>
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<tbody>
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</table>
**Note**

*Record the date on which supervision took place*

WM/CNM/Senior nurse signature_____________________________________________________

Date sent to senior/consultant nurse____________________________________________
Appendix 9

West London Mental Health Safeguarding Children Supervision

Safeguarding Children Supervisors for the WLMHT Safeguarding Children Team must be experienced Safeguarding Children Professionals with a Safeguarding Children qualification and have attended Safeguarding Children/ Child Protection Supervision training.

Supervisors who deliver Clinical Supervision to WLMHT staff must have attended Trust Safeguarding Children Supervision Training.

<table>
<thead>
<tr>
<th>Supervisee</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>WLMHT Named Nurse</td>
<td>Designated &amp; Named Nurse Supervision Group.</td>
</tr>
<tr>
<td>WLMHT Named &amp; Lead Doctors</td>
<td>Designated &amp; Named Doctors Supervision Group.</td>
</tr>
<tr>
<td>WLMHT Safeguarding Children Lead Professionals</td>
<td>WLMHT Named Nurse or Safeguarding Children Training &amp; Development Officer.</td>
</tr>
<tr>
<td>All other WLMHT clinical staff</td>
<td>Safeguarding Children Supervision is to be incorporated into all Trust Clinical Supervision as per Safeguarding Children Supervision Addendum.</td>
</tr>
</tbody>
</table>

Safeguarding Children Supervision Principles

West London Mental Health Trust should ensure that there are structures in place for supervision which explicitly incorporate safeguarding children and child protection issues.
The purpose of including safeguarding children into clinical supervision agendas is to strengthen the safeguarding and protection of children within WLMHT. This is a means of promoting excellence in safeguarding children practice, by supporting staff to practice with confidence.

Safeguarding children supervision will provide a mechanism of support and guidance to all staff that have contact with parents/carers, children including unborn babies, and patients who may pose a risk to children.

This document provides guidance and a framework on acceptable standards for safeguarding children supervision within West London Mental Health Trust.

Supervisors and supervisees should know who the safeguarding children leads and/or named professionals are and how to contact them. Named and/or lead professionals are a valuable source of advice and support when safeguarding concerns arise.

Supervisors and supervisees must know the systems that are in place to refer and/or escalate child protection concerns when they are identified.

The impact of adult mental ill-health on children, including risk, should always be considered during safeguarding children supervision.

Similarly, when the child is the patient, the risk to the child as well as to other children must be explored. These issues should be routinely enquired about and addressed in supervision/case discussion and form part of the holistic approach to all patient care (adults and children).

Supervision discussion and any agreed outcome plans on specific cases must be documented in case notes and integrated into the appropriate RIO pathways. Documentation should be contemporaneous and should be as agreed between supervisee and supervisor. The team must be informed of the plan at the earliest opportunity if the decision was not made at the team meeting.

Supervisors must be up to date with current safeguarding children legislation, policy and practice. They must have attended and be up to date with Trust safeguarding children mandatory training, including safeguarding children supervision training.

Supervisors should fully understand their roles, responsibilities and the scope of their professional discretion and authority.

Risks associated with peer supervision are recognised and can include collusion, avoidance, delay and lack of professional challenge: it is important that supervisors and supervisees are aware that such issues may arise during practice and within supervision itself.

Personal issues and values may impact on safeguarding children practice. Supervision should provide an opportunity for frank discussion when these issues are identified, allowing for reflection and professional challenge with a view to an outcome of safer practice and improved outcomes for the children and their families.

If unsafe practice is identified by the supervisor but is not acknowledged and addressed by the supervisee, appropriate action must be taken. Issues of unresolved unsafe practice should be explicitly discussed with the supervisee, if appropriate to do so, before taking outside the supervisory relationship. Any issue that is seen to compromise safe practice or is of significant concern should be progressed through the relevant channels, such as the relevant line manager or Executive lead. In certain situations, e.g., concerns that a staff
member may pose a risk to children, such concerns should not ordinarily be discussed with the supervisee but advice sought as a first step. (Detailed guidance on what to do if an allegation is made against a member of staff is given in appendix 8 of the Safeguarding Children Policy C18).

**Safeguarding children concerns in pregnancy**

The impact of the patients mental ill health on the unborn and concerns about the patients capacity to safely and adequately parent when the baby is born needs to be explored. An action plan should be agreed including a decision as to whether children's social care should be informed so that a pre birth planning meeting can be convened.

**General questions for inclusion in all supervision**

**Where the patient is an adult.**

1. Is the patient a parent or carer or living with or in contact with children?
2. What are the possible implications, concerns and impact of the adult's mental ill-health or behaviour on the child?
3. Are there any risks to the children or needs identified?
4. What actions have you taken or do you need to take?

If risks or concerns are identified then an action plan needs to be agreed, implemented and escalated, when required. This should be recorded and signed by both the supervisor and supervisee in the clinical case records as a change to the care plan and, if relevant, as a change to the risk management plan. The team must be informed of the plan at the earliest opportunity if the decision was not made at the team meeting.

When decisions are made not to take action or not to share information, the issues and risk factors should have been fully explored by the supervisor and supervisee. The decision must be based on a full and thorough discussion and analysis of the case, with the best interests of the child always being at the forefront of the process. The reasons must be fully documented.

If a child is considered to be suffering or at risk of suffering significant harm then a referral to children’s social care (and in some instances the police) must be done immediately.

**Where the patient is a child.**

1. Do you have any safeguarding concerns about the child (or other children in the household/wider family network).
2. Does the child pose a risk to other children?
3. Does the child’s specific circumstance lead to increased concerns about vulnerability, e.g., parental mental ill health, parental substance misuse, domestic violence, private fostering, unaccompanied minors, young offenders, children in gangs?
4. What actions have you taken and what actions need to be taken to improve the outcome for the child?
If risks or concerns are identified then an action plan needs to be agreed, implemented and escalated, when required. This should be recorded and signed by both the supervisor and supervisee in the clinical case records as a change to the care plan and, if relevant, as a change to the risk management plan. The team must be informed of the plan at the earliest opportunity if the decision was not made at the team meeting.

When decisions are made not to take action or not to share information, the issues and risk factors must have been fully explored by the supervisor and supervisee. The decision should be based on a full and thorough discussion and analysis of the case, with the best interests of the child always being at the forefront of the process. The reasons must be fully documented.

If a child is considered to be suffering or at risk of suffering significant harm then a referral to children’s social care (and in some instances the police) must be done immediately.