

Clinical Supervision and Peer Review Policy

Document Summary

Clinical supervision is essential in achieving and sustaining high quality practice which improves patient experience, safety and outcomes. Cumbria Partnership NHS Foundation Trust is committed to ensuring all clinical staff have access to and receive clinical supervision.

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Important Note:

The Intranet version of this document is the only version that is maintained.

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1 SCOPE

Cumbria Partnership, NHS Foundation Trust recognises the importance of clinical supervision in contributing to the development of practitioners and improving the patient experience, safety and outcomes.

This policy applies to all clinical staff working within Cumbria Partnership Trust including those staff employed by the county council who work within integrated teams. It requires all employees in the organisation to be supervised to a common set of principles and structures compliant with their own professional practice and background.

2 INTRODUCTION

Clinical supervision is essential in achieving and sustaining high quality practice which is safe and effective and improves the patient's experience. The Trust believes clinical supervision should be available to all clinical staff from all professional backgrounds, registered and non-registered.

Clinical Supervision is a practice focused, professional relationship involving a clinician reflecting on practice guided by a skilled supervisor. The supervisor is not routinely expected to be the practitioner's line manager but can be another professional who has specialist theoretical/practice knowledge of a particular treatment or intervention model. Therefore no single model of clinical supervision can be adopted across the trust; each clinical team/service will be responsible for the implementation of clinical supervision models that support their clinical practice. However there are key elements that research tells us are likely to be present in all effective supervision which will be outlined in the policy.

Clinical Supervisors must have the appropriate qualifications, skills and experience to ensure that clinical supervision is a meaningful process, one that promotes effective clinical practice and reflects appropriate accountability arrangements, facilitates the clinicians learning and development and evaluates how this learning is transferred into practice. All clinicians will receive the type of clinical supervision appropriate to their clinical area and where appropriate in accordance with requirements from relevant professional/regulatory body (e.g. Health Professionals Council; British Psychological Society; The Chartered Society of Physiotherapy, NMC, GMC)

Clinical supervision should be provided by the most appropriate person, as determined by a combination of the line manager, clinical lead (if applicable), and professional lead (where the supervisee is employed within a different discipline to the operational manager).

The supervisor may be a clinician from the same discipline, a clinician from a different discipline, an appropriate peer, or the professional or operational manager her/himself (provided they meet the criteria for the clinical supervisors). If the Clinical Supervisor role is to be fulfilled by the Operational Manager then there needs to be a

clear demarcation between Line Management Supervision and Clinical Supervision and these should be recorded and documented accordingly. Where the supervisee is employed in a different discipline to the Operational Manager, the Professional Lead will determine if professional supervision additional to the clinical supervision is required. This may be the case where the practitioner is working in a different/extended role.

Operational Line Managers remain responsible for providing managerial supervision regardless of professional background.

At all points in time, the Operational Line Manager needs to have a record of the current clinical supervision arrangements for each member of their staff. This may be quite simple for the majority of staff; however more complex cases can occur when staff are receiving clinical supervision from a variety of sources.

The supervisee and Operational Line Manager may be the only people with an overview of the varying clinical supervision inputs. In this case of both individuals are responsible for ensuring that all clinical work is covered by appropriate supervision and that a system is in place to address potential conflicts in supervisory advice received. It is best practice when there are multiple clinical supervisors to identify a Lead Clinical Supervisor.

If the staff member is receiving conflicting clinical advice from their various clinical supervisors, this needs to be discussed and recorded in Management Supervision so that a safe, suitable plan can be developed.

3 STATEMENT OF INTENT

This policy has been formulated to ensure trust staff has a clear understanding of their own and the Trust's responsibility in relation to Clinical Supervision and Peer Review.

This policy provides a framework for practice for all clinical professions within the Trust, including local authority staff in integrated teams, to operate alongside local policies that may vary between professions and specialisms.

Clinical supervision should be in accordance with the standards and guidance produced by appropriate recognised clinical professional bodies such as the Nursing & Midwifery Council (NMC), British Psychological Society (BPS) and other Allied Health Professionals and psychological professions, and meets the CQC requirements within Outcomes 12, 13 and 14.

Specific guidelines stipulated by the Royal College of Psychiatrists (RCP) and the Postgraduate Institute (Northern Deanery) for supervision of trainee doctors are set out in Appendix 8, 9, 10 and 11.

Specific guidelines stipulated by the BPS can be found at www.bps.org.uk.

Specific guidelines stipulated by the NMC can be found at www.nmc-uk.org

4 DEFINITIONS

A recent review defined clinical supervision as specifically

“...the formal provision, by senior/qualified health practitioners, of an intensive, relationship-based education and training that is case/work focused and which supports, directs and guides the work of junior colleagues (supervisees)”... (Milne, 2007: systematic review).

Peer Review is defined as:

Evaluation of the work and performance of a member of staff by a person working in the same field or profession as an opportunity to maintain and enhance good quality of that work and performance.

Review must be provided by a person at least of equal standing and experience, but can be somebody of the same or in a senior position.

Through the development of competence (including appropriate values, relevant knowledge and high quality care) clinical supervision aims to facilitate the delivery of consistently high standards of care enabling the practitioner to reflect on practice, clarify goals, identify appropriate clinical interventions and to accept appropriate individual responsibilities (i.e. duties of post; tasks agreed with supervisors) and the related personal accountability (e.g. by setting and monitoring acceptable standards of practice: Clinical Governance: DOH, 1998).

Clinical supervision brings together practitioners and skilled supervisors, which enables the monitoring and development of practice, providing feedback and support to supervisees. Therefore the supervisor can be seen as a skilled helper, leader, challenger and facilitator. Participating actively in supervision is a clear indication that an individual is exercising his/her clinical governance responsibilities. In turn, supervisors and the organisation have their respective responsibilities (e.g. implementing appraisal systems and supervisor training).

Clinical Supervision should follow a structured and orderly approach and address the three following functions which need to be balanced;

- Time to encourage reflection on practice; feedback, to develop clinical skills; to share and utilise knowledge (Formative).
- Time to discuss clinical difficulties; to express feelings; to provide a supportive structure that is seen as distinct from managerial input. However it is not personal therapy (Restorative).
- Time to ensure high standards of clinical care are met through: expressing, exploring and accepting constructive criticism; providing support in relation to the demands of the job; addressing managerial, service and quality issues, such as monitoring practice, quality of care issues and safeguarding issues (Normative).

Regardless of the model or terminology used to describe the functions of supervision it is important to make clear that the overall purpose of all clinical supervision is to improve patient experience and to provide safe care through promoting the supervisees clinical effectiveness. In pursuit of this purpose, the aims of clinical supervision are:

- To ensure the supervisees fitness for practice (competence).
- To safeguard professional standards (fitness for profession).
- To develop professional expertise (fitness for purpose if qualifies; fitness for award if training).
- To promote high quality care.
- To enable the supervisee to reflect on his/her practice.

5 DUTIES

5.1 The Director of Operations and Executive Nurse

Is the responsible director for overall implementation of this policy.

5.2 The Medical Director

Is responsible for ensuring that a structure exists to ensure all Medical Staff are in receipt of regular clinical supervision and other support in accordance with relevant college and GMC guidelines.

5.3 Clinical Leads and Pathways Leads

Are responsible for working with operational services (Networks and Localities) to ensure an appropriate structure exists for clinical supervision supporting the work of the pathway/locality.

5.4 Professional Heads/Leads

Are responsible for working with operational services to ensure that professional standards are maintained for the professions for which they are responsible: clinical supervision arrangements are one aspect of this. They will determine the appropriate level and provision of clinical and professional supervision for individual staff. In many cases the line manager and the professional lead/head/manager for an individual will be the same person.

5.5 Locality Managers and Clinical Directors

Are responsible for ensuring that all clinical members of their team(s) including themselves have regular clinical supervision. They must determine the most appropriate method(s) of ensuring that all clinical staff receive regular supervision as

individuals, and follow up if it becomes apparent that supervision is not occurring in the prescribed manner.

5.6 Operational Line Managers

Are responsible for enabling the accessibility of clinical supervisors and jointly responsible with the individual staff members to ensure that reviewing that all appropriate staff are having supervision. If it becomes apparent that supervision is not occurring, the line manager will follow up with the supervisor and supervisee to ensure that it recommences, or that any issues are resolved (see Section 6.8).

Line managers will maintain a log of supervision uptake within their teams for audit purposes. It is the responsibility of the Line Manager to follow up if it becomes apparent that supervision is not occurring in the prescribed manner.

5.7 Supervisors and Supervisees

The supervisor and supervisee have joint responsibility for scheduling supervision. The supervisor and supervisee have multiple responsibilities as outlined in Table 1. It is recognised that the extent of the responsibility held by the supervisor, and the closeness of the monitoring of practice required, will vary with the status of the supervisee. At one end of the spectrum, the supervisor of an unqualified trainee will hold clinical responsibility for all the supervisee's clinical work and will need to monitor their work closely. At the other end of the spectrum, the supervisor of an experienced consultant clinician will not allocate work, and will only be responsible for checking that standards of practice are met across a sample of the supervisee's work and for giving appropriate advice in relation to cases discussed.

Table 1 - Supervisor and Supervisee Responsibilities

The Supervisor should	The Supervisee should
Be professional (e.g. ethical, respectful and acting with integrity)	Be honest and constructive
Take the lead, providing appropriate and effective supervision	Undertake relevant training
Offer normative, restorative and formative guidance competently	Prepare for the session
Ensure that they operate within their sphere of competence	Operate within own sphere of competence
Undertake relevant supervision training	
Ensure that the supervisee is working within her/his competence	Contribute to the agenda
Ensure maintenance of supervision standards e.g. via reflective practice with other supervisors	

Monitor the quality of the supervisee's work, as appropriate to the supervisee's status (e.g. trainees will normally require very close monitoring)	Accept support
Avoid personal or dual relationships that might compromise objectivity and effectiveness	Voluntarily accept the supervisors right to control and direct your work where appropriate
Communicate effectively (e.g. being open about their training and experience as a supervisor)	
Raise any concerns in a timely way with the supervisee (and if necessary, with their line manager)	Accept constructive criticism
For trainees and unregistered staff accept overall clinical responsibility <i>for work that is allocated to the supervisee</i> (due to duty of care; vicarious liability)	Be reflective
Be trusting and acknowledging, seeking feedback on their supervisory practice	Accept praise
Be able to challenge, and to be challenged.	Be committed to the process
Provide clarification	Notify their line manager that clinical supervision is/is not taking place
Act as a role model	

6 DETAILS OF POLICY

6.1 Framework for Clinical Supervision

The process of supervision is negotiable and will address essential ground rules (e.g. confidentiality; record-keeping). It may be provided on an individual or group basis dependent upon the service and individual needs.

If supervision is being delivered on a group basis there need to be a clearly identified lead supervisor within the group who retains overall responsibility for the delivery of supervision. A similar arrangement should apply for peer review and what is commonly referred to as peer supervision. Whilst there is nothing inherently wrong with being supervised by a peer (and there may be times when it is appropriate) there needs to be clarity around who is receiving supervision from whom at any individual point and who retains responsibility. Group supervision may include team supervision to mixed professionals working within the same service, or professional supervision with staff of the same professional backgrounds from different teams/services.

There are a number of ways of approaching supervision, referred to as 'methods' or 'models'. The purpose of a model of supervision is to provide a framework for practice, one which clarifies the purpose and characteristics of supervision for both parties. Models can vary quite widely in their perspective but all include an educational emphasis and adopt a developmental perspective (i.e. that supervisees will change as they gain experience, proceeding through different stages towards expertise. Whichever model is adopted by the supervisor it is important that it is applied properly (i.e. with adherence to the selected approach). Also *all* sessions should use a structure which includes:

- An agenda agreed at the outset.
- Feedback from previous sessions if appropriate (e.g. progress with action points).
- Attention to the normative, formative and restorative functions.
- Discussion of recent clinical work.
- Consideration of the various options for addressing clinical challenges.
- Summary of the session, noting any further actions and including mutual feedback, which is recorded.
- Arrangements for future meetings.

Arrangements will also be made to apply this process to a random sample of the supervisees clinical cases: it needs to be agreed at the supervision contract planning stage, together with operational managers, whether this will occur at each supervision session, or at a different frequency or via a different explicitly identified process.

For group supervision or group peer review, the occurrence of supervision should be recorded and notes should be kept to the same standard as for individual supervision, identifying all those present, the lead clinician and reflecting accurately the contribution of each member to the session. All participants should have a copy of the supervision records. Where group supervision is provided the supervisor has responsibility for ensuring that all supervisees actively engage in the process, alerting managers where this is not the case.

Clinical supervision within each of the clinical professions should be carried out in accordance with this policy and within the standards and guidance published by the relevant professional bodies.

6.2 Contracts

A contract should be negotiated, agreed, signed and dated by both parties at the start of any supervisory relationship in order to protect both parties. For example, it is vital that the extent and limits of confidentiality are clarified and agreed, and an understanding reached about what does and does not fall within the scope of clinical supervision. Also, the frequency and length of meetings, record keeping and other practical details should also be included. This contract should be agreed for a fixed period and subject to review. (See Appendix 1 for a sample contract).

As referred to earlier, if someone receives clinical supervision from more than one source, it is essential that they contract for each supervisory relationship and that

each supervisor (as well as the Line Manager) is kept aware of the various supervisory arrangements.

6.3 Frequency and Duration

Supervision will occur a minimum of four times a year but in many pathways or service, the recommended frequency will be significantly higher (commonly these stipulate monthly). Specific requirements will be detailed in pathway or service-specific documents such as Operational Policies.

For staff in a part-time clinical role, supervision sessions should be arranged on a pro rata basis reflecting the hours worked and the supervision needs of the supervisee. The frequency of supervision should be recorded in the supervision contract.

Clinical supervision should take place in a comfortable environment that provides privacy, confidentiality and promotes best use of time, and is acceptable to all participants. It may be conducted face to face, by phone, or by video conferencing.

It is acknowledge that much informal case discussion takes place during the working day and this complements formal supervision and so the formal supervision contract should recognise this activity.

In addition to planned and/or contracted clinical supervision, supervision can take place:

- Simultaneously with practice, e.g. in service user areas or co-counselling, (Live Supervision).
- Informal after practice, e.g. debriefing, (Immediate Supervision).
- After a period of time where past events are explored, (Delayed Supervision).
- In anticipation of events, (Proactive Supervision).

In practice, this may mean that clinical advice and supervision can be given by a member of staff, (e.g. the nurse in charge of the ward/Lead Care Manager) who is not the formal supervisor. It is the responsibility of all staff giving supervision, clinical advice, and “debriefing” opportunities to do so only within their sphere of competence, to declare relevant information to the identified supervisor, and for the supervisee to document any such significant activity by the use of a clinical diary/reflective journal which can be shared in clinical supervision sessions.

6.4 Confidentiality

The content of clinical supervision sessions should be regarded as confidential. The exceptions would be

- if one or other party felt that there was an issue that invoked a professional responsibility, to report information to an appropriate person and was able to justify this. This should be made clear in supervision contracts. Any disclosures should ideally be communicated to the other party in advance.
- for supervisors to maintain and develop their clinical supervision standards, they may periodically need to reflect on their supervision practice with a senior

colleague: this will be made explicit in contracts where supervisors who routinely do this, or agreed in advance and recorded in supervision notes where done on an infrequent basis. Some services visually record supervision in order that the supervisor can receive supervision of their supervision.

6.5 Documentation

Accurate notes will be taken during the session by either party. These will be agreed, signed as a correct record by both parties and kept securely. More detailed documentation may be necessary in different professional groups. No patient identifiable information should be recorded in supervision notes; initials only should be used when it is necessary to record a discussion or action points relating to any specific individual.

It should be noted that documentation might be requested for legal purposes. Whilst confidentiality is assured, written information, may ultimately be accessed by service users and legal representatives, this should be borne in mind. All documentation should fall within the professional standards stipulated by the profession e.g. NMC, BPS and General Medical Council (GMC).

In addition to the supervision notes described above, a note should also be made in the records of each Service User when their care has been discussed in supervision. This should include the date the supervision took place, the identity of the supervisor, the issues discussed and the outcomes that are relevant to the care of the service user.

After each supervision episode, supervisees will inform their line manager that supervision has occurred. Line Managers will record incidence of clinical supervision (example in Appendix 3).

6.6 Retention of Supervision Notes

Comprehensive records of clinical supervision are essential to support continuity of service user care and ensure evidence based clinical practice. Originals and copies of supervision notes should be kept for a minimum of three years in secure storage to be arranged locally. In exceptional circumstances clinical supervision records can be subpoenaed by a court of law. Both parties should be cognisant of this when storing and retaining clinical supervision records.

In the event of a supervisee changing supervisors then the supervisee and the supervisor will agree what supervision records will be passed to the incoming supervisor and ideally a tripartite hand-over of supervision will take place.

6.7 Third Parties

An appropriate third party may be called into supervision for the following reasons:

- Expertise in a particular area
- Arbitration in the case of difficulties within the supervisory relationship.

The person identified as third party should be acceptable to both supervisor and supervisee. If a third party is to be brought in, notice and agreement must be reached between both supervisor and supervisee.

6.8 Difficulties

If a clinical supervisory relationship is viewed by either party as unproductive, then it is important to attempt to address these difficulties within supervision.

If there were no resolution the use of a third party would be the usual next step to take, (see 6.7 Third Parties). However whilst there is an obligation to receive clinical supervision, it is important that no one becomes locked into a destructive or unproductive relationship without any means of escape. Therefore either the supervisee or supervisor should be able to call an end to the relationship at any time and rearrange this relationship. If this were to occur this should be discussed within Management Supervision, issues addressed and replacement supervision arrangements agreed.

In the event of conflicting supervisory advice being received from multiple supervisors, this can be addressed via discussion with the Line Manager.

If clinical staff refuse to participate in clinical supervision then the line manager, with advice from the professional lead should determine the appropriate action to be taken to resolve the issue.

7 TRAINING

The Trust offers supervision training to equip supervisors and supervisees with the skills necessary to make full and effective use of clinical professional supervision.

For information on training see the Learning Directory and the Training Needs Analysis (TNA). Attendance at training will be managed in accordance with the Learning and Development Policy.

8 MONITORING COMPLIANCE WITH THIS POLICY

The table below outlines the Trusts' monitoring arrangements for this policy/document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
The Management of clinical supervision is in accordance with this policy, to include: <ul style="list-style-type: none"> duties process for checking that all clinical staff receive appropriate supervision 	Audit of 50 records of staff attending clinical supervision held by managers	Head of Learning Network	Annually	Governance, Quality & Risk Committee	Locality Governance facilitators
Supervision contracts are in evidence	Audit of 50 records of staff attending clinical supervision	Deputy Director of Operations	Annually	Governance, Quality & Risk Committee	Locality Governance facilitators
Supervisors have attended Supervision Training	Training will be monitored in line with the Learning and Development Policy.				

9 REFERENCES/ BIBLIOGRAPHY

The NHS Next Stage Review (Department of Health 2008)
CNO Review of Mental Health Nursing (Department of Health 2006)
NMC Code of Conduct 2008
Core Strategy Tools to assist with action learning and clinical supervision can be accessed on the following link
http://www.mindtools.com/pages/main/newMN_STR.htm

10 RELATED TRUST POLICY/PROCEDURES

Learning and Development Policy

Management Supervision Policy

Preceptorship Policy

11 APPENDIX 1 - SAMPLE CLINICAL SUPERVISION CONTRACT

CLINICAL SUPERVISION CONTRACT

Supervisor:	Supervisee:
Date:	Unit:
Job Title:	Grade:
Frequency of sessions (this must be 4 times per year as a minimum but refer to service or pathway documents for specific guidance)	Duration of sessions:
Model and/or purpose of supervision:	
Arrangements for random sampling of clinical work:	
Person to contact if supervision arrangements aren't working:	

As a Supervisor, I take responsibility for –

- a) Collaborating closely with the supervisee to establish the 'facilitative conditions' for a learning alliance; take account of the work context (e.g. team/service arrangements) to ensure a good 'fit';
- b) Providing support: Being trustworthy and responsive to the supervisee's learning needs. The acid test of this 'safe base' is that the supervisee will feel valued, respected and safe;
- c) Creating a clear and consistent structure and show appropriate interest in supervision, and the supervisee will also contribute to this alliance;
- d) Modelling: using every opportunity to demonstrate the skills and respectful relationships that are expected of professionals;
- e) Facilitating reflection in supervisees through questioning and other developmentally appropriate methods, so as to facilitate learning;
- f) Being sensitive to the spoken and unspoken anxieties that will naturally occur, and matching my supervision to the supervisee's stage of development;

- g) Giving feedback: Providing constructive, regular and open feedback (i.e positive and negative comments, made sensitively) which will maximises the alliance and its effective contribution to the supervisee's development and clinical effectiveness.
- h) Taking account of the learning contract and selecting methods that I feel comfortable with, and which help you to work in the supervisee's 'zone'
- i) Varying my use of supervision methods in order to provide variety and stimulation with promote motivation to learn.

As a Supervisee, I take responsibility for –

- Using supervision to enhance my knowledge and further develop the skills that I use within my current role
- Identifying problems with which I need help and using the time available to deal with them.
- Identifying and communicating the type of response, which is useful to me.
- Becoming aware of my own role and scope and its implications to myself and the organisation and profession for which I work.
- Informing my line manager of my supervision arrangements, when sessions have occurred and annually in my appraisal.

Supervisor and Supervisee. We shall take shared responsibility for –

- Arranging when, where and how long each supervision session will be.
- The frequency of supervision sessions.
- The limits to and maintenance of confidentiality, including record keeping arrangements.
- Reviewing regularly, at agreed and predetermined intervals, the usefulness of supervision.
- Agreeing the boundaries of the clinical supervision process.
- Cancellation – acceptable reasons and arrangements.

Signed (Supervisor) Date

Signed (Supervisee) Date

12 APPENDIX 2 - SAMPLE CLINICAL SUPERVISION RECORD

Supervisor

Supervisee

Date

Date of next meeting

Topic Discussed – Patient Identifier where relevant	Decision and actions	Actions By	When

Confirmed as an accurate record and agreed actions:

Supervisor Signature:.....

Supervisee Signature:.....

