# CLINICAL SUPERVISION POLICY
A STATEMENT OF GOOD PRACTICE

## Version: 3

### Summary:
Clinical supervision is part of the clinical governance agenda, supporting safe, high quality patient care; promoting professional development, and fostering an open culture of learning from positive and negative events and replicating best practice.

### Keywords (minimum of 5): (To assist policy search engine)
- Patient Quality & Safety
- Continuous Improvement of clinical practice

### Target Audience:
All clinical staff registered and non registered.

### Next Review Date:
July 2018

### Approved and Ratified by:
Quality Improvement and Development Forum  
**Date of meeting:** 10 November 2014

### Date issued:
September 2016

### Author:
Paula Hull, Deputy Director of Nursing & AHP  
Lindsey Hilton, Integrated Services Matron

### Sponsor:
Julie Dawes, Director of Nursing, Allied Health Professionals and Quality
# Version Control

## Change Record

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<td>28.09.14</td>
<td>Lindsey Hilton</td>
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<td>20.9.16</td>
<td>Paula Hull</td>
<td>3</td>
<td>1,4,5,6, 7,8,9,11, 23</td>
<td>Policy reviewed and amended following CQC action</td>
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## Reviewers/contributors

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<th>Name</th>
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<td>Sarah Baines</td>
<td>Deputy Director of Nursing MH/LD</td>
<td>Draft 1 April 2011</td>
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<td>Jude Diggins</td>
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<td>Lindsey Hilton</td>
<td>Integrated services Matron</td>
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Clinical Supervision Policy
Author: Paula Hull, Deputy Director of Nursing & AHP
Version: 3
September 2016
Clinical Supervision Policy: A statement of good practice

1. Introduction

1.1 Southern Health NHS Foundation Trust is made up of a range of diverse services which are committed to providing high quality patient centred care in all areas that we serve. This is achieved through the efficient and effective use of resources to provide a comprehensive range of services.

1.2 Staff are our most important resource and therefore the facilitation of highly competent, patient focused, experienced and resourceful staff is a key requirement of achieving a high quality service.

1.3 Clinical supervision is not a new concept and has been recommended as highly important within ongoing NHS policy in documents such as the NHS plan and Darzi next stage review (2008) and the CQC report “supporting effective clinical supervision” (2013).

1.4 Equity & Excellence white paper (DOH 2010) promotes patient choice “no decision about me without me” and clearly aims for all NHS staff to be world class. The well being of staff and their ability to perform at a high level of expertise is crucial to this.

1.5 Clinical supervision is part of the clinical governance agenda, supporting safe, high quality patient care; promoting professional development, and fostering an open culture of learning from positive and negative events and replicating best practice.

Clinical supervision in the workplace is a way of using reflective practice and experiences as part of continuing professional development, and improving care for patients

2. Aims

The primary aim of clinical supervision is to facilitate and develop staff in order to ensure the service user/patient has high quality care. In addition it:

- Contributes to improved clinical practice
- Enables clinicians to become more self aware, self-assured, assertive and confident
- Provides guidance for individual development and skills progression
- Broadens thinking through problem solving
- Provides the opportunity for clinicians to feel supported and motivated
- Improves professional development processes
- Can oversee the wellbeing and safety of the public, patients, staff and service users

3. Scope

3.1 This policy has been developed for all staff working within SHFT who care for our service users. This includes registered professionals, as well as associate practitioners and health care support workers in health care assistant, technician and assistant practitioner roles.

3.2 This policy is a framework for clinical supervision that can be used locally to develop models and systems suited to local need.
4. Definitions

4.1 Clinical supervision is a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care (DOH 1993)

4.2 Clinical supervision is a designated interaction between two or more practitioners within a safe environment that enables a continuum of reflective critical analysis of care, to ensure quality patient services, and the well being of the practitioner. Bishop & Sweeney, 2006 cited in Bishop V (2007)

4.3 Clinical supervision is a formal process of professional support and learning that enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance patient protection and safety of care in a wide variety of situations. (A dictionary of Nursing 2008)

5. Duties / Responsibilities

Directors are responsible for ensuring that:
- An annual audit is undertaken and reported to ascertain the robustness and adequacy of the clinical supervision systems and structures.
- Staff are in receipt of regular clinical supervision which meets the needs of the area and its staff.

Medical Director is responsible for ensuring
- A structure exists to ensure all medical staff are in receipt of regular clinical supervision and other support in accordance with General Medical Council and Royal College of Psychiatrists guidelines.
- Annual audit reports are produced

Line managers/team leaders/ward managers are responsible for:
- Ensuring that all members of their team(s) including themselves, have regular clinical supervision
- Determining the most appropriate method(s) of ensuring that all clinical staff have regular supervision i.e. individual, group/team or peer supervision
- Clarifying and agreeing their own role and responsibility within clinical supervision
- Making the time available for clinical supervision
- Ensuring the privacy of the environment in which the supervision will take place
- Reviewing the arrangements for clinical supervision on a regular basis
- Ensuring that all staff are appropriately trained to participate and benefit from clinical supervision
- Ensuring that the job descriptions of all clinicians include a statement regarding the responsibilities of the individual in respect of clinical supervision
- Collecting data re improvements, staff/service user feedback and actions taken as a result of clinical supervision within their teams

Clinicians/practitioners are responsible for:
- Ensuring that they participate in clinical supervision at least 3 monthly. This supervision may be in a group or on a one to one basis and should last approximately one hour
- Setting appropriate, agreed ground rules within the session and agreeing limits of confidentiality
• Making time available for clinical supervision and ensuring that the time set aside is used effectively
• Ensuring that they have the necessary skills and competencies to provide effective clinical supervision
• Developing a supervision contract collaboratively with the supervisee
• Informing their line manager if they are not receiving regular, effective clinical supervision
• Keeping accurate records of the supervision session with appropriate action points
• Taking responsibility for ensuring that all actions identified within supervision are carried out within the agreed time frame. **Taking an active role in their own personal and professional development**

6. **Safeguarding Adult Supervision**

Safeguarding Adult Supervision is provided within the Trust to support the clinical teams.

It is recognised that staff at times may require more specialist advice and knowledge in relation to the Safeguarding Adults agenda. In these cases the Corporate Safeguarding Adults Team can provide this function.

There are no regular Safeguarding Adult supervision sessions in place, however, responsive (bespoke) supervision is available. This is on a case by case basis. Responsive supervision can be accessed by contacting the Corporate Safeguarding Team directly. Please see Trust Safeguarding for details.

7. **Main policy content**

7.1 **The benefits of Clinical Supervision**

**What it is**

• A confidential, safe and supportive environment, to critically reflect on clinical practice. A forum for improving the quality of patient care and individual clinical practice through self-reflection and enhanced self-awareness
• An opportunity to explore developmental needs and to learn and develop new skills
• An opportunity to learn from negative and positive events in order to replicate best practice
• An opportunity to express feelings, consider new perspectives and identify solutions
• A forum for professional groups to feel supported to minimise professional isolation
• An environment that supports the safe high quality delivery of patient centred care

**What it isn’t**

• Forum for identifying problems without identifying solutions
• For resolving personal or professional conflicts
• For resolving poor performance or disciplinary issues
• Line management supervision
• An opportunity to collude with poor practice or undermine individuals
7.2 **Clinical Supervision the process**

The Clinical Supervision Models illustrated below are for all staff; starting with a foundation 1:1 for everyone to gain underpinning knowledge. Once staff have gained this knowledge they can choose to use other models. Supervision may be delivered in a 1:1, group or peer group setting.

**Some Acceptable Clinical Supervision Models**

- **Appraisal** must identify objectives for professional ongoing clinical supervision.
- **Revalidation** - will require reporting of clinical supervision activity to enable registration.
- **Foundation level 1:1** an initial supervision session must be obtained by all clinical staff to ensure a basic understanding of the process, skills and knowledge required. This can be used to develop a plan of action for ongoing reflection.
- Following this session clinical supervision training will be provided as required through Learning and Development which will include practical sessions to facilitate competence. This could also be facilitated by e learning or journal articles.
- **Reflective 1:1** supervision will involve a clinical supervisor of your choice and a framework of your choice such as Driscoll model of reflection (2007) see Appendix C
- Specialist Supervision for staff who are providing specialist interventions which require focussed, specialist supervision such as Cognitive Behavioural Therapy.
- **Professional Supervision 1:1** supervision with an experienced practitioner in order to reflect on caseload management and treatment plans and receive coaching to improve practice and professional development
- Solution Focused Groups supervision can be obtained using the Solution-Focused Model for Reflecting Teams by Norman (2003) & O’Connell (2005). An inclusive approach should be adopted when developing group sessions including all those involved in the patient pathway including various disciplines and organisations where appropriate. e.g. porters, housekeepers
- Involving Service Users in time the groups will develop in order to involve service users to engage them in the reflective process – pilot sites will be developed to test the reality of how this may be achieved
- **Case Management Supervision** - when care plan goals are not met this will trigger the need to discuss the case of the patient/service user with a more experienced practitioner in order to reflect on clinical practice and treatment options in order to meet the clinical and patient goals.

7.3 **Confidentiality**

All discussions will be treated as confidential and not disclosed without prior permission. However, staff must be aware that in honouring confidentiality they have a duty to report issues of professional misconduct or safeguarding concerns and that these concerns must be reported immediately to the appropriate manager.

Where issues or concerns about the practice or welfare of the supervisee are identified as part of the supervisory process the supervisor will inform the supervisee that the line manager will be informed and will act accordingly.
Confidentially rules will be agreed by the group or individuals, ideally as part of the supervision contract and will be maintained within the supervision, in line with the relevant codes of conduct and guidance as outlined above.

7.4 Record Keeping

- Ground rules must be agreed and understood ideally as part of the supervision contract.
- A written record of the supervision sessions with agreed actions will be completed and kept securely.
- A record will be kept of the date, time and attendees of each clinical supervision session.
- The Supervision template in appendix D is a tool for staff to use. Supervision records may be handwritten or kept electronically and services may devise record templates to suit local needs.
- Line managers will keep records of clinical supervision attendance within their teams for audit purposes.
- Contracts will be agreed with staff and outcomes recorded as part of the appraisal process

8. Training Requirements (refer to TNA)

8.1 All staff are responsible for maintaining their own professional competence, according to their own professional accountability. Staff must maintain a portfolio of clinical practice demonstrating evidence of their ongoing competence to practice. This includes evidence of attendance at clinical supervision sessions.

8.2 It is the responsibility of SHFT to ensure that training is provided to equip supervisees and supervisors with an understanding of the supervision process and supervisors with the necessary competencies to provide effective clinical supervision. The Learning and Development Team will ensure there is access to the necessary education and training to provide initial training for new staff and to allow existing staff to update skills as identified as necessary.

9. Audit the Clinical Supervision Process

Clinical Supervision compliance and quality will be monitored within the Quality Assessment Tool and in the annual audit programme. Attendees will evaluate clinical supervision sessions including learning and patient outcomes. This will be evaluated annually through the use of questionnaires. (see appendices)

10. Monitoring Compliance

All clinical staff will be required to verify electronically via the LEaD system at least every 3 months that they:

1. have participated in clinical supervision within the previous 3 months
2. have discussed / escalated all safety and safeguarding concerns where appropriate.

10.1 Outcome 14 from the CQC essential standards (2010) “People who receive the service from a provider that supervises its staff in line with the relevant national guidance from professional bodies"
10.2 An annual audit will be undertaken on behalf of the SHFT board to monitor compliance with this policy and elicit outcomes in relation to clinical supervision performance.

10.3 Essential standards of quality and safety – guidance about compliance: what providers should do to comply with the section 20 regulations of the Health and Social Care Act 2008 (CQC 2009) is as follows:

- Supervisory or peer group support arrangements are in place, monitored and reviewed for all staff involved in delivering care, treatment and support. This is line with relevant national guidance from professional regulators/ bodies, and is monitored and reviewed.
- A support structure is in place for supervision which includes one to one or group sessions undertaken at a time and frequency agreed through line management.

11. Policy Review

The policy will be reviewed in 2017

12. Supporting References


Department of Health (1994) Clinical supervision for the nursing and health visiting professions CNO letter 94(5)


### Appendix A

#### Learning & Development Training Needs Analysis (TNA)

<table>
<thead>
<tr>
<th>Type of Training</th>
<th>Target Audience (by division/directorate)</th>
<th>Frequency</th>
<th>Length</th>
<th>Delivery Method</th>
<th>Trainer</th>
<th>Recording attendance</th>
<th>Strategic responsibility</th>
<th>Operational responsibility</th>
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<tr>
<td><strong>What type of training is required?</strong></td>
<td>Identify specific staff groups who need to attend from each Business Unit see below for examples</td>
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<td><strong>Describe Subject:</strong></td>
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<tr>
<td>Solution Focused Model</td>
<td>Adult: All Registered and on registered health &amp; social care professionals, All staff involved with the patient journey e.g housekeeper</td>
<td>How often will staff need to attend?</td>
<td>How long will the training take?</td>
<td>How will the training be delivered?</td>
<td>Who will deliver the training?</td>
<td>Where are they held, who records attendance?</td>
<td>Who has ultimate responsibility for the training?</td>
<td>Who makes it happen?</td>
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<tr>
<td>Clinical Supervision</td>
<td>Children: All staff involved with the patient journey</td>
<td>Initial then 3 yearly updates on e-learning</td>
<td>Half a day session</td>
<td>Group training with a practical session</td>
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<td>Associate Director of Learning &amp; Development</td>
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<td>1:1 models of reflection</td>
<td>Dental: All staff involved with the patient journey</td>
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</table>

Please ensure you consult with the Head of L&D for any training topics regarding your policy, via - learning&development@hchc.nhs.uk, or bobby.scott@hchc.nhs.uk this must be approved by L&D before it goes to Policy Management Group.
Appendix B


Solution Focussed Model
In the Solution Focused Clinical Supervision model the group roles are;

1. Presenter
2. Time keeper
3. Facilitator (process manager)

Presenter:

- Bring a prepared reflection about a patient episode that went well or that went badly that you want to analyse further to understand where improvements can be made
- Patient centred reflections only should be brought, managerial issues should be managed with coaching rather than clinical supervision
- Make recommendations following the session and agree and follow up any actions arising from the clinical supervision
- Identify learning needs from supervision and include these as objectives in Personal Development Plans

Time keeper:

- Keep time as per the solution focussed model briefing and remind people to draw to a close in a sensitive manner allowing them to finish what they are saying.

Facilitator / Process Manager:

- This person ensures the group follows the solution focussed format and agreed ground rules. Ensures the questions are not leading and that they are open and not seeking to identify a solution until the appropriate stage of the process.
- Calls the meeting to a close should it be necessary e.g if someone if upset or a conflict occurs

This is a very structured approach to supervision and generally uses solution-focused principles except in one aspect the reflection where suggestions are offered. Stages include- 1) Preparation, Presentation, 2) Clarification 3) Affirmation 4) Reflection 5) Conclusion
1) **Prepare & Presentation 5 minutes**
- Only the presenter speaks
- S/he gives the team the background to the issue or describes the work done to date
- Important to keep to the main points and not “get bogged down” with unnecessary details

2) **Clarification 7 minutes**
- Members of the team, asking one question in turn seek to clarify the situation
- Questions masking advice are ruled out
- PM ensures that no-one dominates and everyone has an opportunity to speak
- Members just say pass if no question

3) **Clarifying question may include:**
- Has there been a time when you feel that you have been more effective with this client?
- What do you like about what you have done with this client?
- What would you say your client would say he valued about your input?
- If a miracle were to occur in the way you worked with the client what would be the first signs for you that it had happened?
- On a scale of 0 to 10 with 10 being that you are doing your best, where would you put yourself at the moment?

4) **Affirmation 3 minutes**
- Each member in turn pays a compliment to the presenter about the content and the manner of the presentation.
- The presenter simply accepts the feedback.
- Members may indicate their agreement with other members.

5) **Reflection 12 minutes**
- Members take turn to share their thoughts about the issue
- They do this by raising and answering questions with the presenter remaining silent
- The presenter listens and takes notes about what is being said
- Ideas should build on the presenter’s view and give them what was originally requested

6) **Conclusion 3 Minutes**
- Conclusion belongs to the presenter with no one else speaking
- S/he thanks them for their ideas and summarises what s/he is taking from the session
• Mentioning specific things s/he is going to think about further to do

7) **Ending**

• The process will take 30 minutes.
• There should be no further discussions unless the team have agreed to discuss general issues arising from the session for a specific length of time
• It can be helpful for each member to say how s/he has benefited from the session.
Appendix C


WHAT
(returning to the situation)
• is the purpose of returning to this situation?
• exactly occurred in your words?
• did you see? did you do?
• was your reaction?
• did other people do? eg. colleague, patient, visitor
• do you see as key aspects of this situation?

SO WHAT
(understanding the context)
• were your feelings at the time?
• are your feelings now? are there any differences? why?
• were the effects of what you did (or did not do)?
• “good” emerged from the situation, eg. for self/others?
• troubles you, if anything?
• were your experiences in comparison to your colleagues, etc?
• are the main reasons for feeling differently from your colleagues etc?

NOW WHAT
(modifying future outcomes)
• are the implications for you, your colleagues, the patient etc.?
• needs to happen to alter the situation?
• are you going to do about the situation?
• happens if you decide not to alter anything?
• might you do differently if faced with a similar situation again?
- information do you need to face a similar situation again?
- are your best ways of getting further information about the situation should it arise again?


Driscoll Model of Reflection

- Having an experience in clinical practice
- A description of the event
- Purposefully reflecting on selected aspects of that experience
- An analysis of the event
- Discovering what learning arises from the process of reflection
- Proposed actions following the event
- Actioning the new learning from that experience in clinical practice

Taken from Driscoll (2007), p.44
## Clinical Supervision Record

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<td>Name of Group or individual supervisor:</td>
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<th>What? Description of the event or issue</th>
<th>So What? Analysis of the event or issue</th>
<th>Now what? Proposed actions and any learning that took place</th>
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**Signed:**

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Clinical Supervision Policy  
Author: Paula Hull, Deputy Director of Nursing & AHP  
Version: 3  
September 2016
Appendix E

Clinical Supervision Record of Activity

Name:  
Job Title:  
Year:  

Please record all sessions as they occur, or are cancelled and forward copy to locality manager

<table>
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<th>Name</th>
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Clinical Supervision Policy  
Author: Paula Hull, Deputy Director of Nursing & AHP  
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Appendix F  Clinical Supervision Contract

SUPERVISOR

As a supervisor, I take responsibility for:

1. Ensuring a safe environment for the supervisee to discuss their practice in their own way.
2. Helping the supervisee explore, clarify and learn from their own thinking, feelings and perspectives regarding their practice.
3. Giving and receiving open, honest and constructive feedback.
4. Sharing with the supervisee information, experiences and skills appropriately.
5. Challenging professional practice in an open and honest manner.

Signed...............................................................................Supervisor. Date........................

SUPERVISEE

As a supervisee, I take responsibility for:

1. Identifying issues for which I need help and asking for time in which to deal with them.
2. Becoming increasingly able to share these issues freely and honestly.
3. Identifying and communicating the type of response, which is useful to me.
4. Becoming aware of my own role and scope and its implications to myself and the organisation and profession for which I work.
5. Being open to others feedback.
6. Noticing when I justify, explain or defend before listening to feedback.
7. Informing my line manager of my supervision arrangements.

Signed...............................................................................Supervisee. Date........................

SUPERVISEE & SUPERVISOR

We shall take shared responsibility for:

1. Arranging when, where and how long each ensuing supervision session will take place.
2. The frequency of supervision session
3. The limits to and maintenance of confidentiality.
4. Reviewing regularly the usefulness of supervision at agreed and predetermined intervals.
5. Knowing the boundaries of the clinical supervision process
6. Our responsibilities should the boundaries be infringed

Signed...............................................................................Supervisor. Date........................

Signed...............................................................................Supervisee. Date........................
Appendix G  
Clinical Supervision Questionnaire  
(Ladany, Hill & Nutt, 1996)

1. How would you rate the quality of the supervision you have received?

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<tr>
<td></td>
<td>Excellent</td>
<td>Good</td>
<td>Fair</td>
<td>Poor</td>
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2. Did you get the kind of supervision you wanted?

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<td>No, definitely not</td>
<td>No, not really</td>
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<td>Yes, definitely</td>
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3. To what extent has this supervision fit your needs?

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<tr>
<td></td>
<td>Almost all of my needs have been met</td>
<td>Most of my needs have been met</td>
<td>Only a few of my needs have been met</td>
<td>None of my needs have been met</td>
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</tbody>
</table>

4. If a friend were in need of supervision, would you recommend this group to him or her?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No, definitely not</td>
<td>No, I don’t think so</td>
<td>Yes, I think so</td>
<td>Yes, definitely</td>
</tr>
</tbody>
</table>

5. How satisfied are you with the amount of supervision you have received?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quite dissatisfied</td>
<td>Indifferent or mildly dissatisfied</td>
<td>Mostly satisfied</td>
<td>Very satisfied</td>
</tr>
</tbody>
</table>

6. Has the supervision you received helped you to deal more effectively in your role as a practitioner?

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes, definitely</td>
<td>Yes, generally</td>
<td>No, not really</td>
<td>No, definitely</td>
</tr>
</tbody>
</table>

7. In an overall, general sense, how satisfied are you with the supervision you have received?

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very satisfied</td>
<td>Mostly satisfied</td>
<td>Indifferent or mildly dissatisfied</td>
<td>Quite dissatisfied</td>
</tr>
</tbody>
</table>

8. If you were to seek supervision again, would you come back to this group?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No, definitely not</td>
<td>No, I don’t think so</td>
<td>Yes, I think so</td>
<td>Yes, definitely</td>
</tr>
</tbody>
</table>
### Clinical Audit Tool

<table>
<thead>
<tr>
<th>Name of team:</th>
<th>Team leader:</th>
<th>Contact no:</th>
</tr>
</thead>
</table>

**Appendix H**

<table>
<thead>
<tr>
<th>Name of staff in team.</th>
<th>Are you familiar with the Solution Focused Model for Clinical Supervision?</th>
<th>Do you receive Group or Individual supervision or both?</th>
<th>How often do you have</th>
<th>Have you attended clinical supervision training?</th>
<th>Please give a brief description of the learning outcomes and changes in practice that have occurred from your groups.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes / No?</td>
<td></td>
<td>Yes / No?</td>
<td></td>
<td>Please do not use identifiable data.</td>
</tr>
<tr>
<td></td>
<td>Yes / No?</td>
<td></td>
<td>Yes / No?</td>
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<td>Yes / No?</td>
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<td></td>
</tr>
</tbody>
</table>

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Clinical Supervision Policy
Author: Paula Hull, Deputy Director of Nursing & AHP
Version: 3
September 2016
<table>
<thead>
<tr>
<th>Name of staff in team.</th>
<th>Are you familiar with the Solution Focused Model for Clinical Supervision?</th>
<th>Do you receive Group or Individual supervision or both?</th>
<th>How often do you have it?</th>
<th>Have you attended clinical supervision training?</th>
<th>Please give a brief description of the learning outcomes and changes in practice that have occurred from your groups.</th>
<th>Please do not use identifiable data.</th>
</tr>
</thead>
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</tbody>
</table>
Equality Impact Assessment (or ‘Equality Analysis’) is a process of systematically analysing a new or existing policy/practice or service to identify what impact or likely impact it will have on protected groups.

It involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. The form is a written record that demonstrates that you have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

For guidance and support in completing this form please contact a member of the Equality and Diversity team.

<table>
<thead>
<tr>
<th>Name of policy/service/project/plan:</th>
<th>CLINICAL SUPERVISION POLICY A STATEMENT OF GOOD PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Number:</td>
<td>SH CP 11</td>
</tr>
<tr>
<td>Department:</td>
<td>Clinical</td>
</tr>
<tr>
<td>Lead officer for assessment:</td>
<td>Paula Hull, Deputy Director of Nursing &amp; AHP</td>
</tr>
<tr>
<td>Date Assessment Carried Out:</td>
<td>October 2014</td>
</tr>
</tbody>
</table>

1. Identify the aims of the policy and how it is implemented.

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Answers / Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefly describe purpose of the policy including:</td>
<td>Clinical supervision is part of the clinical governance agenda, supporting safe, high quality patient care; promoting professional development, and fostering an open culture of learning from positive and negative events and replicating best practice.</td>
</tr>
<tr>
<td>• How the policy is delivered and by whom</td>
<td></td>
</tr>
<tr>
<td>• Intended outcomes</td>
<td></td>
</tr>
<tr>
<td>• Staff understand the process to access supervision to support their personal and professional development</td>
<td></td>
</tr>
<tr>
<td>• Staff recognise the availability of supervision</td>
<td></td>
</tr>
</tbody>
</table>
### 2. Consideration of available data, research and information

Monitoring data and other information involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data**
- Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or **complaints or compliments** about them
- Recommendations of **external inspections** or audit reports

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Data, research and information that you can refer to</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1</strong> What is the equalities profile of the team delivering the service/policy?</td>
<td>The Equality and Diversity team will report on Workforce data on an annual basis.</td>
</tr>
<tr>
<td><strong>2.2</strong> What equalities training have staff received?</td>
<td>All Trust staff have a requirement to undertake Equality and Diversity training as part of Organisational Induction (Respect and Values) and E-Assessment</td>
</tr>
</tbody>
</table>
### 2.3 What is the equalities profile of service users?

The Trust Equality and Diversity team report on Trust patient equality data profiling on an annual basis.

### 2.4 What other data do you have in terms of service users or staff? (e.g. results of customer satisfaction surveys, consultation findings). Are there any gaps?

The Trust is preparing to implement the Equality Delivery System which will allow a robust examination of Trust performance on Equality, Diversity and Human Rights. This will be based on 4 key objectives that include:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and included staff
4. Inclusive leadership

### 2.5 What internal engagement or consultation has been undertaken as part of this EIA and with whom?

What were the results? Service users/carers/Staff

### 2.6 What external engagement or consultation has been undertaken as part of this EIA and with whom?

What were the results? General Public/Commissioners/Local Authority/Voluntary Organisations

In the table below, please describe how the proposals will have a positive impact on service users or staff. Please also record any potential negative impact on equality of opportunity for the target:

In the case of negative impact, please indicate any measures planned to mitigate against this.
<table>
<thead>
<tr>
<th>Positive impact (including examples of what the policy/service has done to promote equality)</th>
<th>Negative Impact</th>
<th>Action Plan to address negative impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong>&lt;br&gt;Applied to all protected characteristics:&lt;br&gt;To provide a framework for the provision of Clinical Supervision in the trust, showing organisation structure, monitoring, reporting and accountability for managers and staff. This should ensure a standardised approach across all Divisions.&lt;br&gt;Provides clear guidelines and accountabilities on the provision of Clinical</td>
<td>No negative impacts have been identified at this stage of screening</td>
<td><strong>Actions to overcome problem/barrier</strong></td>
</tr>
</tbody>
</table>

Clinical Supervision Policy  
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Version: 3  
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<table>
<thead>
<tr>
<th>Supervision in the Trust. Defines clear standards and expectations of managers and staff.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disability</strong></td>
</tr>
<tr>
<td><strong>Gender Reassignment</strong></td>
</tr>
<tr>
<td><strong>Marriage and Civil Partnership</strong></td>
</tr>
<tr>
<td></td>
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<tr>
<td>------------------------</td>
</tr>
<tr>
<td>Pregnancy and Maternity</td>
</tr>
<tr>
<td>Race</td>
</tr>
<tr>
<td>Religion or Belief</td>
</tr>
<tr>
<td>Sex</td>
</tr>
<tr>
<td>Sexual Orientation</td>
</tr>
</tbody>
</table>
**Sign Off and Publishing**

Once you have completed this form, it needs to be ‘approved’ by your Divisional Director or their nominated officer.

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designation:</td>
</tr>
<tr>
<td>Signature:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>