

**Supervision Policy and Procedure**

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| **See also:** | **Located in the following policy folder on the Trust Intranet** |
| Safeguarding children policy | Clinical policy and procedures |
| Minimum standards for health records | Clinical policy and procedures |
| Assessment and management of safety needs policy | Clinical policy and procedures |
| Risk assessment policy and procedures | Corporate and risk |
| Health and attendance policy | Workforce and OD |
| Disciplinary policy procedures | Work force and OD |
| Health and attendance policy | Workforce and OD |
| Psychological therapies register | Clinical register |
| Portable devices / recording of clinical video/ material | Information governance |

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| People and Culture Committee | April 2019 | Quality Committee/ People and Culture Committee | | |

 **Did you print this document?**

Document published on the Trust Intranet under: People’s Services Policies and Procedures

Please be advised that the Trust discourages retention of hard copies of policies and can only guarantee that the Policy on the Trust Intranet site is the most up-to date version

**ACCESSIBLE INFORMATION STANDARD**

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Ensure you have considered an agreed process for: sending out correspondence in alternative formats and appointments for patients / service users with communication needs, where this is applicable.

**Checklist for Supervision Policy and Procedure**

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| **Summary (Plain English)** Summarise the main points of the policy below in a style that is clear and easy to understand. Ensure the whole policy is written in plain English, using simple language where possible and avoiding convoluted sentences and obscure words. The resulting policy should be easy to read, understand and use, |
| This policy incorporates the principles of supervision in all of its guises including clinical, managerial and professional supervision, delivered in a variety of ways. |

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| **Name / Title of policy/procedure** | Supervision Policy and Procedures | |
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| **Sponsor (Director lead)** | Executive Director of Nursing & Patient Experience | |
| **Author(s)** | Head of Safeguarding Children | |
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| Over 40 clinical staff and managers across the Trust were consulted prior to the policy being updated | September 2018 | | All suggestions incorporated into the updated policy |
| Trust Management Team | Jan 2019 | | Agreed in principle, to go out for final consultation to GMs with one adjustment explicitly refer to appraisal |
| General Managers and Senior Leaders | Jan 2019 | |  |

**Version control (for minor amendments)**

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| --- | --- | --- |
| **Date** | **Author** | **Comment** |
|  | *Job title, not name* |  |
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**Supervision Policy**

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**SUPERVISION POLICY**

# Introduction

**Why this is important**

*People in our care have the right to expect safe, competent and evidence-based care. Appropriate supervision provides assurance for our service users, our carers, our communities and our regulators that a practitioner is safe and supported. The emotional wellbeing of staff and their professional development is important.* (Adapted from text by Senior Nurse on the Radbourne Unit, 2018)

This policy is relevant for all staff employed by Derbyshire Healthcare NHS Foundation Trust who may or may not be engaged in clinical interaction with clients. This policy incorporates the principles of supervision in all of its guises including clinical, managerial and professional supervision, delivered in a variety of ways. Managerial and clinical supervision are mandatory activities, and all service areas must have processes and systems in place to manage and support their provision, and their recording onto our supervision recording system on Connect. With regards to bank and sessional / agency staff, the provision of supervision should be considered proportionate to the number of hours worked in the Trust. However, this will not need to be reported within this structure.

The professional requirements of medical staff, including clinical supervision, are set out by the medical regulatory body (the General Medical Council) in documents including “Good Medical Practice” and “Leadership and Management for Doctors”. This duty is in line with the General Medical Council & Royal College of Psychiatrists & Academy of Medical Royal Colleges guidelines. The requirements are upheld through the process of appraisal and revalidation. In the case of doctors in training, these requirements are upheld through the Annual Review of Competency Progression (ARCP) process. Therefore, this will be monitored and reported outside of the process described in this report.

The policy highlights in particular that clinical staff must have an opportunity to reflect on their clinical interactions as a means to practice safely, to maintain and improve the quality of their practice, and to address their own needs for support and well-being.

The aim of the policy is to:

* reaffirm the focus on the quality and purpose of supervision
* reinforce the value of reflective supervision in improving the quality of services
* reduce work related staff stress
* provide clear definitions of the terminology surrounding supervision
* outline the overall vision of the Trust in relation to supervision for all staff
* clarify individual responsibilities / duties in relation to supervision
* clearly identify supervision as an element of effective clinical governance and performance management systems

# Our compliance responsibility

* CQC Regulation 18: Staffing: **Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities**
* Compliance will be monitored quarterly via our systems; with reports being disseminated via operational meetings.
* In order to meet commissioner expectations, the Trust must demonstrate that **95%** of its clinical facing staff are undertaking supervision in line with policy.

# Definitions

**Supervisor** - A supervisor is a suitably qualified individual who is in a position to offer supervisory practice (as defined within this policy) to an individual or group. Where group or peer supervision is undertaken, a ‘facilitator’ or ‘supervisor’ may be appointed to lead the process.

**Supervisee** - is the individual who receives supervision from another person or from other people

**What supervision is:**

* Supportive and reflective
* Clear and challenging
* Agreed by both parties as being supervision, and that it can be recorded as such

**What supervision isn’t:**

* A team meeting, ward round, or non-supervision focussed conversation

# Types of supervision

This policy has been developed following the guidelines set out in CQC document: Supporting effective clinical supervision (July 2013). This describes how there are several types of supervision – the three most commonly referred to are clinical, managerial and professional supervision. The terms used in this area may sometimes overlap and in practical terms, it may sometimes be difficult to separate them from each other.

**Managerial supervision** is carried out by a supervisor with authority and accountability for the supervisee. It provides the opportunity for staff to:

* + review their performance
  + set priorities/objectives in line with the organisation’s objectives and service need
  + identify training and continuing development needs

**Clinical supervision** provides an opportunity for staff to:

* + reflect on and review their practice
  + discuss individual cases in depth
  + change or modify their practice and identify training and continuing development needs

**Professional supervision** is often interchangeable with clinical supervision. This term is sometimes used where supervision is carried out by another member of the same profession or group. This can provide staff with the opportunity to:

* + Review professional standards
  + Keep up to date with developments in their profession
  + Identify professional training and continuing development needs
  + Ensure that they are working within professional codes of conduct and boundaries

**Skills for Care (2007),** highlights that the optimum frequency for supervision for an individual will depend on a number of factors:

* + the experience of the worker
  + the length of time in the job
  + the complexity of their work
  + the individual’s support needs

# Specific aspects of management supervision

This provides the opportunity for a staff member and their manager to:

* review the support required for the person to do their role, giving due consideration to work life balance
* review workload
* discuss patient safety issues and safeguarding, both children and young people and adults. ( with all cases please consider Think Family ).
* review the staff member’s sickness and well-being
* review interpersonal issues that may affect performance
* timekeeping / time management
* identify training and development needs
* discuss career planning
* plan / monitor the appraisal process
* reflect on training opportunities
* identify and discuss new policies / procedures applicable to that member of staff
* set priorities / objectives
* check competencies are up to date and relevant to the role
* check objective progression in conjunction with the overarching aims of the organisation
* plan / monitor mandatory training
* identify and act on any managerial / performance issues
* review adherence to Trust performance standards

# Specific aspects of clinical supervision

This is a method of ensuring safe and accountable practice for clinical staff within healthcare settings. The purpose of clinical supervision is to:

* have time to engage in supportive self-examination, to facilitate reflection and learning with regards to clinical skills and practice
* drive and maintain care standards
* identify practice issues and to consider evidence based approaches
* consider the client / family members / carer and their journey through the service inclusive of risk, safeguarding, assessment, analysis/formulation and intervention ( care/action plan ).
* be challenged about clinical work in a safe environment
* have the opportunity to consider future training and development needs to inform Personal Development Plans
* promote innovations in practice
* ensure staff are up to date with any national clinical developments which impact on practice e.g. NICE guidance
* have the opportunity to discuss home life / personal issues as appropriate and where these have an impact of practice
* develop clinical skills and expand knowledge through discussion and review
* be supportive and encouraging of new skills learnt through training courses, e.g. assisting the supervisee in implementing a new process / way of working
* review assessments, formulations, care planning and outcomes
* review patient safety issues or safeguarding issues
* review any engagement or interpersonal issues with service users or carers
* review any ethical issues

Ad-hoc clinical supervision is provided by colleagues / peers / other disciplines. It is an opportunitistic time to reflect on a clinical case, formulate care and plan interventions. It can be at a point of crisis or after a difficult interaction at work. This can also be recorded as supervision, with the minimum reportable time being 10 minutes.

# Specific aspects of professional supervision

This is necessary in instances where the supervisee is a practitioner and is not clinically or managerially supervised by someone of their own profession. The supervisor must be of the same professional background as the supervisee. It provides the opportunity for staff to:

* maintain professional identity
* identify professional development needs and career progression
* keep up to date with developments of their particular profession
* be clear that they are working within professional boundaries
* review clinical work with specific reference to their professional speciality
* discuss the supervision of students
* review professional standards and codes of conduct

Professional supervision can be provided by a senior or peer of the same profession as the supervisee. For some professions this is required for revalidation in profession and or / additional accreditation with bodies. Professional supervision addresses core professional standards, competency issues, development of skills and career development, and as such should be used by the supervisee for the purposes of revalidation and appraisal.

N.B. It is expected that wherever possible professional supervision should be integrated into either or both clinical and managerial supervision

Staff can negotiate with available colleagues to identify a supervisor for other areas of supervision or can use their manager for management, professional and clinical if felt appropriate. The functions of these areas can overlap but when all areas are addressed it ensures safe, supported and effective practice.

# Specific aspects of safeguarding supervision

This offers a formal process of professional support and learning for practitioners and is about the ‘how’ of safeguarding practice. Safeguarding supervision provides a framework for examining and reflecting on a case from different perspectives and also facilitates the analysis of the risk (vulnerability and adversity) and protective (resilience) factors involved. Safeguarding supervision should help to ensure that practice is soundly based and consistent with local procedures for safeguarding adults and children (Derby and Derbyshire Safeguarding Children Board policies and procedures).

Safeguarding supervision is a way of ensuring that that all staff have access to immediate advice and supervision and a systematic process to review their work, to ensure that all vulnerable individuals are protected from harm. All Trust staff will have access to advice and support on an ad hoc/ needs led basis about any cases causing them concern. This may be from their peers, managers, or from their named or designated safeguarding professionals.

The policy aims to promote and support the development of a culture within the Trust in which staff value and engage in regular supervision in order to ensure the quality and safety of services to adults at risk, children, young people and their families across the Trust.

Effective practitioner supervision can play a critical role in ensuring a clear focus on a child’s welfare. Supervision should support practitioners to reflect critically on the impact of their decisions on the child and their family, (Working together to Safeguard Children 2018). Working to ensure children are protected from harm requires professional curiosity, professional judgment and professional challenge and authoritative practice. It is recognised that working in the field of Safeguarding entails making difficult and professional judgments which may include a level of risk. It is demanding work that can be distressing and stressful. Therefore all frontline practitioners must be well supported by effective safeguarding supervision, advice and support.

As a general rule all Trust staff will have access to advice and support on an ad hoc/needs led basis about any cases causing them concern. This may be from their peers, managers, or from their named or designated safeguarding professionals. Safeguarding Children and Adult concerns/on-going cases **must be a standing item at all supervision sessions**, and case discussions must be recorded alongside any actions to be taken. This will include recording that no safeguarding issues were discussed during the supervision session.

In addition to the provision of ad hoc supervision, it is required that identified staff who carry out day to day work with children and families receive safeguarding children supervision on a minimum of quarterly basis provided by the children’s safeguarding team, according to local service agreements, which are informed by the specific team’s management process.

The various formats for providing supervision are described within this section above; these formats are equally applicable to safeguarding supervision. Any other practitioner may request individual or group supervision in relation to a child or family.

Specialist safeguarding supervision is supplementary to other types of supervision (management and clinical) in accordance with national guidance. Personal Development Reviews / Appraisals must include reference to child protection training and supervision for all staff working with children and young people.

Safeguarding children supervision is available to ALL staff facilitated by the Safeguarding Children Team or with support from cascade models, through the following methods:

* Face to face, one to one or group for arranged via:
  + planned (including local drop-in) sessions facilitated by the Safeguarding Children Nurses
  + cascade model (where managers who have undertaken safeguarding children supervision training also supervise teams members within management supervision on safeguarding children issues)
* Telephone:
  + Any health practitioner may request advice or support by telephone during office hours in respect of any vulnerable child or family
  + The advice system operates Monday, Tuesday, Wednesday, Thursday and Friday afternoon or by appointment (which could include face to face)
  + Advice and support can be accessed at any time; if emergency and immediate action is required via police or social services, for out of hours urgent advice via the medical out of hours service - 01332 623730 (answer phone) or during working hours 01332 623700, ext 31537
  + ALL calls to the advice line where cases are discussed need to be recorded as Safeguarding Children Supervision

The safeguarding protocols can be accessed at: <http://connect/Corporate/NursingandQuality/PatientSafety/safeguarding/safeguardingchildren/SitePages/Practice%20Guidance.aspx> –

For issues relating to adult safeguarding, advice and supervision are accessed ad hoc as required, according to policy:

<http://connect/sites/ConnectTeams/Resources/PnP/_layouts/WordViewer.aspx?id=/sites/ConnectTeams/Resources/PnP/Policies/Safeguarding%20Adults%20_%20External%20Links.docx&Source=http%3A%2F%2Fconnect%2Fsites%2FConnectTeams%2FResources%2FPnP%2FPages%2FPublished%5FPolicies%2Easpx&DefaultItemOpen=1>

**Safeguarding Supervision has three primary functions:**

1. The management (or normative) function is primarily to provide accountability to and involvement with the organisation. This involves overseeing the quality of practice through the monitoring of professional and organizational standards, for example, by ensuring that policies and procedures are adhered to, ensuring that care/action plans are developed and updated with progress and timescales and to consider threshold criteria and escalation as necessary.

2. The educational /development (or formative) function is primarily to address the professional development needs of the supervisee. In this aspect of supervision practitioners are assisted to reflect on their work, deepen their understanding and encouraged to develop new skills

3. The support /mediation (or restorative) function recognises the emotional impact of safeguarding work. This provides support for practitioners and explores strategies for coping and self-care whilst ensuring that the individual and the organisation are compatible in terms of values, aims, task and function

**Key Responsibilities:**

All staff members (supervisee’s) are responsible for:

* Identifying cases of concern to discuss at supervision, whether planned formal supervision or ad-hoc supervision
* Taking part in safeguarding supervision as stipulated in this policy for their role
* Recording all child specific supervision in the child’s health record, and the parent / carer’s records as appropriate if they are also open to the organisation, reflecting on the discussion /challenge and analysis with a clear action plan recorded as agreed at supervision, ensuring that the date and time and name of supervisor are recorded
* Providing feedback and participating in the evaluation of the safeguarding supervision process
* Managing the security of their copy of the supervision session. When using the session for revalidation ensuring that the patient details are non-identifiable.
* Seeking ad hoc supervision from the appropriate person at the appropriate time to avoid any delay in keeping a child safe if they are concerned for the health, safety and wellbeing of a child in their care or about a parent, carer or a vulnerable adult (The appropriate person may be for instance their peer, manager, on-call site practitioners / matrons / safeguarding team / MASH (multi Agency Safeguarding Hub) / police

# Minimums Standards – Quality

Supervisees should have as much supervision as they need in order to fulfil their role. It depends on experience and position / type of role and should be negotiated accordingly (See \*\* below re Trainee Clinical Psychologists). Self-assessment can help the professional think about their supervision needs (see appendix 2 )

The focus of all conversations around supervision needs to be the value of it from the perception of the supervisee, for all the reasons described in this policy. Frequency of supervision might increase or decrease in line with changes in the work environment or the person’s home life. As such, the standards below should be seen as the **minimum** required to support a colleague in the workplace, not the target to aim for.

To provide assurance as to agreement of the experience of supervision, supervisees will receive an email whenever supervision is recorded as being provided to them.

# Minimum Standards – Recording

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Management supervision** | **Clinical Supervision** | **Child Safeguarding Supervision** | **Professional Supervision** | **Non-medical prescribing supervision** |
| **All staff** | 5 hours per year pro rata (plus Appraisal) |  |  | As required, reported as part of management supervision |  |
| **Non-medical colleagues in clinically focussed roles** | 5 hours per year pro rata (plus Appraisal) | 6 hours per year pro rata | As required | As required, reported as either part of clinical or management supervision |  |
| **Medical colleagues** | 5 hours per year pro rata (plus Appraisal) | Aligned with Royal College of Psychiatry expectations | As required | As required, reported as either part of clinical or management supervision |  |
| **Health Visitors and School Nurses** | 5 hours per year pro rata (plus Appraisal) | 6 hours per year pro rata | A 1:1 session, at least once every three months (so 4 per year) | As required, reported as either part of clinical or management supervision |  |
| **Team leaders/managers with safeguarding children supervision responsibilities** | 5 hours per year pro rata (plus Appraisal) | 6 hours per year pro rata | A 1:1 session, at least once every three months (so 4 per year) | As required, reported as either part of clinical or management supervision |  |
| **Non –medical prescribers** | 5 hours per year pro rata (plus Appraisal) | 6 hours per year pro rata | As required | As required, reported as either part of clinical or management supervision | Four sessions per year with their medical supervisor |

* All staff (inclusive of corporate and medical) must have a minimum of **five hours of management supervision per year** (pro rata) **with the clear expectation of at least an additional hour per year in the form of an appraisal.**
* All clinical staff must have a minimum of **six hours of clinical supervision per year (**pro rata)
* **Safeguarding supervision** for relevant staff - four sessions per year in addition to the above
* **Non-medical prescribing** supervision - four sessions per year in addition to the above with their medical supervisor, and specific to their prescribing role
* For **group supervision**, depending on the size of the group and the experience of the different individuals present, it can be difficult to state how much of that group supervision time can be allocated to the individual attendee’s personal supervision record. Therefore, the group members should decide how much of the time spent in any session should be recorded against their individual supervision records
* A record of the content of supervision must be kept by both the supervisor and the supervisee
* All formal supervision records should be signed by both supervisor and supervisee (this can be an email confirmation of agreement with content). See appendix 3 for example of recording sheet
* All supervision should be logged electronically on the Connect site
* Where relevant to care an appropriate summary must be made in the relevant Electronic Patient Record when it changes the plan of care or decision previously made
* Format of recording is not prescriptive but should reflect the content and outcome of supervision.
* Where safeguarding or safety of clients or public or where practice / standards / clinical concerns are raised this must be reflected in the session record
* When specialist safeguarding supervision is accessed and the client has been named in the supervision a record of the discussion and outcome or action should be made in the client’s clinical record, with timescales. Where the client is not named the safeguarding supervisor will keep a record in the name of the professional accessing supervision
* For group supervision all participants should keep a copy of the record of the content of the session, if a client is discussed any decisions and action must be recorded in the EPR.
* Feedback from supervisors should be incorporated into the member of staff’s annual appraisal

**Important to note:**

Different combinations of recording supervision are possible on the connect site:

* Individual Supervision
* Combined management / clinical (50/50 split)
* Combined clinical / safeguarding (80/20 split)
* Group Supervision
* Peer Supervision
* Peer Group Supervision
* External supervision
* Professional supervision can be recorded as having taken place, and can be aligned with either clinical or managerial supervision, depending on the focus of the particular session

# Duties

**Chief Executive,** on behalf of the Trust Board has overall responsibility for ensuring that the organisation complies with its statutory obligations

**Director of Nursing & Patient Experience** is the responsible Director for the overall implementation of this policy

**Medical Director** is responsible for ensuring that a structure exists to ensure all medical staff is in receipt of regular supervision and other support in accordance with relevant college and GMC (General Medical Council) guidelines.

**General Managers / Heads of Service** are responsible for:

* implementing and monitoring the effectiveness of the policy
* ensuring all staff within their areas of responsibility comply with the policy and that professional standards are maintained
* ensuring that all staff are supported and released to undertake supervision
* ensuring action plans to address areas of non-compliance with this policy are fully implemented

**Line managers** are responsible for ensuring that:

* all staff have access to this policy – especially those without access to the Trust intranet, and that the policy has been read / understood by staff in their teams
* all staff in their teams (including themselves) access supervision, in accordance with the agreed guidance of their regulatory body and this policy
* teams prepare a supervision plan for new starters, so managerial supervision (and clinical supervision for clinical staff) is planned for their arrival
* recommendations are addressed where issues of concern are identified about the implementation of this policy
* anyone acting as a supervisor in their team is considered to be competent and has had the necessary preparation for the role
* staff in their team receive supervision from supervisors who are also considered to be competent and has had the necessary preparation for the role
* supervisees have suitable supervisors for their role and professional group
* when agreeing supervision terms this covers all areas of the individual’s competence / responsibilities
* any unresolvable disagreements between the Line Manager and staff member within the managerial supervision process, may be resolved through a formal Trust process, or third party mediation (i.e. involving a peer or other manager within the service)
* if the supervisee is under-performing or needs specific support in their role, the line manager may consider including the clinical supervisor (if different) to ensure that an action plan and appropriate support systems are put in place. This should not preclude following Trust policies when appropriate
* where there is non-compliance with this policy, the manager must take the appropriate steps / actions to ensure any issues are resolved. The manager should report back within their own line management structure.

**Supervisors** have a joint responsibility with the supervisee for ensuring supervision occurs, formulating a supervision contract, identifying boundaries and confirming record keeping arrangements.

* The supervisor has a responsibility to ensure all supervision activity is recorded and reported monthly for performance compliance purposes
* The supervisor should:
  + ensure that they operate within their sphere of competence
  + undertake supervision training as appropriate
  + ensure the supervisee is working within their sphere of competence
  + ensure maintenance of supervision standards
* The role of the supervisor is determined by the needs of the service, staff development and the needs of the organisation. It is acknowledged that it is possible for one person to provide all three types of supervision to certain staff members

**Supervisors** must also:

* Avoid personal relationships with supervisees that might compromise objectivity and effectiveness
* raise any concerns in a timely way with the supervisee, and with the line manager (if different)
* Undertake supervision training where relevant

**Supervisees** have a joint responsibility with the supervisor for ensuring supervision occurs, formulating a supervision contract, identifying boundaries and confirming record keeping arrangements.

The **supervisee** should:

* be honest, open and constructive
* ensure that they operate within their sphere of competence
* jointly contribute to the supervision agenda
* prepare for the supervision session
* avoid personal relationships with the supervisor that might compromise objectivity and effectiveness
* accept support
* be committed to the process
* accept constructive criticism and challenge
* act on any outcomes/ actions from the supervision session in a timely manner
* be reflective

# Other supervision experiences.

**External supervision** is provided by experts in their field (either by qualification or experience). This is provided where there is an identified need and no-one with the required skill-set is available within the Trust. It is also appropriate to use external sources when feedback on clinical practice is required to allow services to reflect and benchmark their practice, or where we are addressing service improvements in relation to practice. It can be formal or informal. Formal supervision of this nature will require a contract whereas informal supervision can be recorded in a reflective summary. The supervisee’s line manager must be aware and have agreed to the input from the external supervisor, and clear lines of communication and escalation must be established between the line manager and the external supervisor

**Supervision for supervisors** ensures standards of supervision are consistent and any issues arising from supervision of others can be reflected upon. All supervisors should identify a process by which they can seek support, advice and reflective space. This can be planned or organised in response to need. Training in supervision for supervisors will also need to be considered.

\*\* Trainee Clinical Psychologists are on a three year training contract with the Trust, a requirement of their employments is that they must meet all the requirements for the Doctorate of Clinical Psychology as monitored by the University of Nottingham and Lincoln.  As such the trainees are closely monitored by their clinical tutors with annual reviews being undertaken to ensure that they are progressing towards their targets.  Any issues are fed back by the clinical tutors to the line manager within the Trust and addressed accordingly.  The nature of this role is significantly different from the majority of staff within the Trust and therefore are exempt from both the clinical and management supervision recording system

**Interaction between the areas of management, clinical and professional supervision and its relationship with appraisal process. Fig 1**

Identifies competency issues to inform professional practice and training

Identifies individual’s professional diligence to inform supervision process

Identifies issues regarding professional conduct e.g. addressing outcome of notes, audits, complaints re contact etc.

Identifies career potential so management can utilise untapped talent, skills and knowledge

Identifies skills and knowledge of individual along with identifying problems with care delivery to inform operational delivery

Identifies issues regarding caseload management, lack of progress, measures etc.

# Supervision Contracts

Supervision contracts must stipulate:

* names of supervisor for each area of supervision and identification of who will provide professional sign off and who will co-ordinate yearly supervision review for appraisal
* focus on areas based on supervisees specific needs/ strengths, assets and areas for improvement
* frequency agreement
* responsibilities for recording and logs outcome etc.
* See appendix 5 for example of supervision contract
* See appendix 6 for supervision agendas
* See appendix 7 for boundaries of supervision

# Ad hoc supervision

Informal supervision / case discussion – does not require a contract but requires a reflective log entry to be made if used as supervision hours for professional accreditation or revalidation purposes.

1. **Group supervision**

Group supervision should have agreed terms of reference which should include:

* responsibilities for facilitation
* agenda setting and prioritisation of discussion
* aims of supervision – percentage of agenda supportive and percentage clinical case work
* responsibilities of attendees
* expected participation of members in agenda and discussion

Where group supervision is amongst peers, the supervision records should be overseen by a named member of the group

1. **Specific Models of Therapy**

* Anyone delivering identified therapies must ensure that they have the training and competency to do so and that provision is made in clinical supervision to ensure that this is the case and practice is safe and informed
* Professionals delivering specific interventions within a model of therapy should ensure that they can evidence that they have the knowledge and skills to apply the interventions appropriately and are aware of the evidence base for the disorder / problem they are treating

# Dealing with concerns / disagreements

* Where there are concerns or disagreements in the supervision process supervisors should reflect on the issue and how to manage it in their own supervision. It may require inter-communication between identified supervisors for the supervisee.
* Should a supervisee receive a notification email that defines them as having received supervision and they do not agree that the conversation was supervision, this needs to be raised with the supervisor concerned and / or within their line management structure.
* For supervisees it can be raised with one of the other supervisors or in an informal session with a professional / manager of their choice.
* It is expected that, (unless in cases of serious misconduct or malpractice which require immediate action), concerns or disagreements are dealt with through early detection and implementation of strategies to improve the issue. This should be a supportive process and involve an action plan with review identified. If the plan is not followed individuals have opportunity to use formal policy and procedure for grievance or issues relating to competency.

# Recorded clinical sessions and live supervision

* Where recordings of client sessions or live supervision is used it is the supervisees responsibility to ensure written consent has been given by the client and that policy is adhered to regarding usage, storage and disposal of the recording.
* In records of supervision it should be noted whether part of the recording was viewed in the supervision process or whether there was formal assessment of the whole recording.

# Monitoring and Reporting Compliance

|  |  |
| --- | --- |
| Minimum requirement to be monitored/audited | Monitoring method e.g. audit |
| Duties | Updated when policy reviewed |
| How clinical supervision is provided | Audit |
| **How the organisation makes sure that all clinical staff receive appropriate clinical & relevant safeguarding supervision** | Via electronic recording, Team Managers report compliance to Area Service Managers who in turn report quarterly compliance to General Managers. |
| How the organisation makes sure that all clinical staff receive management supervision | Ongoing review of performance figures, assurance re quality re agreement of supervisees of their receipt of supervision, periodic review of the experience of supervision |
| How the organisation trains staff in line with the training needs analysis (Training Framework) | All staff issued with a ‘Training Passport’ to identify training requirements.  Compliance monitored through Divisions and Workforce Strategy Group. |
|  | |
| Monitoring Report presented to | Governance Committee |
| Frequency of Monitoring Compliance Report | Quarterly, and via Trust Management Team Deep Dives |
| Report to be prepared by | General Managers |

# APPENDIX 1: Staff WRAP Plan

As staff we need to look after ourselves.

To be healthy at work we need to be psychologically aware of our own stress levels, how we respond to distress, how we are responding to aggression, loss, sexual abuse and trauma.

**Working with stress and being mindful of your own triggers is important to productive and healthy reflective supervision.**

**Who am I?**

|  |
| --- |
| **A mum**  **An OT**  **A carer** |

**How do I respond to stress in my life?**

|  |
| --- |
| **Alcohol**  **Chocolate**  **Depression**  **Domestic abuse** |

**How do I respond to stress in my work life?**

|  |
| --- |
| **Overworking – in the evenings and weekends**  **Underwork- distracted**  **Sickness**  **Irritability**  **Help seeking**  **Impact on my competency/judgement** |

**What are my early warning signs of stress?**

|  |
| --- |
|  |

**My plan**

|  |
| --- |
| **What will I do?**  **What do I want from my line manager?**  **Who supports me/ mentors/coaches? How can you help me?**  **Specific – Family/ caring / Children responsibilities to be taken into account?** |

|  |
| --- |
| **Reviewing my plan** |

|  |
| --- |
| **Signed by Plan owner** |
| **Signed by plan supporter/ line manager or another** |

# APPENDIX 2: SELF ASSESSMENT OF SUPERVISEES

It is recommended that supervisees consider what they want from supervision and discuss this with their supervisor to ensure that there is a common understanding in the relationship.

Things to consider will include

* What you have felt helpful / unhelpful in previous supervision
* What do you expect to gain from supervision and how will this be managed if expectations can’t be met
* What are your strengths and what areas do you want to develop with your supervisors help
* What should your supervisor know about you – either professionally or personally which may impact on your supervision
* How would you want difficulties that arise from supervision to be managed
* How do you respond to feeling criticised in supervision
* Would you want opportunity to observe you supervisor working
* How will you handle disagreements in supervision
* How do you feel about your supervisor observing your practice - live or recorded
* Are there any areas of your role that you find difficult/uncomfortable which you want to address in supervision
* How would you raise having too much/ too little to do, not having the skills to do what is expected, not having your skill set recognised or utilised.
* Do you have a reasonable idea of how your work is going to be evaluated and how will you clarify this with your supervisor. Scaife (2001)

# APPENDIX 3: SUPERVISION RECORD

|  |  |
| --- | --- |
| **Record of Clinical Supervision** (Suggested Template) | **Confidential** |
| Date: | Venue: |
| Name of Supervisor: | Designation |
| Name of Supervisee: | Designation |

|  |
| --- |
| Reflection on previous session (if applicable). Please spend a few minutes reflecting on the outcomes (if any) from your last session. |

|  |  |  |
| --- | --- | --- |
| Key points/issues for discussion | Actions | Initials |
|  |  |  |
| Date, time and venue of next meeting: | | |

# APPENDIX 4: SUPERVISION REVIEW AND SIGN OFF FORM

# 

**Supervisee Name**

**Supervision**

**Management**

Occurrence and duration

Report

Supervisor signature Supervisee signature

**Clinical**

Occurrence and duration

Report

Supervisor signature Supervisee signature

**Professional**

Occurrence and duration

Report

Supervisor signature Supervisee signature

**Safeguarding**

Occurrence and duration

Report

Supervisor signature Supervisee signature

PADR date

Professional sign off

Name Signature Date

# APPENDIX 5: SUPERVISION CONTRACT

# 

**SUPERVISEE**

Name

Profession

Job title

**SUPERVISORS**

**Management**

Name Profession Signature

Agreed process for recording, note keeping, frequency

Individual area of focus and aims

**Clinical** (if peer group name of senior colleague overseeing)

Name Profession Signature

Agreed process for recording, note keeping, frequency (if group list group members and formula for hours recorded)

Individual area of focus and aims

**Professional**

Name Profession Signature

Agreed process for recording, note keeping, frequency

Individual area of focus and aims

**Safeguarding** (where applicable)

Name Profession Signature

Agreed process for recording, note keeping, frequency

Individual area of focus and aims

**PADR attendees or name of supervision co-ordinator**

**Additional comments**

# APPENDIX 6: SUPERVISION AGENDAS AND PREPARATION FOR SUPERVISION

Think about

* Management of client sessions – engagement, endings, boundaries, timing and frequency
* Relationship factors – how the client makes you feel and how you manage this, responses to psychological disturbance and substance misuse, managing dependency in the relationship
* Data gathering – history taking, use of verbal and non-verbal communication, assessment skills, use of diaries, questionnaires, self-monitoring by the client. Inclusion of relatives and significant others
* Thinking formulation and planning – applying theory to the information available in order to understand the client to determine the most appropriate care pathway and thinking about how progress is reviewed
* Interventions – knowledge and skills of interventions, applying theory to practice, gauging whether interventions are consistently applied and relevant to the problem. Recognising appropriateness to the therapeutic model and evidence based care. Reviewing progress
* Professional issues – working within codes of conduct, awareness of power issues, prioritising workload and self-care, taking advantage of learning opportunities, professional relationships, working within levels of competence, maintaining appropriate documentation, awareness of legal obligations
* Supervision issues – supervision contracts, expectations of supervision, use of role play, recordings, live supervision, dealing with feedback, setting the supervision agenda, keeping records of supervision
* The service context – awareness of the services available for the client group, knowledge of issues influencing the client group, developing knowledge and skills base appropriate to role, recognition of the roles of other agencies, awareness of the politics and organisational agenda. Scaife (2001)

# APPENDIX 7: BOUNDARIES OF SUPERVISION

Things to consider include

* Confidentiality and its limitations
* Responsibilities
* Awareness of supervisees support networks and not straying over personal and professional boundaries of the sup agreement
* Dual relationships – friends and supervisee/supervisor/manager – must have an independent supervisor in another area… potential for collusion
* Choice of supervisor – should ideally be internal – if external rationale has to be given – can’t be about choice needs to be skill / service rationale
* Some flexibility for training in supervision – skill enhancement / teaching / directed learning – to be logged to acknowledge the developmental side of supervision and liaised via management so encompassed in PADR and aims of supervision contract

# APPENDIX 8: Considerations for Group supervision

**What is group supervision?**

The intense and sometimes emotionally-depleting work of our profession demands that the work (and worker) be supervised by someone who knows what the work entails and the toll it can take on the worker.

A supervision group can be helpful to be heard, understood, guided, protected, validated, supportively challenged on your blind spots, supported, and reassured!

Most importantly, when ethical dilemmas arise, and it’s hard to admit difficulties and not having the answers and colleagues just fail to see the potential consequences of a sticky ethical boundary crossing or some other situation with potential ethical implications.

Having a set of peers to question- culture, we have always done it this way, is healthy.

Group supervision at its best is mediation and mutual aid.

The most fascinating part of group work for me is the concept of mutual aid. In self-help groups, this concept is known as the “helper-therapy principle.” When one helps someone else, the helper is also helped. This concept is especially salient in group supervision. All help all in a supervision group, including the leader.

Supervision groups can be theme-centred, case-centred, or worker-centred.

For theme-centred sessions, discuss a topic such as self-disclosure in interventions, or introduce a particularly relevant journal article for discussion.

For case or work-centred sessions, you would discuss a particular case for which a member would like collegial input, or an interdisciplinary conflict, or a difficult systems issue or co-worker!

Sometimes most important aspect of group supervision, is discussing the impact of the work on the worker. What emotional toll might the worker anticipate? What personal impact may give a clue to countertransference issues? And what can be done to ameliorate some of the stresses incurred at and because of the work?

One purpose of the group is to provide a safe and rejuvenating place where people can share fears and emotional consequences of their profession and discover ways to deal with work-related stress.

An unintended benefit of group supervision is the networking that will occur and often a sense of organisational pride form having like-minded but different ethical colleagues all making a difference when often under pressure.

It is important to evaluate the effectiveness of interventions, and evaluating the effectiveness of supervision is no different.

It’s important to measure the impact of group supervision

First, through a type of goal-attainment scaling, members have noted where they were at the beginning of supervision, where they wanted to go, and in what ways that goal may or may not have been accomplished. Group participation can be evaluated through instruments such as the Group Rating Session Scale developed by Scott Miller and colleagues (2003).

**Ground rules for group supervision**

You set your own – group contract, as a group, it should be challenging not too comfortable, but supportive. If it turns into a whingeing / upset and moaning forum, you have lost your restorative functions. Stop the group and restart.

Groups must be reviewed at 18 months at which point its effectiveness and membership should be objectively addressed. Where staffing and skills allow, it is good practice to consider groups reforming with a 50% change in membership

# APPENDIX 9: PROTOCOL FOR SAFEGUARDING CHILDREN SUPERVISION

*for Derbyshire Healthcare NHS Foundation Trust supervising Child and Family Teams, Children’s Community Specialist Services and CAMHS/Perinatal Services*

**Introduction**

All children, whatever their age, gender, racial origin, culture, religious belief, language, disability or sexual identity, have the right to grow up unharmed, to have the opportunity to develop fully and have their basic needs met. They should be respected in body and mind, their safety and well-being assured, and their personal dignity guaranteed.

Working to ensure children are protected from harm requires sound professional judgments to be made. It is demanding work that can be distressing and stressful. Practitioners may be working with ambivalence, ambiguity and conflict.

National guidance is explicit in stating that “all of those involved should have access to advice and support from, for example peers, managers, named and designated professionals.”

For many practitioners involved in day to day work with children and families, effective supervision not only promotes good standards of practice but it is also the safety net that makes sure children are safe and supports individuals with the difficult challenges they face. This guidance is applicable not only to practitioners working directly with children but also for those who primarily work with parents or carers.

The role of the team working in the Safeguarding Children's Service (SCS) is to ensure that the needs and rights of children are upheld through the co-ordination of resources, support for healthcare staff, maintaining professional standards and working in partnership with other agencies to safeguard the well-being of children.

“Supervision is the cornerstone of good practice and should be seen to operate effectively at all levels of the organisation” (Lord Laming 2003).

For many practitioners involved in day-to-day work with children and families, effective supervision is important to promote good standards of practice and to supporting individual members (Working Together to Safeguard Children – 2010).

Safeguarding children 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 patient/client protection and safety of care in complex clinical situations (DOH Safeguarding children – Guidance for Senior Nurses, Health Visitors, Midwives and their managers 1997).

**Aim**

The aim of safeguarding children supervision is to ensure that protected time is given to professionals involved in safeguarding children work to reflect on practice/management of cases and personal development needs in order to enhance best practice.

Good quality supervision helps to:

* Keep a focus on the child.
* Avoid drift.
* Maintain a degree of objectivity and challenge fixed views.
* Test and assess the evidence base for assessment and decisions.
* Address the emotional impact of work.

**Objectives**

To ensure that the multi-agency Safeguarding Children Protection Plan/Action Plan is reflected in all Care Plans discussed and remains child focused and in line with Safeguarding Children’s Boards (SCBs) and organisational procedures.

Ensure that practitioners fully understand their roles, responsibilities and the scope of their professional discretion and authority.

To identify practice/management issues which could have an impact on safe childcare practice and discuss with managers as appropriate.

To explore the impact of any potential emotionally harmful environments on the child and agree the course of action.

To provide emotional support due to sensitivity of cases discussed.

Identify the training and development needs of practitioners, so that each has the skills to provide an effective service.

To review other areas of safeguarding management issues which could have an impact on professional workload and safe childcare practice.

To agree workload priorities and discuss changes agreed with line managers as appropriate.

**Guidance of cases to consider for supervision**

Children and young people on a protection plan, analyse and agree an action plan and ensure that the supervisee is confident in carrying the advice given.

Review of cases previously discussed, analyse and agree the next action, ensure the supervisee is confident in carrying out the advice given.

Cases of drift, accumulation of concerns multi-disciplinary and multi-agency challenge around thresholds.

Cases of poor/non-engagement / disguised compliance/co-operation of parents/carers and access to services.

Cases of significant domestic abuse, parental mental health, substance misuse and highly resistant/violent/dangerous families (past or present).

Cases of concern around parent/carer ability/capacity to parent.

Cases transferred into the area on a protection plan or any of the above.

Cases where the supervisee feels concerned/anxious or worried about any aspect of the child or young person’s life and feels unsure about the situation and if there are any significant risks.

Cases where the supervisee lacks confidence and doesn’t feel competent in dealing with the specific issues involved, e.g. self-harm/potential fabricated induced illness/ sexual exploitation/ interfamilial sexual abuse/cultural challenges/ bruising/ obesity.

Cases involving large families with over 6 children – with complex inter-familial relationships.

**Methodology**

Research has shown that long term safeguarding children work can be very stressful and priority will be given to those staff involved in this area of work to access supervision on a regular/needs led basis.

It is therefore advisable that professionals share areas of concern relating to children and families and their own practice with the Trusts’ Named Professionals at an early stage to reduce unnecessary stress.

Supervision within Derbyshire Healthcare NHS Foundation Trust will be carried out by the Named Nurse, Head of Safeguarding Children or Designated Nurse for Safeguarding Children.

All Health Visitors, School Nurses, Nursery Nurses, Community Nurses, Children in Care Nurses, Specialist Nurses and CAMHS workers employed by Derbyshire Healthcare Foundation Trust should be seen by a Safeguarding Children Named Nurse as part of their induction within one month of coming into post to discuss their safeguarding children supervision and training needs.

Health Visitors and School Nurses will have 1: 1 safeguarding children supervision on a needs-led basis (minimum 3 monthly) and other healthcare professionals involved in safeguarding children work can have supervision on request from the SCS.

Nursery Nurses and Community Nurses will be supervised by their Health Visitors or School Nursing Teams in line with their working arrangements.

A supervision structure is in place for Children’s Community Specialist and CAMHS and Perinatal Services. Team leaders/managers with safeguarding children supervision responsibilities will have 1:1 safeguarding children supervision on a needs led basis (minimum 3 monthly) from the Safeguarding Unit. Clinical Managers currently access group safeguarding children supervision. All Children’s/CAMHS and Perinatal Services involved in safeguarding children work can access supervision on request from the Safeguarding Children Service.

In some situations team supervision may be more appropriate/or joint supervision with other health professionals involved in the family, in more complex cases may be a consideration.

Group supervision will also be offered to healthcare professionals as resources allow and need dictates.

For immediate advice or support a Named Nurse Professional can be contacted via the Safeguarding Children Service. The Named Nurses operate an advice system via telephone or face to face on a Tuesday and Thursday afternoon from 1pm to 5pm or by appointment Monday to Friday 9am to 5pm. The Consultant Paediatricians also provide a 24 hour on call service for advice and support out of hours.

Supervision of Named Nurses will be provided by Head of Safeguarding Children on a needs led basis (minimum 6 weekly). Head of Safeguarding Children will receive supervision by an external Nurse Consultant with regular 1:1 meetings with the Designated Nurse for Safeguarding Children.

Individual supervision is essentially confidential but any issue causing concern will only be discussed with a third party (for example a line manager). The intention to share information will be made clear and the information will be shared as appropriate.

Copies of the action plan will be retained in the child health record and case holder’s supervision file and a copy will be forwarded to the Operational Manager.

**SUPERVISION AGREEMENT 1: 1**

**Boundaries**

Supervised sessions should be treated as a mandatory requirement for practitioners and therefore should not be cancelled or interrupted except in exceptional circumstances. If this becomes an area of concern, it will be discussed with line managers.

The frequency and duration of a supervision session will be agreed with the Named Nurse and the practitioner.

**Process**

A suitable venue that is private and convenient to both supervisee and supervisor will be used, preferably in supervisee’s base.

It is the responsibility of each practitioner to come to the session prepared with cases and completed documentation for discussion and reflection on actions.

There will be an agreed agenda between supervisor and supervisee but this must include an update or review of previously discussed cases, any cases of concern to include domestic violence, MARAC, East Midlands Ambulance Service and NHS Direct referrals or those subject to a safeguarding children plan where care plans need to be formulated. The supervisor will enquire if there are any cases of drift or threshold difficulties for discussion.

If a Early Help Assessment has been completed this may be discussed, reviewed and action plan agreed, and copy maintained in the Supervision File.

A written record of case discussions and action plan will be maintained and reviewed/updated at subsequent supervision sessions. Group supervision records and advice sheets also to be reviewed.

Practice issues which have an impact on performance will be shared with managers so that appropriate action can be taken.

Identified individual training and development needs will be recorded and shared with the appropriate manager in order to inform individual Professional Development Plan (PDP). Reflection and discussion around training attended and the learning outcomes should take place to include how the learning will be applied in practice.

In addition to formal supervision, named professionals in the SCS will continue to respond to individual queries and specific concerns.

Following supervision, a copy of the agreed care plan will be retained by the supervisor and the original filed in the child/family records and also to their operational manager to form the health component of the integrated plan for the child/family as necessary.

Signed**:**

SUPERVISOR: SUPERVISEE:

Date: Date:

**GROUP SUPERVISION**

Research has shown that long term safeguarding children work can be very stressful and it will be the priority to ensure that staff receive full support and advice at all times.

**AIM**

The aim of Group Supervision is to provide a forum for practitioners involved in safeguarding children to come together to reflect on practice, share knowledge, experiences and skills in order to maximize learning and improve outcome for children.

All staff involved in Safeguarding Children work should share areas of concerns with the Safeguarding Children's Service staff in the early stages to reduce un-necessary anxiety and stress.

Groups are facilitated and established by initial invitation from the Named Nurses for Safeguarding children.

* Supervision will be planned in advance and at a time convenient to the group members. The duration of supervision will be flexible by agreement. (A minimum of two hours should be timetabled).
* Group supervisory sessions must be treated as a priority and therefore, should **not** be cancelled except in exceptional circumstances.
* A group agreement will be drawn up for ownership by all members attending for supervision. Peer support, within a trusting and learning environment will be promoted.
* There will be an agreed agenda for supervision sessions which will include case presentation and reflection through group discussion.
* The detailed content of the sessions is confidential to the group members. Issues relating directly to practice will be discussed with an individual group member and may be discussed with line managers.
* The Named Nurse/Nurse Practitioner will complete group supervision documentation after each session. This will be retained by the Named Nurse/Nurse Practitioner as a reference and audit tool.
* In addition to formal supervision, staff in the Safeguarding Children's Service will continue to respond to individual queries and specific concerns.
* If an Action Plan is required, this should be documented and filed in the Clinical Record, with a copy to the Named Nurse/Nurse Practitioner, who will review this formally in 1: 1 Supervision or by the agreed timescale.
* Value the opinion of others
* Honesty
* Listening
* Expression of emotion
* No use of mobile phones during the supervision session
* Time out option

**Facilitator: Date:**

|  |  |
| --- | --- |
| **Name** | **Signature** |
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**REGARDS EIRA: Assessing Equality Relevance (Stage 1)**

1. Name of the service / policy / project or proposal (give a brief description):

|  |
| --- |
| Supervision policy |

2. Answer the questions in the table below to determine equality relevance:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Insufficient data / info to determine |
| Does the project / proposal affect service users, employees or the wider community, and potentially have a significant effect in terms of equality? |  | x | All staff are required to participate in supervision and managers to adapt to support staff to engage |
| Is it a major project / proposal, significantly affecting how functions are delivered in terms of equality? |  | x |  |
| Will the project / proposal have a significant effect on how other organisations operate in terms of equality? |  | x |  |
| Does the decision/ proposal relate to functions that previous engagement has identified as being important to particular protected groups? |  | x | Not that we are aware of |
| Does or could the decision / proposal affect different protected groups differently? |  | x |  |
| Does it relate to an area with known inequalities? |  | x |  |
| Does it relate to an area where equality objectives have been set by our organisation? |  | x |  |

1. On a scale of high, medium or low assess the policy in terms of equality relevance.

|  |  |  |
| --- | --- | --- |
|  | Tick below: | Notes: |
| High |  | If ticked all ‘Yes’ or ‘Insufficient data’ |
| Medium |  | If ticked some ‘Yes’ and / or ‘Insufficient data’ and some ‘No’ |
| Low | x | If ticked all ‘No’ |

**EIRA completed by:** Risk and Assurance Manager on behalf of the policy author

**Date: April 2019**