GIG CYMRU NHS WALES
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Swansea Bay University Health Board

MENTAL HEALTH AND LEARNING DISABILITIES SERVICE GROUP

POLICY FOR CLINICAL SUPERVISION & REFLECTIVE PRACTICE

Document Author:	Lead Nurse – Quality Improvement Education, Training & Professional Development Lead
Approved by:	Mental Health and Learning Disabilities Service Group Policy Review Group
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CLINICAL SUPERVISION & REFLECTIVE PRACTICE POLICY

1. Policy Statement

This policy sets out the arrangements for and approach to the provision of effective Clinical Supervision and Reflective Practice.

2. Scope of Policy

This policy relates to all clinical staff employed within the Mental Health and Learning Disabilities Delivery Unit of Swansea Bay University Health Board.

3. Aims and objectives

3.1 The policy aims to outline the requirements for all staff to undertake Clinical Supervision and Reflective Practice.

3.2 The policy outlines:

- The basic principles of Clinical Supervision.
- The basic principles of Reflective Practice.
- The recommendations from professional bodies relating to Clinical Supervision and Reflective Practice.
- The arrangements for carrying out Clinical Supervision.
- The arrangements for carrying out Reflective Practice.
- Record keeping arrangements
- Expectations and standards for supervisors and supervisee's

3.3 The scope of this policy does not include the requirements of managerial supervision and elements of appraisal. The SBUHB Personal Appraisal Development Review (PADR) Policy should be referred to in relation to this and read in conjunction with this policy.

4. Responsibilities

4.1 Various professional organisations recommend and advocate supervision as essential for their practitioners' continuing professional development and recognise its importance in the development of best practice.

- British Association for Behavioural and Cognitive Psychotherapies (BABCP)
- British Dietetic Association (BDA)
- British Psychology Society (BPS)
- Chartered Society of Physiotherapists (CSP)
- General Medical Council (GMC)
- Health Care and Professions Council (HCPC)
- Nursing and Midwifery Council (NMC)
- Royal College of Occupational Therapists
- Royal College of Speech and Language Therapists (RCSLT)

- Health Care Support Worker Code of Conduct Wales

4.2 Supervision supports the Governance, Leadership and Accountability Standard fostering a culture of learning, self-awareness and personal and professional integrity (Health and Care Standards, 2015). Supervision focuses staff and practitioners on their competence, standards of practice and continuing professional development (as identified by the clinician).

4.3 It is recognized that each professional group will have its own defined approaches to supervision as outlined from their professional bodies; therefore, there may be professional variation in terms of their approach.

4.4 NICE Interim guidance on Reflective Practice (2015) outline how Reflective Practice promotes professionalism and encourages the practitioner to think analytically about their clinical practice, monitoring the progress and evaluating the outcomes which can lead to the practitioner having a better understanding of implications of their actions in a given situation.

5. Definitions

5.1 Clinical Supervision is defined as "A formalized relationship (one to one or group) in which regular, protected time is allocated in which a trained supervisor supports, develops and evaluates the practice of the supervisee through the use of a range of methods and techniques. The primary outcome for supervision is improved service provision. Thus supervision is focused on competence, ethical practice, quality and the emotional impact on the practitioner (the formative, normative and restorative functions)." Davies et al (2015)

5.2 Clinical Supervision is considered to be an important factor in delivering safe and effective services (Department of Health, 1993) and to support new practice developments (Butterworth et al, 2008). It is also seen to support professional development and lifelong learning in order to maintain standards and improve patient quality and care (e.g. Department of Health, 1999; Francis Report, 2013)

5.3 The main 3 functions are summarised by Proctor (2010) as "restorative; personal refreshment", "formative; learning from self-experience and the experience of others" and "normative; the supervisor comparing their perspective of good practice with the practice of the supervisee".

5.4 Reflective Practice is a process whereby an individual/group thinks analytically about a clinical situation or activity, exploring its progress, evaluating the outcome and the identified learning. As this implies, it can (and should) take place before, during and after the situation.

Reflective Practice results in a better understanding of a situation and enables the individuals concerned to recognise the possible impact of their actions. The aim of this process is to aid clinical team development and support enhanced performance when similar situations are encountered in the future, allowing the experience gained from previous situations to be put into action.

This was adapted from NICE Interim guidance on Reflective Practice (2018).

5.5 Platzer, Blake and Ashford (2000) identifies that participating in Reflective Practice Groups increase professionalism, greater autonomy in decision making, more self-confidence to challenge the status quo and making their own judgements and are less rule bound approach to their practice. The processes by which these changes occur are identified as support and challenge within the groups offered by both the facilitators and other group members.

6. Implementation/Policy Compliance

6.1 The arrangements for carrying out clinical supervision

6.1.1 The content and duration of supervision may vary according to the role and needs of the individual.

6.1.2 Supervisors are required:

- To have relevant experience and skills for providing Clinical Supervision.
- To be receiving supervision themselves;
- Where specialist clinical approaches are being used, supervisors with experience and competency in that specialism should be accessed.

6.1.3 Frequency of Supervision

Guidelines for Clinical Supervision varies according to role and disciplines. All staff should refer to their professional codes and guidelines relating to this.

Decisions about frequency will take into account a range of factors including:

- The preference of the supervisee;
- The number of hours worked by the supervisee;
- The development needs of the supervisee;
- The recommendations or requirements about supervision of the professional body that the supervisee belongs to, where relevant;
- The degree of informal and live supervision normally available for the supervisee;
- The degree of complexity and risk in the work when the supervisee may need more frequent supervision than usual;
- The supervisor's own capacity to provide supervision;
- The other resources available that provide additional support and development for the supervisee.

6.1.4 Reviewing Clinical Supervision

6.1.4.1 The supervisor will ensure that there is a review process in place for the supervisory relationship. The purpose of this review discussion is to ensure that the supervision continues to meet the needs of the supervisee, is fulfilling the functions as outlined above of being normative,

formative and restorative.

6.1.4.2 If and when a supervision relationship comes to an end the supervisor will, where possible, initiate a final review session with the supervisee.

6.1.4.3 If the supervisee is dissatisfied with the quality or quantity of supervision they are receiving, their first action should be to raise their concerns directly with the supervisor at the earliest opportunity to review the Supervision Agreement.

6.1.4.4 The supervision contract should outline arrangements should there be any conflict between the supervisee and supervisor.

6.1.5 Standards for Clinical Supervision

Standards for supervisee

a. All registered staff will receive regular Clinical Supervision, as per professional standards (i.e. BPS, HCPC, NMC)
b. Supervisee's can select a clinical supervisor, who would be in a more senior role to themselves. Depending on professional standards, this supervisor may also be a healthcare professional from a different discipline to themselves.
c. If the supervisee is unable or unsuccessful in attaining a clinical supervisor, their line manager can allocate a clinical supervisor, until one is sourced.
d. Supervisee's should make a supervision agreement/contract with their supervisor. The contract will specify the frequency of the supervision and stipulate a date for review, which will be no less than annually.
e. Staff can access informal support / additional supervision at times of crisis / in an emergency however these are in addition to regular supervision
f. Supervisees will complete their personal Supervision Record Booklet to evidence their supervision/participation and type of supervision received (Appendix 1).
g. It is recognised that on occasions alternative supervision is sought due to unexpected circumstance i.e. shift patterns, sickness/absence, and should be recognised as regular supervision and reflects as such in the Supervision Record Booklet.

Standards for Supervisor

a. All staff providing supervision within the MH/LD Delivery Unit must have relevant experience and skills for providing Clinical Supervision.
b. Supervisors should receive supervision in relation to their supervisory practice.
c. Supervision may be provided across discipline where this is appropriate.
d. It is acknowledged that some individuals may receive supervision from Professionals outside of SBUHB and therefore this supervisory relationship cannot be subject to these standards and requirements.
e. Novice Clinical Supervisors are required to limit the number of supervisees to a maximum of two. Experienced Clinical Supervisors are required to limit the number of supervisees to a maximum of six.

6.1.6 Expectations of supervisors and supervisee's

A matrix detailing the rights and responsibilities of both the supervisee and supervisor can be found

in Appendix 2.

6.2 The arrangements for carrying out Reflective Practice

6.2.1 Effective Reflective Practice can take place individually, in facilitated groups, or a combination of both but should be distinguished from clinical supervision (i.e. individual and group).

6.2.2 There are a variety of conceptual frameworks and models for Reflective Practice, which facilitators and groups will choose together. Examples of these can be found in Appendix 3.

6.2.3 Reflective Practice sessions will be available on a monthly basis within each clinical setting, in addition to other Reflective Practice activities being offered (e.g. individual/peer supervision, staff training and development sessions).

6.2.4 Staff can also access Reflective Practice at times of crisis / in an emergency however these are in addition to regular RPG sessions. Serious Incidents may require a formal debriefing, which would be dealt with outside of this arrangement.

6.2.5 Reflective Practice facilitators are required:

- To be registered & to maintain their registration (an across discipline approach is favoured)
- To be recognised as having significant experience in their area of expertise and of group facilitation skills; (for specialised clinical approaches RP facilitators are required to be competent and experienced in that approach – this may mean an external facilitator may be sourced);
- To be receiving supervision themselves;

6.2.6 Standards for Reflective Practice

Clinical Area/Team:

a. To occur on a monthly basis.
b. RPG's should be jointly facilitated by a combination of two different registered MDT members external to the clinical area/team. An exception to this standard would be if only one facilitator is unavailable at short notice. If the facilitator is experienced and feels confident and competent to continue this may outweigh the impact of the session being cancelled.
c. Facilitators will be recognised as having significant experience in their area of expertise and of group facilitation skills;
d. A process will operate within the locality whereby each RP facilitator is to be assigned a workplace setting to facilitate an RPG.
e. The facilitator is responsible for the completion of the Supervision/Reflective Practice Attendance Record (Appendix 1) and report as required.
f. The facilitator is responsible for arranging cover in any absence or informing the ward of any changes to the schedule
g. The facilitator/s must record any missed RPG sessions. For example, where it is not possible to deliver RPG and/or where the facilitator has been unable to attend (i.e. crisis management; staff shortages; new admissions; fire). Please identify the reason for this on the Monthly Clinical Supervision and Reflective Practice Audit (Appendix 4)

Attendees:

a. It is expected that staff members prioritise their attendance at the RPG (when this is offered to them) within their working environment
b. Attendees will complete their personal Supervision Record Booklet to provide evidence of Reflective Practice received (see Appendix 1).

6.3 Record keeping arrangements

6.3.1. The recording of Clinical Supervision and Reflective Practice is a useful way of capturing evidence for professional development and meeting requirements set out by your professional body.

6.3.2. Within the MH/LD Delivery unit the use of an individual booklet for each supervisee/attendee to capture occurrences and the key themes of both scheduled and unscheduled Clinical Supervision and Reflective Practice (See Appendix 1)

6.3.3 As per standards, a Clinical Supervision contract will be drawn up at the commencement of the supervisory relationship. This can be found and kept within the Booklet (see Appendix 1)

6.4 Confidentiality

6.4.1 It is recognised that for an open exchange to occur, there needs to be trust on both sides. Trust is more likely to be achieved if both parties are clear when and how information arising from supervision discussions may need to be shared with others.

6.4.2 All issues discussed as part of a supervision session or activity will be in confidence, unless there is anything disclosed that may affect the wellbeing or safety of the supervisee, service users, professional practice, the team or the Health Board.

6.5 Escalating Concerns

If some form of malpractice, negligence or misconduct is revealed during supervision or Reflective Practice it should be recognised this must be acted upon in line with Health Board policies and procedures. This may mean that the manager occasionally needs to access the individual booklet.

6.6 Audit, Monitoring and Training

6.6.1 Audit and Monitoring

6.6.1.1 Clinical Supervision and reflective practice will be captured on a monthly basis via the Clinical Supervision and Reflective Practice Audit Form, by the Ward/Team/Department Manager. Please see Appendix 4

6.6.1.2 Data captured will be uploaded via locality leads to inform the locality Scorecard (work on the process is underway).

6.6.1.3 Quarterly report submitted to the MH/LD Learning and Development Committee, focusing

on progress and exceptions

6.6.1.4 MH/LD Learning and Development Committee to submit Bi-annual DU wide report on Clinical Supervision and Reflective Practice

6.6.2 Training

6.6.2.1 Registered practitioners are enabled and promoted to use reflection as a core element during preregistration in preparation their role. Therefore, registered staff will already possess the required skills to facilitate and guide reflection for both Clinical Supervision and Reflective Practice.

6.6.2.2 However, some individuals may identify some developmental needs in preparedness for the role of a clinical supervisor and where this is the case, upskilling will be supported as necessary/required. This will be achieved through your personal development plan.

6.6.2.3. Where individual identify developmental needs around the facilitation of Reflective Practice Groups, again support will be provided in upskilling these individual practitioners to fulfil this role.

This may include co-facilitation with experienced facilitators and in areas where processes are already established.

7. Equality Impact Assessment Statement

This policy has been screened for relevance to equality.

No potential negative impact has been identified so a full equality impact assessment is not required.

8. References

Nice Interim Guidance on Reflective Practice 2015

Platzer, H., Blake, D. and Ashford, D. (2000) An Evaluation of Process and Outcomes from Learning through Reflective Practice Groups on a Post-Registration Nursing Course. Journal of Advanced Nursing, 31, 689-695.

Proctor, B. (2010). Training for the supervision alliance. Attitudes, skills and intention. In: Routledge Handbook of clinical supervision. Eds. John. R. Cutcliffe, Kristina Hykras and John Fowler. Abingdon: Routledge

9. Getting Help

Help with any aspect of the policy can be obtained from the Mental Health and Learning Disabilites Nurse Leadership Team, the Lead Nurse for Quality Improvement or the Lead Nurse for Education Training and Professional Development.

10. Related Policies

Swansea Bay University Health Board - Personal Appraisal Development Review (PADR) Policy HB67

11. Information, Instruction and Training

Please refer to 6.6.2 of this policy.

12. Main Relevant Legislation

Welsh Government Health and Care Standards 2015

Appendix 1 – Supervision Booklet

MENTAL HEALTH AND LEARNING DISABILITIES SERVICE GROUP

Staff Supervision Record

Name: _____

How this Supervision Record will work?

It is the responsibility of you as a supervisee to retail this supervision record and to seek evidence that supervision has occurred for a minimum of 1 hour each month.

The supervision record will be formally reviewed by your managerial supervisor during formal managerial supervision sessions. Your attendance at supervision will be recorded through the Monthly Clinical Supervision and Reflective practice audit

Types of supervision that should be recorded in this supervision record

- Clinical Supervision

Clinical Supervision is defined as "A formalized relationship (one to one or group) in which regular, protected time is allocated in which a trained supervisor supports, develops and evaluates the practice of the supervisee through the use of a range of methods and techniques. The primary outcome for supervision is improved service provision. Thus supervision is focused on competence, ethical practice, quality and the emotional impact on the practitioner (the formative, normative and restorative functions)." Davies et al (2015)

As per the Mental Health and Learning Disabilities Service Group Clinical Supervision and Reflective Practice Policy (2022)

- Reflective Practice

Reflective Practice is a process whereby an individual/group thinks analytically about a clinical situation or activity, exploring its progress, evaluating the outcome and the identified learning. As this implies, it can (and should) take place before, during and after the situation.

Reflective Practice results in a better understanding of a situation and enables the individuals concerned to recognise the possible impact of their actions. The aim of this process is to aid clinical team development and support enhanced performance when similar situations are encountered in the future, allowing the experience gained from previous situations to be put into action.

This was adapted from NICE Interim guidance on Reflective Practice (2018).

- Peer Supervision

This model of supervision is clinically focused, non-hierarchical and takes places between two or more professionals of the same profession with similar levels of experience and expertise. Peers alternate the role of supervisee and facilitator. This may include case discussions, consultation regarding complex situations, advice about care planning.

Peer supervision will be captured in this record and signed by both peers

- Managerial Supervision

Management supervision is provided in line with the HB PADR policy and is a formal way to support you within your role

Date:	Length of session:	Total time this month:
Supervisor/Facilitator:		
Type of Supervision:	☐ Clinical ☐ Managerial	☐ Reflective Practice ☐ Peer Supervision
Themes discussed:	☐ Patient Issues ☐ Group work ☐ Care plans / Reports ☐ Supervision of others ☐ Other _____	☐ Interpersonal ☐Ward/Team Issues ☐ Staff Issues ☐ PADR /Development
Reflection on themes discussed:		
Supervisee Signature:		
Supervisor/Facilitator Signature:		

Date:	Length of session:	Total time this month:
Supervisor/Facilitator:		
Type of Supervision:	☐ Clinical ☐ Managerial	☐ Reflective Practice ☐ Peer Supervision
Themes discussed:	☐ Patient Issues ☐ Group work ☐ Care plans / Reports ☐ Supervision of others ☐ Other _____	☐ Interpersonal ☐Ward/Team Issues ☐ Staff Issues ☐ PADR /Development
Reflection on themes discussed:		
Supervisee Signature:		
Supervisor/Facilitator Signature:		

Appendix 2 **Rights and Responsibilities of a Supervisee**

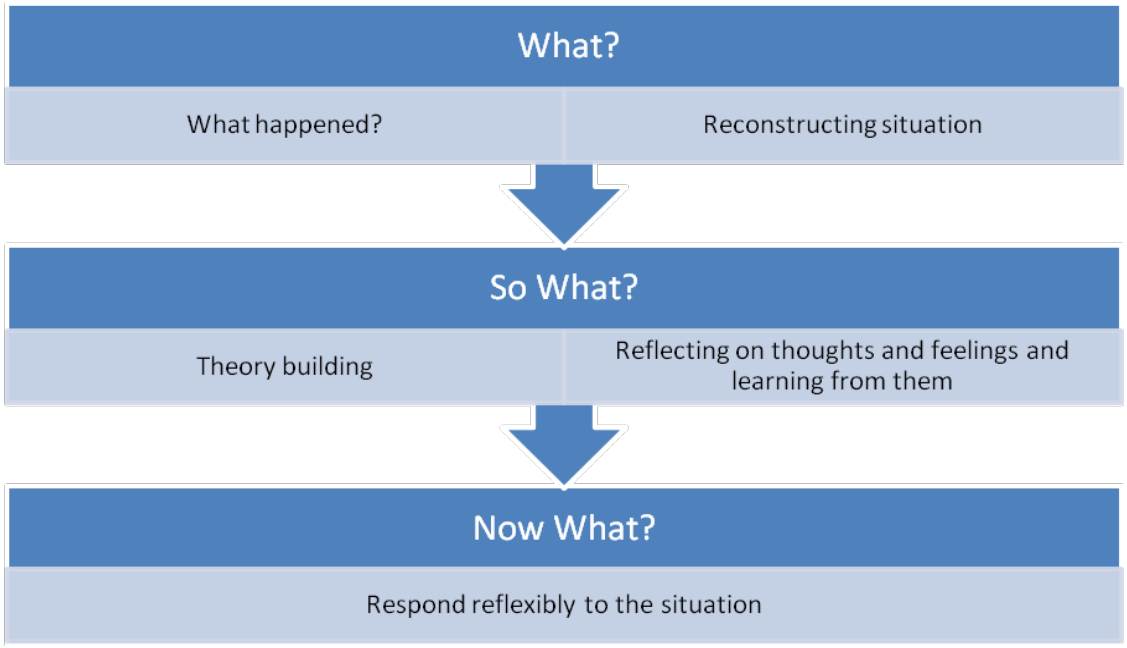
Rights	Responsibilities
As supervisee you have the right to: • Be treated with respect as an equal partner in the clinical supervision relationship: e.g. any decisions that affect the relationship are made with your involvement; sessions are held in a non-hierarchical setting. • Choose the mode of clinical supervision (e.g. one to one or group) and who will be your clinical supervisor. • Set most of the agenda: to talk about what you want to talk about during the clinical supervision sessions, as long as the issue effects your clinical work. • Confidentiality, with the two exceptions of revealing unsafe or illegal practice (or third, not attending or using clinical supervision). This includes records: you have the right to have no record made of anything personal you have talked about. • Protected time for the clinical supervision sessions: support to be able to be released from your clinical responsibilities in order to attend; have the clinical supervisor give your sessions priority and stick punctually to appointments; appropriate length of 'air time' • Protected space for the session: in private with no interruptions • Talk about any difficulties and vulnerable feelings, if you wish, without being criticised for having these vulnerabilities	As supervisee, you have the responsibility for: • Asserting yourself in negotiating decisions about clinical supervision. Considering yourself as an equal and empowering yourself to use the clinical supervision session in the most effective way. • Asserting yourself in negotiating the mode of clinical supervision and who will be your clinical supervisor. • Preparing for clinical supervision sessions by identifying issues upon which you wish to reflect. • Outcomes in terms of your own development and for any actions you take in practice as a result of the sessions. • Making and following through action plans that arise from your reflection during clinical supervision. • Protecting the time for your clinical supervision by giving the appointments a high priority; turning up punctually. • Arranging cover so that you will not be 'on-call' during the clinical supervision. • Being open to challenge. • Giving feedback to the clinical supervisor about their facilitation: e.g. what is most and least helpful. • Using the time to reflect in depth on issues affecting clinical practice • **Keeping a record of the session and ensuring that this is signed by both supervisee and supervisor**

Rights and Responsibilities of Clinical Supervisor

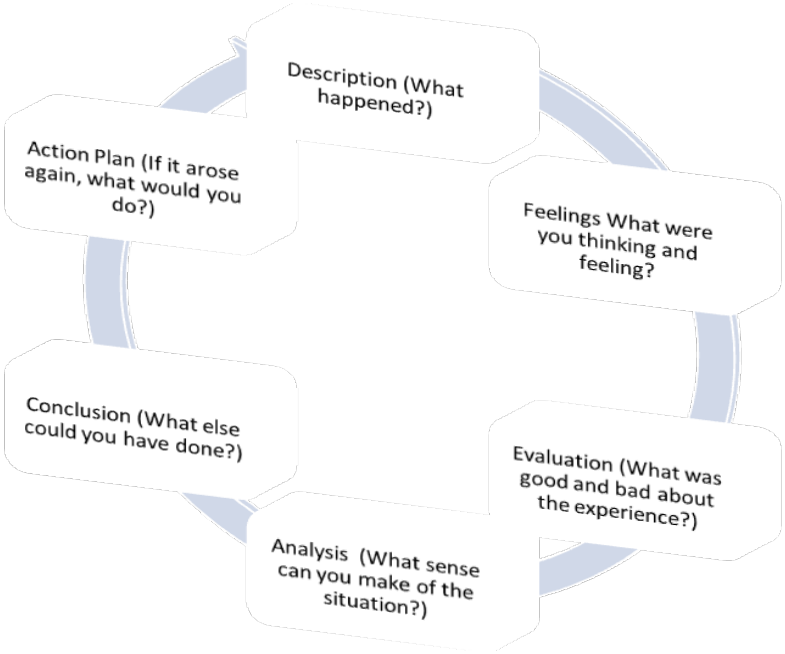
Rights As supervisor you have the right to:	Responsibilities As supervisor you have the responsibility for:
• Be treated with respect as an equal partner in the clinical supervision relationship. • Break confidentiality in exceptional pre-agreed circumstances. • Explore any behaviour or values that the supervisee displays or talks about which give you would like to further clarify about their practice, development or use of clinical supervision. • Withdraw from any behaviour that is insulting or personally hurtful to you. • Decide if the commitment in your role as clinical supervisor is being used effectively, by ensuring that all supervisees you support are given an equal opportunity for clinical supervision. • Set personal and professional boundaries on what issues you listen to the supervisee talk about. • Choose whether to work with someone as a clinical supervisor • Review the clinical supervision relationship at any point.	• Preparing for the clinical supervision session: minimising interruptions; settling yourself beforehand; and taking time to recall the previous sessions. • Being reliable, sticking to agreed appointments, time boundaries, clinical supervision contract, keep confidentiality, (except for explicitly agreed exceptions). • Preparing for clinical supervision sessions by identifying items which you wish to include in the agenda for the clinical supervision session. • Ensuring that the session is purely a clinical supervision session. • Keep to the clinical supervision agreement arrangements made with the supervisee. • Focusing on how quality professional practice can be supported. • Encouraging the supervisee to seek specialist help or advice when necessary • Exploring any behaviour or values that the supervisee displays or talks about which may have an impact on their practice, development or use of clinical supervision. • Ensuring that you have support, e.g. your own clinical supervision • Be aware of who your clinical supervision lead is in your service • Attend updates provided by the Health Board

Appendix 3 – Reflective Practice Models

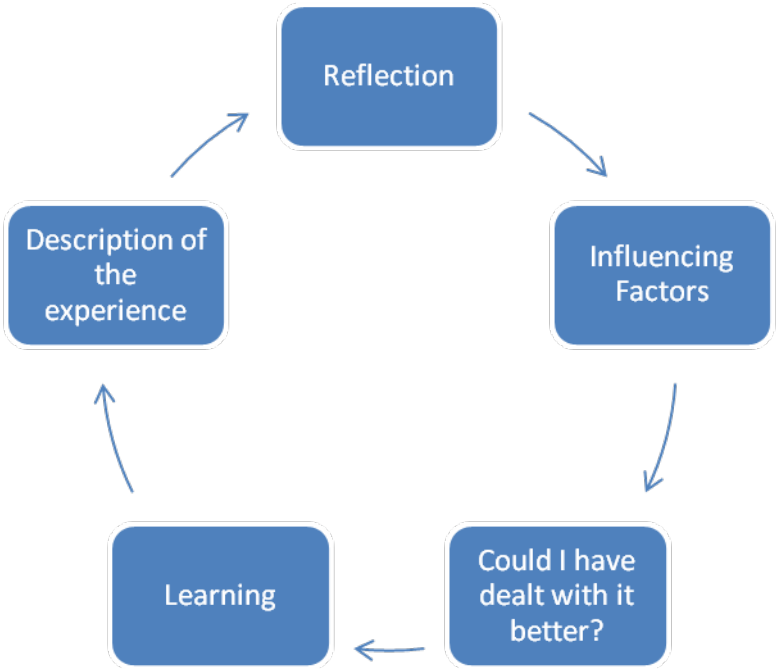
1. **Borton (1970)** - A reflective framework that is regarded as easy for practitioners to carry around in their heads (Rolfe et al, 2011);



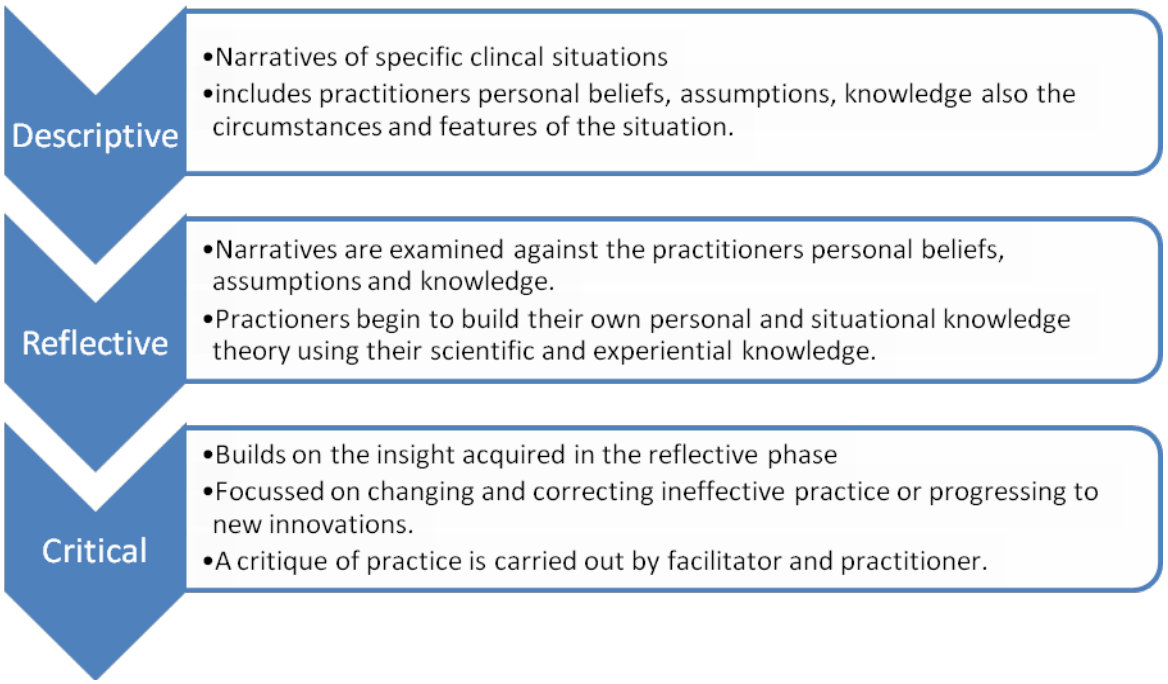
2. **Gibbs (1988)** – Examines three aspects of a situation: a) describing what happened; b)critically evaluating what happened; and c) considering what else could have been done and what to do in the future:-



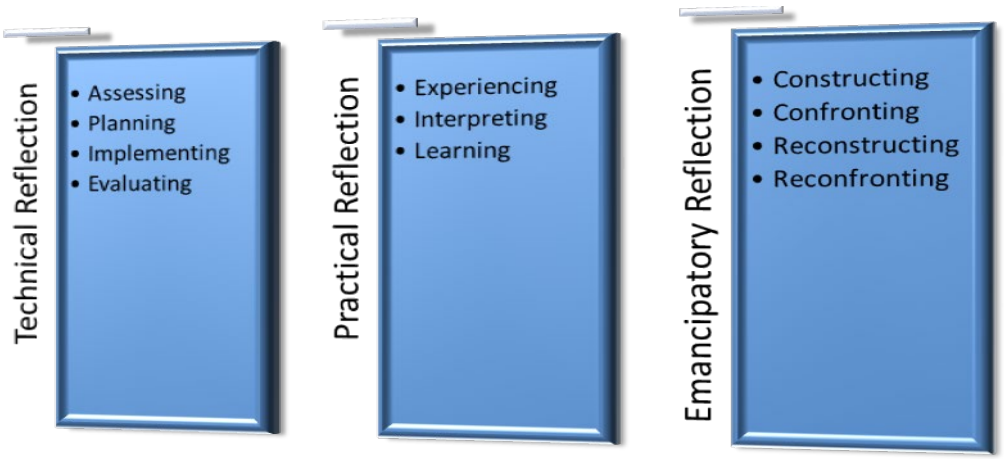
3. **Johns (1995)** - Developed a model of reflective cues with a logical stage by stage approach allowing the practitioner a progression of thought assisting them to focus on issues within the experience:



4. **Kim (1999)** - Framework for Reflective Inquiry.
This framework breaks reflection down into three phases, as described by Rolfe 2011;

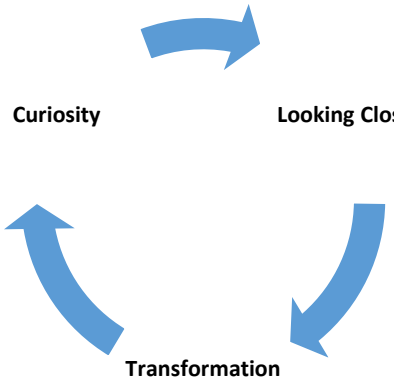


5. **Taylor (2006)** - Framework for Critical Reflection:



Each of the reflective activities is broken down into series of cue questions.

6. **Oelefsen (2012)** - Three Stage Reflective Cycle:



- **Curiosity** –
  This step involves questioning and questioning assumptions.

- **Looking closer –**
  This step involves the practitioner engaging with the questions, contemplating their thinking and actions

- **Transformation -**
  This step is about using observations from the first step in conjunction with the insights gained from the second step, the aim of the transformation phase is to take action that leads to better practices and, ultimately, service improvement.

Appendix 4

Mental Health and Learning Disabilities Service Group

Swansea Bay University Health Board

MONTHLY CLINICAL SUPERVISION AND REFLECTIVE PRACTICE AUDIT

Ward/Team:_____

MONTHLY CLINICAL SUPERVISION AND REFLECTIVE PRACTICE AUDIT - FENDROD WARD										
Ward/Team	Number of Staff	Number of staff received clinicial supervision	Percentage of staff received clinicial supervision	Number of reflective practice sessions held in month	Reason if not held	If Other - Please Specify	Number of staff received reflective practice	Percentage of staff received reflective practice	Name	Date
January										
February										
March										
April										
May										
June										
July										
August										
September										
October										
November										
December										

STANDARDS:

- **Staff member will receive 1-hour clinical supervision each month**
- **Reflective practice sessions will be undertaken on a monthly basis on each ward/team**

To be submitted on a monthly basis

COIN clinical online information network

Swansea Bay University Health Board

Authorisation Form for Publication onto COIN

PLEASE ENSURE THAT ALL QUESTIONS ARE ANSWERED – IF NOT APPLICABLE PLEASE PUT N/A

COIN ID.	CID49
Title.	Policy for Clinical Supervision and Reflective Practice
Name and Signature of Author/Chair of Group or Committee.	MH/LD Policy Review Group
Name and Signature of Lead Pharmacist.	N/A
Please specify whether the document is New, Revised or a Review of a previous version.	Revised Replacing CID49 Practice Governance and Supervision Policy
Please specify the section on COIN where you wish the document to be published.	Mental Health and Learning Disabilities Policies Section
Please sign to confirm that the document has been authorised by an approved governance process in a specialty or delivery unit.	MH/LD Policy Review Group Quality and Safety Committee
Has NICE guidance been considered/referenced when producing this guidance? If yes, please state the title or reference number.	No
Is the document relevant to the GP Portal?	N/A
Equality Statement (Mandatory for Policies). (1)	Yes
Please specify keywords to assist with searching. (2)	Clinical Supervision, Reflective Practice, Managerial Supervision, Revalidation, Peer Supervision
Published.	February 2012
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Next Review Due/Expiry Date.	January 2024

(1) All policies need to comply with the Policy for the production, consultation, approval, publication and dissemination of strategies, policies, protocols, procedures and guidelines

(2) Relevant keywords will assist COIN users with searching for documents.