

Clinical Supervision Policy

Ref No: 1652
Date: 26 August 2016

Partners in Care

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative.

On receipt of a new version, please destroy all previous versions.

Document Information

| | | | |
|---|---------------------|-------------------|----------------|
| Date of Issue: | 26 August 2016 | Next Review Date: | 26 August 2018 |
| Version: | 4 | Last Review Date: | |
| Author: | Bev Glanville Geake | | |
| Owner: | Bev Glanville Geake | | |
| Directorate: | Organisation Wide | | |
| Approval Route | | | |
| Approved By: | | Date Approved: | |
| Care and Clinical Policies Group | | 17/08/2016 | |
| | | | |
| | | | |
| Links or overlaps with other policies: | | | |
| Clinical supervision | | | |
| Child protection | | | |
| Professional supervision in social care policies | | | |
| Supervision – Overarching Principles for all staff policy | | | |
| | | | |
| <p>The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): Sexual Orientation; Gender; Age; Gender Reassignment; Pregnancy and Maternity; Disability; Religion or Belief; Race; Marriage and Civil Partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership.</p> <p>The Trust is committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy.</p> | | | |

Amendment History

| Issue | Status | Date | Reason for Change | Authorised |
|-------|----------|------------|-------------------|----------------------------------|
| 3 | Ratified | 18/11/2014 | Revised | Care and Clinical Policies Group |
| 4 | Ratified | 26/08/2016 | Revised | Care and Clinical Policies Group |

Contents

| | | |
|----|---------------------------------|-------------------------------------|
| 1 | Introduction..... | Error! Bookmark not defined. |
| 2 | Statement/Objective..... | Error! Bookmark not defined. |
| 3 | Definitions..... | Error! Bookmark not defined. |
| 4 | Roles and Responsibilities..... | Error! Bookmark not defined. |
| 5 | Accountability..... | Error! Bookmark not defined. |
| 6 | Access and Process..... | Error! Bookmark not defined. |
| 7 | Documentation..... | Error! Bookmark not defined. |
| 8 | Training..... | Error! Bookmark not defined. |
| 9 | Monitoring and Review..... | Error! Bookmark not defined. |
| 10 | References..... | Error! Bookmark not defined. |

1. Introduction

- Clinical Supervision is a process by which clinicians are assisted to improve practice and deal with the stresses inherent in a caring role.
- Supports and develops competence by providing the opportunity to discuss and reflect upon work in a supportive yet challenging environment.
- Clinical Supervision is strongly recommended to all clinical staff.
- Reflective Learning is part of professional accountability

1.1 Torbay and South Devon NHS Foundation Trust (TSDFT) is committed to enable all practitioners to undertake clinical supervision in order to spread good practice and learn from reflective practice.

1.2 Participating in clinical supervision in an active way is a clear demonstration of an individual exercising their responsibility under clinical governance. It needs to be recognised that clinical supervision takes place in a wider framework of activities that are designed to manage, enhance and monitor the delivery of high quality services. The components of clinical governance are:

- Education and training
- Clinical Audit
- Risk Management
- Clinical Effectiveness
- Research and development
- Patient and Public Participation – Patient experience
- Staffing and staff management

2 Statement/Objective

2.1 This policy aims

- To provide a framework and process to support the ongoing implementation and development of clinical supervision for practitioners.
- To ensure consistency in the practice of clinical supervision.
- To provide standards of good practice for clinical supervision

- 2.2. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice. (CQC 2013)
- 2.3. It is about promoting an ethos of openness and honesty in the practice setting. To help staff manage the personal and professional demands of their work. By using reflection and challenge, in a safe environment, to develop and enhance practice. It can help to promote a person's awareness of the strengths and weaknesses in their practice and identify development and support needs
- 2.4. It should have its base in awareness, enquiry and support, not blame.

3 Definitions

- 3.1 **Clinical Supervision** has been defined by the Nursing and Midwifery Council (NMC) (2006 p6) 'A formal practice of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations.
- 3.2 Bishop (1998) calls it: A designated interaction between two or more practitioners within a safe/supportive environment, which enables a continuum of reflective, critical analysis of care, to ensure quality patient services.
- 3.3 **Supervisee** - A practitioner who receives professional advice, support and guidance from a facilitator.
- 3.4 **Supervisor** - A skilled professional who assists practitioners in the reflective development of their skills, knowledge and professional values

4 Roles & Responsibilities

- 4.1 **Professional Leads** - must ensure that clinicians are encouraged to access clinical supervision and support managers in providing the structures in which this can be achieved. Professionals should initiate supervision if they have particular concerns following an incident/complaint.
- 4.2 **Managers** – must ensure their support for clinical practitioners in accessing clinical supervision, successfully balancing operational pressures with professional support. Managers should initiate supervision if they have particular concerns following an incident/complaint
- 4.3 **Professional Practice Education Facilitator**- will be responsible for ensuring training and for providing support to ensure that supervision is accessible to clinicians.

4.4 **Clinical Practitioners** - will be responsible for maintaining access to clinical supervision as necessary for professional support and learning.

4.5 **Supervision Facilitators**

- Encourage reflective practice
- Assistance in identifying issues presented by the group i.e professional development, training, therapeutic requirements
- Identification of actions in order to progress
- Facilitating and monitoring the understanding of changes.

5. Accountability

5.1. Clinical supervision will be clinically audited regularly for both qualitative and quantitative outcome.

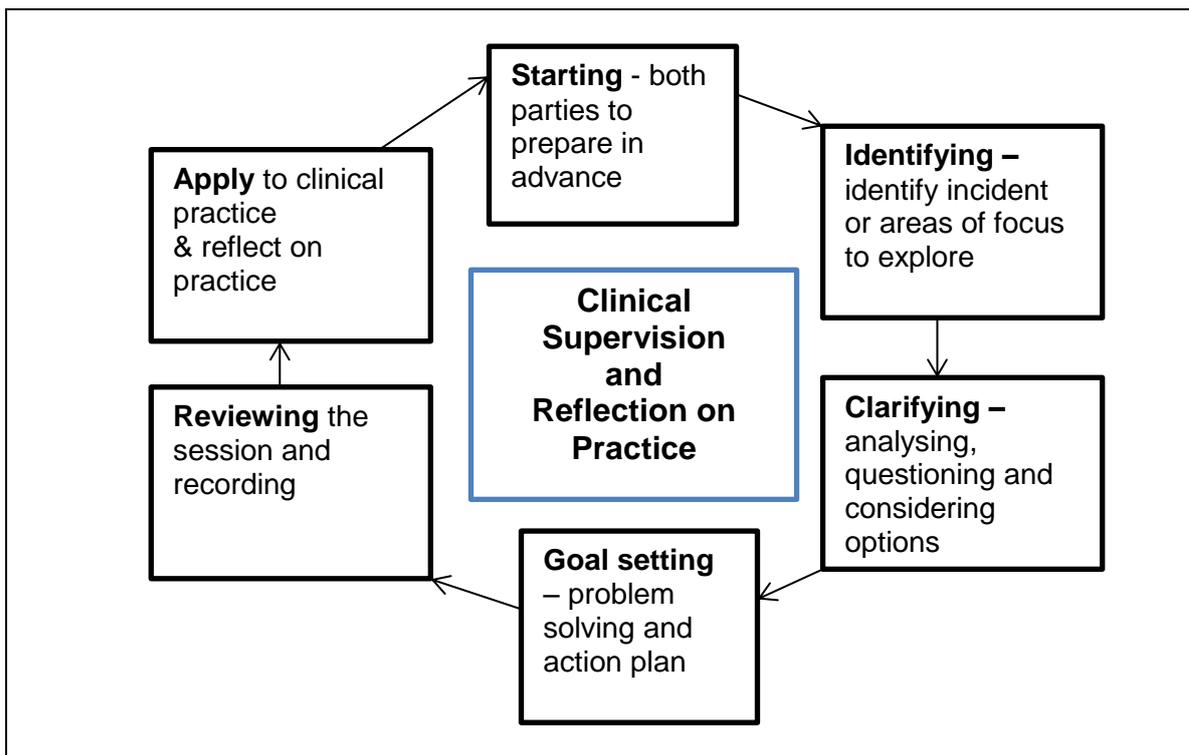
5.2. Clinical supervision should be monitored as part of an individual's performance review.

5.3. The professional portfolio is an integral part of maintaining professional registration. It provides a focus for the recording of experience and professional development. Documenting either individual clinical supervision or the long term benefits to the individual and their own practice in a portfolio can therefore be seen as a legitimate way of demonstrating lifelong learning. The supervisor's skills should assist the supervisee to reflect and focus on their current practice, any development needs and interpersonal requirements or challenges. As a result outcomes can be acted on or used in personal development planning. Outcomes may be entered into a professional portfolio to assist practitioners to meet post-registration requirements.

6. Access and Process

- 6.1. There are 3 core principles that should be met:
1. At least 2 people should meet for the purpose of clinical supervision.
 2. Supervision should be used to focus upon practice and actions identified.
 3. Meetings are structured, organised and documented.

6.2. Clinical supervision model



6.3. Clinical supervision can be accessed in various ways. It should be recognised that an individual's needs may be different at different times. At present the training programme concentrates on promoting all types of clinical supervision as many skills are transferable.

One-to-one supervision

- Clinical supervision.
- Peer supervision.
- Management Supervision.

Group supervision.

- Group supervision with a facilitator.
- Peer group supervision.
- Action Learning Set.
- Team meetings incorporating reflective discussion.

6.4. Every member of staff will be encouraged to access clinical supervision using a method to meet their needs for 1 hour every 2 months as a minimum.

6.5. Best practice indicates that staff accessing clinical supervision should attend a clinical supervision training session. This should be supported by managerial staff, when the training provision is available.

6.4.1. Good supervision relies on trust and therefore a supervisee has a right to expect the content of the session to remain confidential. However confidentiality within clinical supervision has limits and it may be breached when:

- The supervisee has broken their code of conduct
- The supervisee has acted illegally
- There is a risk to patients
- There is a risk to the individual, the public or other members of staff

6.4.2. If it is necessary to break confidentiality then these are the steps the supervisor should follow:

- Discuss the issue with the supervisee and encourage them to take appropriate action with an appropriate time limit.
- If this does not happen the supervisor may break confidentiality but should ideally inform and discuss with the supervisee first. Although it is acknowledged there may be times when this is not possible and in those circumstances the reasons for not discussing this with the supervisee should be documented.

6.5. It is essential that a supervisor seeks advice and guidance if they are concerned about the content of any supervision session. This may be by using the appropriate policies such as Whistle Blowing, Bullying and Harassment, or by managerial or supervision support. Guidance may also be sought from the Professional Practice team and HR department as appropriate for to the supervisor in dealing with any concerns raised in reflective sessions

7. Documentation

7.1. All supervision undertaken should use the documentation in appendix 1 or similar local documentation. It is recommended that for staff refusing to undertake supervision that this is documented and kept by the manager.

7.2. Before signing the contract the following issues will need to be discussed:

- Frequency and duration of sessions.
- Arrangement for documentation and records.
- Ground rules.
- Confidentiality agreements.
- Action plans.

7.3. A written record of items discussed, decisions made and agreed actions in an action plan should be produced as an outcome of each session and brought to the next session in order that actions agreed at the previous session can be followed up.

7.4. Where learning and development needs are identified the supervisee should ensure that these are included on the action plan.

7.5. The documentation will be kept by the supervisee in a safe place and must present it at appraisal and if requested by their manager. This should be kept for seven years in line with the Care Trust Retention & Disposal Schedule.

7.6. These records should be recognised as a legal document.

8. Training

8.1 Training, support and a toolkit can be accessed through the Lead for Clinical and Placement Education.

9. Monitoring, Auditing, Reviewing and Evaluation

9.5. The policy will be reviewed every 2 years.

9.6. Further review will occur should practice significantly change, new evidence arises or compliance is not effective.

10. References

Bishop, V (1998). Clinical Supervision: What is it? In: Bishop, V(ed.) Clinical Supervision in Practice Macmillan Press, London, p1-20

Bond, M. & Holland, S. (2001) **Skills of Clinical supervision for Nurses**. London: Open University Press.

Butterworth, T. & Faugier, J (Eds) (1992) **Clinical Supervision and Mentorship in Nursing**. London: Chapman and Hall.

CQC: Supporting information and guidance: Supporting effective clinical supervision (2013) Accessed online 26.5.16

https://www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf

Department of Health (2004) **Standards for Better Health**. London: The Stationary Office.

Hawkins, P. & Shohet, R. (2000) **Supervision in the helping professions**. London: Open University Press Buckingham.

Nursing and Midwifery Council (2004) **Code of Professional Conduct: standards for conduct, performance and ethics**. London: NMC.

Power, S. (1999) **Supervision: a guide for clinical practice**. London: Sage Press.

Royal College of Nursing (2000) **Clinical Supervision**. London: Royal College Nursing.

11. Appendices

[Appendix 1-Contract and record of supervision](#)

[Appendix 2 – Clinical Supervision for Nurses](#)

[Appendix 3- Implementing Clinical supervision in the workplace](#)

[Appendix 4- Facilitating Supervision Groups](#)

[Appendix 5 - Action Learning Groups](#)

[Appendix 6 – Frequently Asked Questions](#)

Contract and Record of Clinical Supervision

Name:

Workplace :

I agree to access regular supervision and to use the time to constructively reflect in depth on issues affecting my practice in order to develop personally and professionally towards achieving and sustaining high quality practice.

Signature:

Date:

Discussion Points.

1. Confidentiality (Must be discussed each time)
2. Educational
3. Professional
4. Therapeutic
5. Skills Development
6. Organisational
7. Other

The Supervisor signs each session to confirm that they have offered support and advice to enable supervision on issues affecting professional practice.

| Date | Time/ duration | Venue | Points discussed | Supervisor Signature | Action Plan Agreed | Type. Group/ 1:1 |
|------|-------------------|-------|---------------------|-------------------------|--------------------------|------------------------|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| Notes Arising from Clinical Supervision Sessions (To be completed for each session) | |
|---|-----------------------------|
| Name | Name of Supervisor |
| Date of Session | Venue |
| Topic(s) Discussed: | Notes on discussion: |
| <ul style="list-style-type: none"> 1. Confidentiality 2. Educational 3. Professional 4. Therapeutic 5. Skills Development 6. Organisational 7. Other | |
| Action Plan: | |
| | |
| Date to Achieve | |
| | |

Appendix 2

Clinical Supervision for nurses

It has been shown that around 60% of nurses do not undertake regular clinical supervision. This is worrying in view of the fact that the Nursing & Midwifery Council (NMC) supports undertaking clinical supervision as an important aspect of clinical governance to support clinicians in achieving high-quality standards of care. In the current climate of immense change, increasing targets, pressures and limited resources it could be argued that it has never been more important to ensure clinical supervision for frontline staff.

Clinical supervision provides a safe environment for clinicians to actively connect with each other to reflect on their clinical practice and improve standards of care. It allows them to reflect, think proactively and discover solutions to problems, such as dealing with difficult situations or conflict. Many of the professional issues clinicians face can be challenging and overwhelming, but being able to discuss these with peers can only enhance practice and individuals understanding of these to ultimately benefit practice in the wider context. The process of supervision facilitates the individual to develop knowledge and competence, and link theory and research to practice.

Time and resources are essential requirements if clinical supervision is to be implemented and it may be that this has had an impact on the progress of clinical supervision in recent years. It is essential that supervisors are adequately trained to undertake this role including receiving regular updates.

Clinical supervision is not mandatory and should not be managerially led if it is to be successful.

As nurses undertake new roles and responsibilities it is essential that support is available and clinical supervision is one of the many ways that this can be achieved. There are benefits to the individual in feeling valued, encouraging reflective practice and it helps practitioners to become more confident in the decision-making process.

The organisation also benefits from supporting clinical supervision for its staff. Essentially it improves patient care; it encourages dissemination of good practice and shared learning. It encourages motivation, innovation and job satisfaction, which in turn have an impact on staff turnover.

Clinical Supervision and similar models

Clinical supervision should not be confused with the following:-

Child Protection Supervision guides and supports the practitioner whilst also includes an element of performance management as the supervisor sets the agenda and monitors quality child protection standards

Preceptorship defined as a teaching and learning relationship in which a newly qualified practitioner is assigned a preceptor. The aim of Preceptorship is to support the growth and development of those who are newly qualified or new to the clinical area.

Mentorship – a term currently used to describe a relationship between a student in clinical placement and their clinical teacher e.g. a health visitor, district nurse or nurse practitioner.

Performance and Development Review is described as a system of individual performance review, combined with personal development planning for continuing professional development, this process is hierarchical in nature. The review will support the individuals work against the competencies required of the role

Caseload Supervision is a process by which practitioners caseloads will be regularly reviewed to support practitioners in the development of skills and knowledge to meet health needs of their client/patient group. This process will also include such aspects of the practitioner's work as record keeping, time management and adherence to clinical guidelines and PCT policies.

Case Supervision is when a practitioner seeks advice from a clinical expert to plan patient care with a specialist in that field of practice. eg health visitor from a member of child and family team, district nurse from a diabetic nurse specialist.

Managerial supervision

Managerial supervision is a meeting between the staff member and their line manager. They are confidential, two-way meetings. Managerial supervision sessions should follow an agenda to structure the meeting from both parties to ensure that nothing is missed

This can cover:

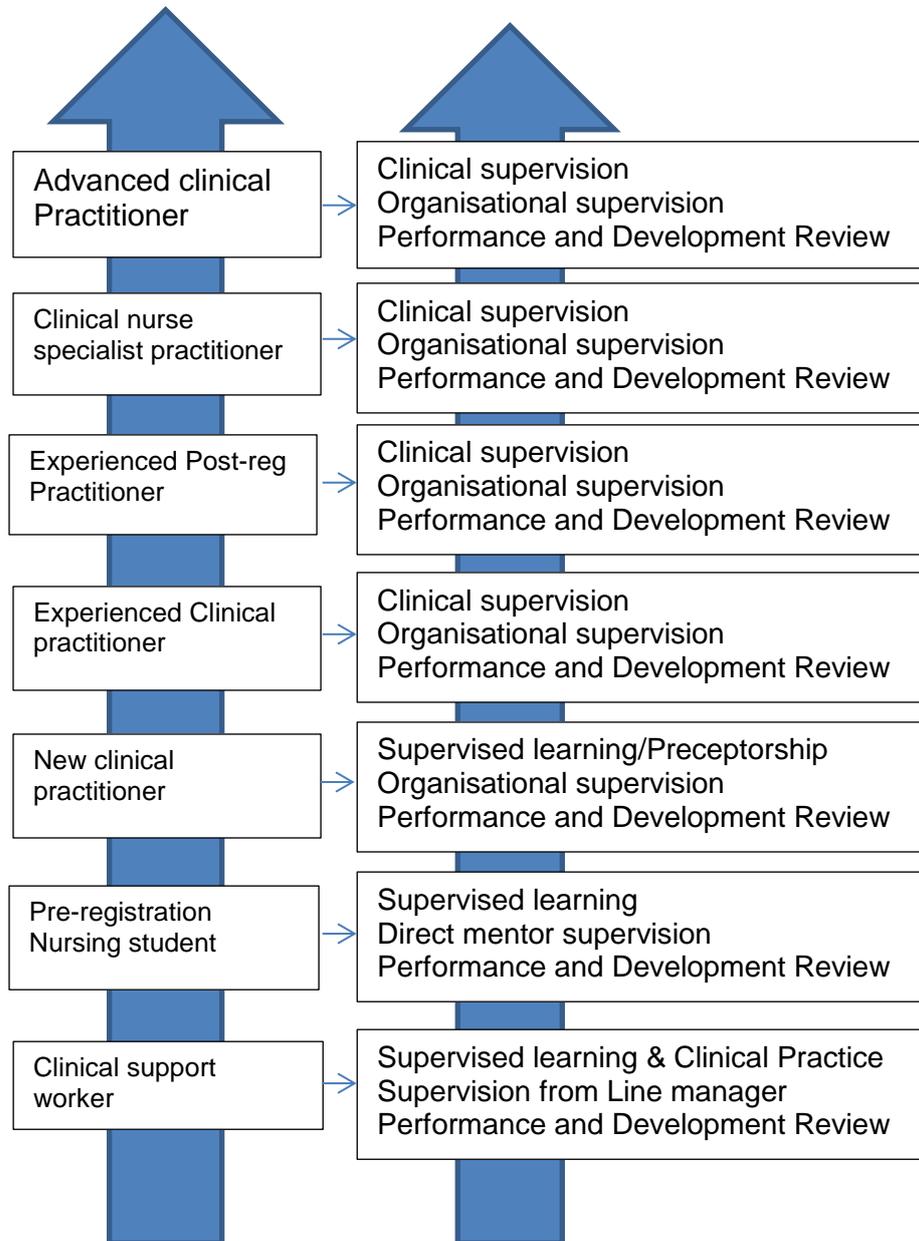
- Case management
- Planning and monitoring workload
- Ensuring quality of work
- Support or training needs
- Emotional support
- Ensuring health and safety
- Time management
- Motivation
- Administration
- Record Keeping

Clinical supervision is distinct from those models described above. The role of manager and clinical supervisor is separate from one another.

Clinical supervision is a self-directed process to establish, maintain and improve standards of care, whilst also providing an additional opportunity to reduce the distress which can occur from the complex clinical situations which occur in practice.

Overview of the Supervision Continuum in Nursing

There are a number of ways supervision can be organised (adapted Driscoll 2000)



Driscoll.J (2000) Practising Clinical Supervision – A Reflective Approach. Bailliere Tindall

Appendix 3

Implementing Clinical Supervision in the workplace



The need for professional staff to be able to reflect and discuss clinical issues in confidence has been well documented, but with time restraints this is not always possible. However, this type of learning has been shown to work well and has many bonuses' for all staff. With careful organisation and planning, staff can be given the opportunity to attend in work time, and encouraged to make the most of this time.

It may seem daunting to consider how you will ensure clinical supervision with your staff and it may be helpful to consider the following points:

- Do the staff in your area have an awareness of what clinical supervision is? If they don't then perhaps the first thing you need to do is provide a briefing session for them to help underpin the principles and the benefits of participating in it. You may have sufficient information to hand but if not refer to the policy and toolkit.
- When considering how to arrange supervision sessions it is helpful to negotiate with your staff how supervision sessions can be arranged. You could consider:
 - Group Supervision as a regular part of handover or team meetings. This can be run as an Action Learning Set (ALS), helping people to talk openly, listen carefully to each other and learn from experience.
 - Allowing 2 or more staff to take coffee breaks together for structured, peer supervision.
 - Groups or ALSs run at a set time of the week and/ or rostered onto the off duty. This enables a number of groups to meet regularly, ensure that the ward is covered and also enable all those who want to access supervision to do so. You will need to think about:
 1. The best time to hold supervision sessions.
 2. Allocating staff when off-duty rotas are completed.
 3. Arrangements if sessions fall during time off duty.
 4. Where sessions could be held.
 5. Whether staff should be asked to volunteer or be allocated to a group.
 6. If you hold regular one to one meetings with staff, you may decide to include a clinical supervision session as part of this.
- Don't forget, it is also helpful to take any difficulties that **you** may be experiencing to your own clinical supervision sessions.
- It is vital that all supervision, however achieved is documented and recorded, without breaching confidentiality issues. There are forms available for staff to use.

Appendix 4

Facilitating Supervision Groups
Points to remember

Managing or facilitating a group supervision or Action Learning Set so that everyone gets the most out of it is a skill that needs to be learnt and developed. A supervisor's role is to help people talk openly, listen carefully to each other and learn from experience. Unfortunately, there are no hard and fast rules about how to facilitate group supervision, only general guidelines. Through practice, and review of your practice, you will become better able to prepare and communicate ideas, encourage all participants to contribute their ideas and build on each other's contributions, achieve the objectives in the given time and motivate people to do any follow-up work. The following pointers will help you to do this:

- Keep the group on track and away from tangents.
- Making sure everyone participates and no one dominates. Invite participants: It's okay to ask people who haven't spoken if they'd like to contribute—this can be done in a tactful, inviting way.
- Keep an eye on the time! Move the discussion on, make sure learning is occurring and leave enough time to consolidate an action plan.
- Keep to the subject. If it becomes a 'chat' or a 'moaning' session move the discussion on!
- Make sure an action plan is made and that all participants know their responsibilities for the next session.
- Listen well: "Active listening" is crucial for good facilitation. It means total listening, instead of only partially listening while thinking about what you want to say next. The active listener thinks of himself or herself as the one whose main job is to help others express themselves.
- Intervene if problems come up, dealing with concerns.
- Make suggestions for how to move forward - after discussion has gone on for a while, try to summarize, look for agreement or sticking points, and come to decision.
- Focus on issues, not personalities.
- Have fun: A sense of humour is invaluable, especially when you're dealing with a controversial topic, or with a participant who won't stop talking.
- Let there be quiet: There's nothing wrong with silence. The job of the supervisor is not to fill every instant with talk. One of the best ways to get others to talk is by not talking.
- Be wary of judgments: In many discussions there is no "right" or "wrong" answer; the main point is to learn through supervision.

Enjoy! Relax and have a good time.

Appendix 5

Action Learning Sets

What is an Action Learning Set?

Action Learning Sets (ALS) is a dynamic and evolving group process that involves peer-discussion groups working to resolve individual workplace issues. They have been described as a:

‘Continuous process of learning and supervision supported by colleagues with an intention of getting things done, it aims to be beneficial to the organisation and the individual.’

What is involved?

ALSs involve meeting regularly with others in order to explore solutions to real problems and decide on the action to take. A group of 3 – 7 is recommended.

The stages include:

1. Describing the problem.
2. Receiving contributions from others in the form of questions.
3. Reflecting on discussion and deciding what action to take.
4. Reporting back on what happened when action taken.
5. Reflecting on the problem-solving process and how well it is working.

What happens in an ALS?

- At the start of the set, members establish a series of ground rules, which might include confidentiality, attendance and listening while others are speaking. These are reviewed at each subsequent set.
- One member of the set presents a professional issue for confidential discussion. This can be a clinical case, an incident or concern.
- Agreed time limits on presentation time should be set – 30 minutes is a realistic time.
- Other members seek clarification of what is involved by asking open questions and challenging the assumptions that the presenter makes.
- The presenter is responsible for making an action plan during the presentation.
- The impact of the action plans in practice become the starting point for discussion in the next meeting.
- Each member is accountable to the set for taking action and for reporting progress.
- After presenting their issue, members rotate and take part in the group.
- Scheduled meeting times are planned and supported by the manager.
- Attendance should be documented in the usual way as in Clinical Supervision

Enjoy! This is your time! Relax and have a good time

Appendix 6**Clinical Supervision – Frequently Asked Questions****What is Clinical Supervision?**

- This is a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety of care in complex clinical situations. It is central to the process of learning and to the expansion of the scope of practice and should be seen as a means of encouraging self assessment, analytical and reflective skills

Dept of Health (1993:15)

- Clinical Supervision brings practitioners and facilitators together to reflect on practice. It aims to identify solutions to problems, improve practice and increase understanding of professional issues

So what does it involve?

There are 3 core principles that should be met:

1. At least 2 people should meet for the purpose of clinical Supervision
2. Supervision should be used to focus upon practice and actions identified.
3. Meetings are structured, organized and documented

What could be discussed during Clinical Supervision?

- Organisational and managerial issues
- Clinical casework
- Clinical incidents
- Professional development
- Educational support
- Interpersonal issues
- Personal matters

How will I be encouraged to use Supervision?

- Promoted by trust and managerial staff as a valuable method of staff reflection and support and improved patient professional practice
- Time set aside of supervision
- Appropriate challenge and reflection in the absence of blame

What are the responsibilities of a facilitator?

- Encouraging Supervision
- Maintaining the boundary of time
- Maintaining the boundary of practice
- Maintaining confidentiality
- Maintaining the boundary of the relationship
- Encouraging the reflector to seek specialist help if necessary

How can I access Clinical Supervision?

- One to one sessions with a facilitator
- Peer group Supervision
- Group Supervision with colleagues
- Action Learning sets

How often should I access Clinical Supervision?

- Every member of staff will be encouraged to access clinical Supervision using a method to meet their needs for a minimum of 1 hour every 2 -3 months, a minimum of 4 times per year.

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

“The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves”. (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Quality Impact Assessment (QIA)

| <i>Please select</i> | | | | |
|--|---------------------------------|--------------------------|------------------------------|--------------------------|
| Who may be affected by this document? | Patient / Service Users | <input type="checkbox"/> | Visitors / Relatives | <input type="checkbox"/> |
| | General Public | <input type="checkbox"/> | Voluntary / Community Groups | <input type="checkbox"/> |
| | Trade Unions | <input type="checkbox"/> | GPs | <input type="checkbox"/> |
| | NHS Organisations | <input type="checkbox"/> | Police | <input type="checkbox"/> |
| | Councils | <input type="checkbox"/> | Carers | <input type="checkbox"/> |
| | Staff | <input type="checkbox"/> | Other Statutory Agencies | <input type="checkbox"/> |
| | Others (<i>please state</i>): | | | |

| | |
|--|--------------------------|
| Does this document require a service redesign, or substantial amendments to an existing process? | <input type="checkbox"/> |
| <i>If you answer yes to this question, please complete a full Quality Impact Assessment.</i> | |

| | | | | |
|---|-------------------------|--------------------------|---|--------------------------|
| Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity? | Age | <input type="checkbox"/> | Disability | <input type="checkbox"/> |
| | Gender re-assignment | <input type="checkbox"/> | Marriage and Civil Partnership | <input type="checkbox"/> |
| | Pregnancy and maternity | <input type="checkbox"/> | Race, including nationality and ethnicity | <input type="checkbox"/> |
| | Religion or Belief | <input type="checkbox"/> | Sex | <input type="checkbox"/> |
| | Sexual orientation | <input type="checkbox"/> | | |
| <i>If you answer yes to any of these strands, please complete a full Quality Impact Assessment.</i> | | | | |
| If applicable, what action has been taken to mitigate any concerns? | | | | |

| | | | | |
|---|----------------------------------|--------------------------|------------------------------|--------------------------|
| Who have you consulted with in the creation of this document? <i>Note - It may not be sufficient to just speak to other health & social care professionals.</i> | Patients / Service Users | <input type="checkbox"/> | Visitors / Relatives | <input type="checkbox"/> |
| | General Public | <input type="checkbox"/> | Voluntary / Community Groups | <input type="checkbox"/> |
| | Trade Unions | <input type="checkbox"/> | GPs | <input type="checkbox"/> |
| | NHS Organisations | <input type="checkbox"/> | Police | <input type="checkbox"/> |
| | Councils | <input type="checkbox"/> | Carers | <input type="checkbox"/> |
| | Staff | <input type="checkbox"/> | Other Statutory Agencies | <input type="checkbox"/> |
| | Details (<i>please state</i>): | | | |

Rapid Equality Impact Assessment *(for use when writing policies and procedures)*

| | | | | | |
|--|---|------------------------------------|---|---|---|
| Policy Title (and number) | | Clinical Supervision Policy | Version and Date | V4 6.8.16 | |
| Policy Author | | Bev Glanville Geake | | | |
| An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected. | | | | | |
| EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population? <i>PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below</i> | | | | | |
| Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below) | | | | | |
| Age | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Disability | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Sexual Orientation | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| Race | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Gender | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Religion/Belief (non) | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| Gender Reassignment | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Pregnancy/ Maternity | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Marriage/ Civil Partnership | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers ¹ ; travellers ² ; homeless ³ ; convictions; social isolation ⁴ ; refugees) | | | | | |
| Please provide details for each protected group where you have indicated 'Yes'. | | | | | |
| VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion | | | | | |
| Is inclusive language ⁵ used throughout? | | | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Are the services outlined in the policy/procedure fully accessible ⁶ ? | | | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Does the policy/procedure encourage individualised and person-centered care? | | | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Could there be an adverse impact on an individual's independence or autonomy ⁷ ? | | | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| If 'Yes', how will you mitigate this risk to ensure fair and equal access? | | | | | |
| EXTERNAL FACTORS | | | | | |
| Is the policy/procedure a result of national legislation which cannot be modified in any way? | | | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?) | | | | | |
| To support Trust staff | | | | | |
| Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions? | | | | | |
| Clinical and social care leads | | | | | |
| ACTION PLAN: Please list all actions identified to address any impacts | | | | | |
| Action | Person responsible | | Completion date | | |
| | | | | | |
| | | | | | |
| AUTHORISATION: | | | | | |
| By signing below, I confirm that the named person responsible above is aware of the actions assigned to them | | | | | |
| Name of person completing the form | Bev Glanville Geake | Signature | | | |
| Validated by (line manager) | | Signature | | | |

Please contact the Equalities team for guidance:

For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net
 For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdht@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation.