NHS
West Hampshire
Clinical Commissioning Group

CLINICAL SUPERVISION FOR NURSE AND AHP REGISTRANTS
ARRANGEMENTS WITHIN WEST HAMPSHIRE CCG

Version 3.3

Subject and version number of document:	Clinical Supervision for Nurse and AHP Registrants Arrangements within West Hampshire CCG Version 3.3
Serial number:	HR/033/V3.03
Operative date:	1 April 2020
Author:	Consultant Nurse for Safeguarding Adults Reviewed by Deputy Director of Quality & Nursing
CCG owner:	Director of Quality & Nursing (Board Nurse)
Links to other policies:	Safeguarding Adult and Children's Policy: A Family Approach
Review date:	April 2022
For action by:	All Nurse and Allied Health Professional (AHP) Registrants in the CCG
Policy statement:	The policy provides the practice framework for clinical supervision within the CCG. It is intended to support professional practice and development and thereby support safe and effective care.
Responsibility for dissemination to new staff:	Line Managers
Mechanisms for dissemination:	Team meetings All policies are published on the CCG website and all new and revised policies are promoted to staff through the CCG internal staff newsletter and through the intranet.
Training implications:	Many senior staff are already competent in the area of clinical supervision. Some staff have already received training. Where further training is required it can be provided by the document authors.
Resource implications	The policy is intended to be implemented within existing resource and the CCG will support the time required for clinical supervision as laid out in this policy.
Further details and additional copies available from:	Website https://westhampshireccg.nhs.uk/document-tag/clinical-and-su-policies/
Equality analysis completed?	Yes: see attached appendix E.

Consultation process	All Nurses and AHPs in the CCG Policy Sub Group
Approved by:	Policy Sub Group
Date approved:	11 March 2020

Website Upload:

Website	Location in FOI Publication Scheme	https://westhampshireccg.nhs.uk/document-tag/clinical-and-su-policies/
Keywords:	Supervision, Registrants	

Amendments Summary:

Amend No	Issued	Page(s)	Subject	Action Date
1	Aug 2016		Updates include: • Strengthening of requirement for supervision • Register of supervisors • Clarity around the choice of group or 1 to 1 supervision models • Reduce list of references	Aug 2016
2	May 2017		Refresh and updates include: • Strengthening the purpose and benefits of clinical supervision and reflection on action • Strengthening the theoretical foundations of the models of guided reflection on action • Addition of a third model of guided reflection for consideration by registrants • Strengthen the references and bibliography to support further reading and enquiry.	Jul 2017
3	Aug 2019	9, 11, 13, 15, 19 and from 24	Review in full. Strengthened references to AHPs and HCPC, updated EIA template used.	Aug 2019
4				
5				

Review Log:

Include details of when the document was last reviewed:

Version Number	Review Date	Reviewer	Ratification Process	Notes
2	August 2016	DD of Quality and Nursing	Policy Sub Group, Board September 2016	See amend 1 above.
3	May 2017	Consultant Nurse, Safeguarding Adults	Policy Sub Group and Board, July 2017	See amend 2 above.
3.03	Aug 2019	DD of Quality & Nursing	Policy Sub Group: November 2019 & March 2020	See amend 3 above

CLINICAL SUPERVISION FOR NURSE AND AHP REGISTRANTS: ARRANGEMENTS WITHIN WEST HAMPSHIRE CCG

Summary of Key Points to Note:

This policy provides the practice framework for clinical supervision within the CCG. It is intended to support professional practice and development and thereby support safe and effective care. Specifically:

- Clinical supervision is important as part of professional regulation and the CCG also supports it as an important component of revalidation. It is a vehicle to support nurses and Allied Health Professionals (AHPs) to improve care quality, to optimise risk management, as a way to monitor one's own performance, and to contribute to robust systems of accountability and responsibility. It can be mapped to the professional codes of conduct for revalidation purposes for nurses and AHPs.
- A supervisee has a right to expect the content of the session to remain confidential. However, should concerns be identified in the course of supervision about a staff member's conduct, competence or physical or mental health, the supervisor may need to disclose information from a supervision session to an appropriate person.
- Supervision can be delivered and accessed as individual (one to one) sessions, or alternatively as group supervision where groups or teams may choose to run a collective supervision for two or more individuals. It is the choice of the individual accessing supervision whether they access one to one supervision or group sessions (if available).
- Nurses and AHPs in front line roles, such as those working in the NHS Continuing Healthcare Team, should access at least eight sessions of clinical supervision in a 12 month period. Nurses and AHPs in non-front line roles, such as those working as a Quality Manager, should access at least four sessions of clinical supervision in a 12 month period.
- Supervisees should take an active role in their own personal and professional development and provide evidence of engagement in clinical supervision at quarterly and annual appraisal reviews.
- For most individuals the supervisor will be an employee of the CCG. Where an individual chooses a supervisor outside the CCG, this may be agreed as long as there is no cost attached. There may be occasions where, due to role specificity/seniority, external supervisors are required. This must be agreed with the person's line manager and the supervisee must be satisfied that the external supervisor is appropriately trained.

CLINICAL SUPERVISION FOR NURSE AND AHP REGISTRANTS: ARRANGEMENTS WITHIN WEST HAMPSHIRE CCG

CONTENTS

CLINICAL SUPERVISION FOR NURSE AND AHP REGISTRANTS: ARRANGEMENTS WITHIN WEST HAMPSHIRE CCG

1. INTRODUCTION AND PURPOSE

1.1 Clinical supervision can be defined as a formal process of professional support and learning which enables the practitioner to develop knowledge and competence, assume responsibility for their own practice, and enhance patient safety in clinical care. It also provides the opportunity to develop new knowledge and expertise, and to gain professional support which is especially important within professional roles. Clinical supervision aims to support nurses and Allied Health Professionals (AHPs) to provide holistic and person-centred care, and to safeguard patients from avoidable harm. Hence, through clinical supervision and the process of reflection, there is opportunity for professional growth.

1.2 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 (Care Quality Commission (CQC) 2013). Clinical supervision can support the acquisition of the skills and knowledge required in a developing, complex modern healthcare system which makes high demands on staff and can help to prevent stress and burnout. It can help staff to manage the personal and professional demands created by the nature of their work. This is particularly important for those who work with people who have complex and challenging needs, as clinical supervision provides an environment in which they can explore their own personal and emotional reactions to their work (CQC 2013).

1.3 Clinical supervision is important as part of professional regulation and the CCG also supports it as an important component of revalidation. It is a vehicle to support nurses and AHPs to improve care quality, to optimise risk management, as a way to monitor one's own performance, and to contribute to robust systems of accountability and responsibility. It can be mapped to the professional codes of conduct for revalidation purposes for nurses and AHPs.

2. SCOPE AND DEFINITIONS

Scope

2.1 This policy applies to all nurse and AHP registrants in the CCG.

Definitions

2.2 CQC (2013) defines clinical supervision and professional supervision separately as below;

‘Clinical supervision provides an opportunity for staff to:

- Reflect on and review their practice
- Discuss individual cases in depth, or issues with clinical and or/ professional implications
- 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’.

2.3 The CCG acknowledges the seniority of many nurses in the workforce and acknowledges that some of the components of both clinical and professional supervision as defined by CQC may therefore be included within clinical supervision depending on the issues raised and the professional role of the supervisee.

3. PROCESS / REQUIREMENTS

3.1 Optimising the opportunity

3.1.1 Of crucial importance is the value attached to reflection by an institution or profession. Optimising clinical supervision requires the commitment of both the organisation and the professionals within it. It requires not only a commitment in terms of resources, but the commitment of individuals to invest intellectually and emotionally in a supportive and interactive professional activity by using reflection on action. Rees (2007) found that reflection on action by nurses enabled them: *‘to engage with the struggle to locate themselves personally and professionally in the context of care, to establish and refine personal and professional values and beliefs, and to consider the realities of their nursing practice. Reflection enabled the participants to recognise and affirm that they had become nurses’* (2007, p.3).

3.1.2 Good clinical supervision relies on trust and therefore a supervisee has a right to expect the content of the session to remain confidential. The content of a supervision session will be agreed between the supervisor and supervisee. However, should concerns be identified in the course of supervision about a staff member's conduct, competence or physical or mental health, the supervisor may need to disclose information from a supervision session to an appropriate person. This would be discussed with the supervisee, explaining why it is a concern and why they need to raise the issue outside the supervisory relationship. In order to support this requirement, within the CCG all clinical supervisors of nurses will be senior nurses (current Registrants) themselves and all clinical supervisors of AHPs will be senior AHPs and therefore duty bound to raise any concerns. The supervisor and supervisee must sign the Clinical Supervision Agreement in Appendix A to formally agree to arrangements and key principles. The template can be found on the HR Portal.

3.2 Reflection on action

"Maybe reflective practices offer us a way of trying to make sense of the uncertainty in our workplaces and the courage to work competently and ethically at the edge of order and chaos…" (Ghaye, 2000, p.7)

3.2.1 Clinical supervision embraces the process of structured guided reflection on action. Reflection on action has its foundations in experiential learning. There are many models of reflection available within the contemporary literature, but as reflection is a personal activity, and experience may vary, the CCG will not prescribe a model for use. Some may prefer models which provide more prompts to guide the reflection. Others may feel more comfortable with a less structured approach. However, using a structured model can address the danger of only focusing on the negative aspects of the situation by moving through all the prompts provided and provide potential for professional growth. The approach chosen by the supervisee should be agreed with the supervisor and noted on the supervision record. Practitioners may wish to move between different models according to the situation chosen for reflection. Some of the available models are presented at Appendix D for the practitioner to consider.

3.3 Creating the right environment for effective supervision

3.3.1 In order for supervision to be effective it is essential that the right environment is created and maintained throughout the session. Empathy and rapport are important concepts within the relationship. Empathy is the capacity to recognise feelings that are being experienced by another person and trying to see the world from the other person's perspective. Rapport develops when two people feel

they relate well to each other, perhaps realising they share similar values, beliefs, knowledge or behaviours.

3.3.2 Also of importance is that there is a balance between challenge and rapport. Challenge should be honest and specific but have warmth and be supportive. The supervisor should also test any assumptions held by checking with the supervisee. In addition challenge may include;

- **Evidencing** – ask for examples to back up generalisation
- **Reality** – what would others think about the same situation? Can it really happen?
- **Consequence** – if you were to do this what would happen?
- **Sharing demonstrated strengths** – reflect back to supervisee any noted strengths when motivation is low
- **Examining patterns** – pick up on when supervisee has taken a similar approach and it worked
- **Mismatching** – when supervisee says they want to achieve something, but their body language disagrees – challenge commitment.

3.3.3 Trust can be developed between people as a consequence of their actions and behaviours towards each other:

- Warmth
- Openness
- Genuineness – really wanting to help the individual – being there in the moment with them
- Self-disclosure
- Investment.

3.3.4 Supervision can be delivered and accessed as individual (one to one) sessions, or alternatively as group supervision where groups or teams may choose to run a collective supervision for two or more individuals.

3.3.5 It is the choice of the individual accessing supervision whether they access one to one supervision or group sessions (if available).

3.3.6 Where group supervision is accessed, all group member supervisees must be in agreement with the approach. The size of any group for group supervision should be regularly discussed and agreed by the whole group at the following suggested opportunities:

- On initial set-up of the supervision group

- After each session
- When reviewing the effectiveness of the sessions.

Any limit on numbers should be agreed by the group.

3.4 Frequency of Supervision

3.4.1 Nurses and AHPs in front line roles, such as those working in the NHS Continuing Healthcare Team, should access at least eight sessions of clinical supervision in a 12 month period.

3.4.2 Nurses and AHPs in non-front line roles, such as those working as a Quality Manager, should access at least four sessions of clinical supervision in a 12 month period.

4. ROLES AND RESPONSIBILITIES

4.1 The CCG supports the principles which CQC (2013) espouse in relation to the roles and responsibilities of supervisors and supervisees, because effective clinical supervision relies on a good working relationship between these parties.

4.2 Supervisee

a) Prepares well for supervision sessions, which includes identifying issues from their practice for discussion with their supervisor and mapping these to the Nursing & Midwifery Council (NMC) Code or Health and Care Professions Council (HCPC) for revalidation purposes.

b) Takes responsibility for making effective use of time, and for the outcomes and actions taken as result of the supervision.

c) Take an active role in their own personal and professional development, keeping written records of their supervision sessions in the CCG format (Appendix B). The template can be found on the HR Portal.

d) Provide evidence of engagement in clinical supervision at quarterly and annual appraisal reviews.

4.3 Supervisor

a) Have current professional registration with the appropriate professional body (e.g. NMC, HCPC).

b) Be on the same professional register as the supervisee.

c) Be appropriately trained, having accessed clinical supervision training. Supervisees are encouraged to ask external supervisors to provide evidence of their supervision training.

d) Adopt a supportive and facilitative approach to help supervisees to identify issues, manage their response to their practice and identify personal and professional development needs.

e) Ensure a supervision contract is in place so that both supervisor and supervisee are aware of roles, responsibilities and boundaries.

f) Keep a record of supervision sessions, reviewing any action plans in the CCG format (Appendix C). The template can be found on the HR Portal.

g) Act appropriately to share information in line with the NMC Code, or other professional code of conduct for AHPs, where there are serious concerns about the conduct, competence or health of a practitioner.

h) Keep up to date with their own professional development including ensuring that they have access to their own supervision.

4.4 Departmental managers

a) Departmental managers will ensure that clinical supervision is well supported within the culture of professional practice in the department.

b) They will support the necessary resource allocation and monitor the uptake of clinical supervision through '1 to 1' meetings, annual appraisals and quarterly appraisal reviews.

c) Departmental managers will ensure staff are supported to access their choice of either individual supervision, or group supervision sessions, or if desired a mixture of both approaches.

d) Departmental managers will ensure all registered nurses and AHPs access supervision at a frequency in line with this policy.

5. TRAINING

5.1 It is acknowledged that some senior nurses within the CCG will have many years of experience of providing clinical supervision and may judge themselves as competent in this area. However, some may want a refresher and for some it may be a new role. The CCG will provide training for supervisors.

5.2 Choosing a supervisor

5.2.1 The CCG anticipates that for most individuals the supervisor will be an employee of the CCG. Where an individual chooses a supervisor outside the CCG, this may be agreed as long as there is no cost attached. There may be occasions where, due to role specificity/seniority, external supervisors are required. This must be agreed with the person's line manager and the supervisee must be satisfied that the external supervisor is appropriately trained. All supervisors will be at Band 7 and above.

5.2.2 The choice of supervisor is the decision of the individual nurse or AHP. Supervisors will be outside of the immediate line management structure, and ideally will be chosen from outside of the individual's immediate team.

5.2.3 The CCG will develop a register of supervisors to support staff to identify and access a potential supervisor.

5.2.4 Individual supervisors should manage their own capacity to provide clinical supervision. Ideally an individual supervisor should not support more than four supervisees at any one time. Some supervisors may only have capacity to support one supervisee at any one time.

6. EQUALITY ANALYSIS

6.1 The CCG is committed to equality, diversity and inclusion for all, as well as to meeting the Public Sector Equality Duty (Equality Act 2010).

6.2 Both new policies, and existing policies when reviewed, come within the Public Sector Equality Duty. This means that policy authors must consider whether the policy will be effective for all patients and / or staff. This process is called equality impact assessment.

6.3 An equality analysis has been conducted and is attached to this policy (see Appendix E).

6.4 In order to minimise potential negative impact, where a supervisee has a disability the supervisor will ensure that reasonable adjustments are put in place to ensure supervision sessions are accessible to that nurse or AHP. This may include ensuring the venue for supervision meetings or group sessions is accessible; or that where a supervisee has accessible information or communication support needs, that notes are provided in a format suitable for them or that a sign language interpreter is arranged for example.

6.5 Similarly where a supervisee(s) works part-time, or has childcare responsibilities, the supervisor should try to take this into account so that the time, day or venue does not prevent access to supervision.

6.6 Where a supervisor does not feel confident to resolve cultural issues raised by a supervisee they will seek the support of a colleague or the equality and diversity lead

6.7 Where a supervisee raises concerns that relate to discrimination the supervisor will ensure that the matter is dealt with in line with the CCGs Conduct, Performance, Grievance & Absence Management Policy and the Equality, Diversity and Human Rights Policy. Supervisors and supervisees should be aware that their or the patient's unconscious bias or prejudice may impact on clinical care and this may need to be explored in supervision.

6.8 The policy intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

7. SUCCESS CRITERIA / MONITORING THE EFFECTIVENESS OF THE POLICY

7.1 The success of the policy will be demonstrated through the implementation of clinical supervision for nurses and AHP's assessed by line managers at appraisal.

7.2 Line managers will monitor engagement with clinical supervision through the submission of the form at Appendix A for the relevant members of their team; supervisees will submit a copy of Appendix A to their line manager for recording on their local personal file.

7.3 Line managers will monitor the frequency of uptake at 1 to1 meetings, quarterly appraisal reviews and annual appraisal.

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed on a biennial basis.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

Resources and References

Care Quality Commission. 2013. *Supporting information and guidance: Supporting effective clinical supervision.* CQC. Nottingham

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Johns C. 2000. *Becoming a Reflective Practitioner.* Blackwell Publishing. Oxford

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Appendix A Clinical Supervision Agreement

NHS
West Hampshire
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Clinical Supervision Agreement

Supervisee Name	
Supervisor Name	
Commencement Date	
Review Date	
Frequency of Supervision	
Duration of Supervision	
Venue	
Model of Reflection	
Supervision Environment (1 to 1 or group)	

SUPERVISOR

As a supervisor, I take responsibility for:

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

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

SUPERVISEE

As a supervisee, I take responsibility for:

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

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

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SUPERVISEE & SUPERVISOR

We shall take shared responsibility for:

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

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

We agree to keep all discussions during clinical supervision confidential. There is a legal duty of care that may override confidentiality in exceptional circumstances, such as where the supervisee describes unsafe, unethical or illegal practice and is unwilling to go through appropriate procedures to address these after initial discussions between supervisee and supervisor.

Supervisees signature:
……

Date: ……

Supervisors signature:
……

Date: ……

COPY TO BE FORWARDED TO SUPERVISEE'S LINE MANAGER

Appendix B Supervision Record (Supervisee)

NHS
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Supervision Record (Supervisee)

Name of Supervisee:

Date: Time of Session: Venue:

Role:

Name of Supervisor:

Role:

Model of Reflection employed:

Supervision Environment (1 to 1 or group):

Main points for discussion	Links to NMC / HCPC Code	Learning and actions
1.		
2.		
3.		
4.		
5.		

Signed (Supervisor):

Signed (Supervisee):

Appendix C Supervision Record (Supervisor)

NHS
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Clinical Commissioning Group

Supervision Record (Supervisor)

Name of Supervisee:

Date: Time of Session: Venue:

Role:

Name of Supervisor:

Role:

Model of Reflection in Use:

Supervision Environment (1 to 1 or group):

Main points discussed	Learning and actions

Signed;

Supervisor;

Appendix D Examples of Clinical Supervision Models

CLINICAL SUPERVISION MODELS

Gibbs (1988) Reflective Cycle

A useful model of reflection put forward by Gibbs in 1988 has been cited as remaining relevant for clinical supervision in nursing by Johns (2000 p.49). Gibbs' reflective cycle encourages you to think systematically about the phases of an experience or activity, and you should use all the headings to structure your reflection to support forward moving and learning. However, models such as Gibbs' can provide useful questions to structure reflection but it has been argued that a broader, more critically reflexive approach is needed. Each practitioner needs to find which model suits their needs. The model is presented below.

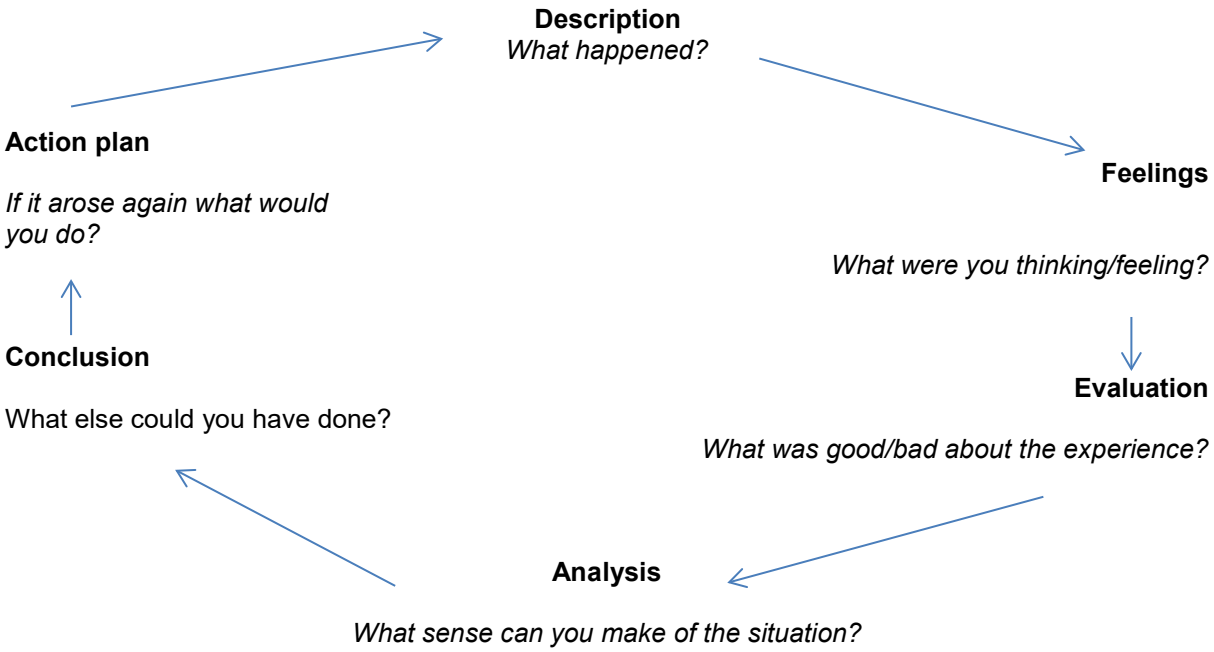

Diagram: Gibbs 1998 Reflective Cycle

Holm and Stephenson's (1994) model of guided reflection

This may also be a useful model to consider. Holm and Stephenson (1994) suggest a series of prompt questions. Not all questions will be appropriate in all situations and it may be appropriate to ask some questions more than once at different points during your reflection.

- Did I feel comfortable or uncomfortable? Why?

- What actions did I take?
- How did I, and others, act?
- Was it appropriate?
- How could I have improved the situation for myself, the patient, my mentor?
- What can I change in the future?
- Do I feel as if I have learnt anything new about myself?
- Did I expect anything different to happen? What and why?
- Has it changed my way of thinking in any way?
- What knowledge from theory and research can I apply to this situation?
- What broader issues, for example, ethical, political or social, arise from this situation?
- What do I think about these broader issues?

John's Ten C's of Reflection

Another useful model of guided reflection is Johns (2000 p.36) Ten C's of reflection which is presented below. Carper's (1978) fundamental patterns of knowing is a typology that attempts to classify the different sources from which knowledge and beliefs in professional practice can be, or have been derived. Johns also uses Carper's (1978) four patterns of knowing, aesthetics, personal, ethics and empirics adding a fifth pattern 'reflexivity'. This model provides a way of challenging our natural tendency to judge ourselves too harshly. It also challenges the assumption that empirical knowledge alone is inadequate for professional practice. John's model is especially useful for more complex situations. Johns considered that through sharing reflections on learning experiences greater understanding of those experiences could be achieved than by reflection as a lone exercise.

- **Commitment -** Believing that self and practice matter; accepting responsibility for self; the openness, curiosity and willingness to challenge normative ways of responding to situations
- **Contradiction -** Exposing and understanding the contradiction between what is desirable and actual practice
- **Conflict -** Harnessing the energy of conflict within contradiction to become empowered to take appropriate action.
- **Challenge and support -** Confronting the practitioner's normative attitudes, beliefs and actions in ways that do not threaten the practitioner
- **Catharsis -** Working through negative feelings
- **Creation -** Moving beyond self to see and understand new ways of viewing and responding to practice

- **Connection -** Connecting new insights within the real world of practice; appreciating the temporality of experience over time
- **Caring -** Realising desirable practice as everyday reality
- **Congruence -** Reflection as a mirror for caring
- **Constructing Personal Knowledge in Practice -** Weaving personal knowing and experiences with relevant existing theory in constructing knowledge in practice.

Equality analysis

Title of policy, project or proposal:
Clinical Supervision for Nurse and AHP Registrants: Arrangements within West Hampshire

Lead director:	Director of Quality & Nursing
Directorate:	Quality

Q1 What are the intended outcomes of this policy, project or proposal?

The clinical supervision policy intends to have a positive impact for nurses and Allied Health Professionals (AHPs) with characteristics protected by the Equality Act 2010. This will be achieved by ensuring all health professionals covered by the policy receive, and benefit from, regular clinical supervision irrespective of their age, disability status, gender, marriage or civil partnership, pregnancy or maternity, religion or belief, race or sexual orientation. Clinical supervision also provides staff with a chance to reflect on practice and explore the impact of attitudes and assumptions when working with diverse patients and their carers.

Q2 Who will be affected by this policy, project or proposal?

- Clinical supervisors
- Nurses and Allied Health Professionals employed by the CCG (supervisees)

Evidence

Q3 What evidence have you considered?

- West Hampshire CCG Workforce Diversity Profile 2018/19

Note: We do not currently collate data on the number, working pattern and protected characteristics of nurses and Allied Health Professionals employed by the CCG and covered by this policy. We will do this prior to the next policy review.

Age

The CCG Workforce Diversity Profile 2018/19 gives an indication of the age profile of employees (snap shot date 31 December 2018):

	2013	2014	2015	2016	2017	2018	Comparator
Total number of employees	190	197	204	229	275	**322**	
Age group							**National CCG workforce**
16-24	3.7%	2%	1.5%	1.7%	2.2%	**4%**	2%
25-44	28.9%	35.5%	35.3%	37.6%	40%	**42%**	43%
45-64	65.8%	60.4%	60.8%	59.4%	56.4%	**53%**	53%
65+	1.6%	2%	2.5%	1.3%	1.5%	**1%**	2%

- The age profile of the CCG workforce has been shifting year-on-year with a gradual increase in 25-44 year olds, and a decrease in staff aged 45-64 (although this older age group still make-up the majority the workforce).
- Employees aged less than 24 years and over 65 years, make-up a small proportion of the workforce at just 4% and 1% respectively.

All health professionals covered by the policy will receive, and benefit from, regular clinical supervision regardless of their age.

The policy intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

Disability (physical and mental)

The CCG Workforce Diversity Profile 2018/19 gives an indication of disability amongst employees (snap shot date 31 December 2018):

	2013	2014	2015	2016	2017	2018	Comparator
Total number of employees	190	197	204	229	275	**322**	
Disability							**National CCG workforce**
No disability	-	31%	72.5%	76.4%	77.1%	**78%**	71%
Yes I have a disability	-	1%	2%	4%	3%	**4%**	3%
Prefer not to say	-	19.8%	21.1%	16.2%	10.9%	**8%**	0%
Undefined	-	48.2%	4.4%	3.9%	8.7%	**10%**	26%*

- The proportion of declared disability in the CCG workforce remains low and does not reflect levels of disability in the local population (7%).

All health professionals covered by the policy will receive, and benefit from, regular clinical supervision regardless of their disability status.

In order to minimise potential negative impact, where a supervisee has a disability the supervisor will ensure that reasonable adjustments are put in place to ensure supervision sessions are accessible to that nurse or AHP. Examples have been added to section 6 of the policy to help supervisors achieve this.

The policy also intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

Dementia

As far as we know no employees have a diagnosis of dementia.

The policy intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

Gender reassignment (including transgender)

The policy intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

All health professionals covered by the policy will receive, and benefit from, regular clinical supervision regardless of their gender identity.

Where a supervisee raises concerns that relate to discrimination the supervisor will ensure that the matter is dealt with in line with the CCGs Conduct, Performance, Grievance & Absence Management Policy and the Equality, Diversity and Human Rights Policy.

Marriage and civil partnership

No impact.

All health professionals covered by the policy will receive, and benefit from, regular clinical supervision regardless of their marital or civil partnership status.

Pregnancy and maternity

The policy intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

All health professionals covered by the policy will receive, and benefit from, regular clinical supervision regardless of their of pregnancy / maternity / paternity status.

The Nursing and Midwifery Council (NMC) do not require nurses to complete supervision whilst on maternity leave in order to maintain their professional registration. Continuing Professional Development and clinical practice hours must be maintained however.

Race

The CCG Workforce Diversity Profile 2018/19 gives an indication of the ethnic make-up of employees:

	2013	2014	2015	2016	2017	2018	Comparator
Total number of employees	190	197	204	229	275	**322**	
Ethnic background							**Local population**
White British	-	69.6%	80.9%	86.5%	84.7%	**84%**	93%
Any other White background	-	2%	3.5%	3.1%	3.3%	**3%**	3.1%
Mixed ethnicity	-	0.5%	1%	1%	1%	**2%**	1.2%
Black, Asian and Minority Ethnic	-	2.5%	3%	3%	4%	**5%**	4.1%
Other specified	-	0%	0.5%	0.4%	1.8%	**0%**	0.2%
Undefined/ not stated	-	25.3%	11.3%	6.1%	4.7%	**6%**	0%

- The proportion of staff from 'White other' ethnic backgrounds reflects the ethnic diversity of local population. This includes staff from European backgrounds
- For the first time since 2013, this year the proportion of employees from 'Black, Asian and Minority Ethnic' and 'Mixed' ethnic backgrounds is higher than the ethnic diversity of the local population. Previously these groups were under-represented in the workforce.

All health professionals covered by the policy will receive, and benefit from, regular clinical supervision regardless of their ethnic background.

The policy intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

Where a supervisor does not feel confident to resolve cultural issues raised by a supervisee they will seek the support of a colleague or the equality and diversity lead

Where a supervisee raises concerns that relate to discrimination the supervisor will ensure that the matter is dealt with in line with the CCGs Conduct, Performance, Grievance & Absence Management Policy.

Religion or belief

The CCG Workforce Diversity Profile 2018/19 shows there remain significant data gaps for the employee protected characteristic of religion or belief. This means we do not know the faith

profile of the workforce.

	2013	2014	2015	2016	2017	**2018**
Religion or belief						
Atheism	-	5.1%	6.4%	7%	11.6%	**14%**
Christianity	-	15.2%	33.8%	37.6%	40.7%	**41%**
Other	-	0%	10.3%	12.6%	11.6%	**13%**
Prefer not to say	-	33.5%	48.5%	40.2%	30.9%	**25%**
Undefined	-	45.2%	1%	3%	5%	**7%**

All health professionals covered by the policy will receive, and benefit from, regular clinical supervision regardless of their religion or belief.

The policy intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

Where a supervisor does not feel confident to resolve cultural issues raised by a supervisee they will seek the support of a colleague or the equality and diversity lead

Where a supervisee raises concerns that relate to discrimination the supervisor will ensure that the matter is dealt with in line with the CCGs Conduct, Performance, Grievance & Absence Management Policy.

Sex (gender)

The CCG Workforce Diversity Profile shows that on 31 December 2018:

- 79.5% of employees were female
- 20.5% were male.

The gender balance of the workforce has remained similar since 2013, at around 80% female and 20% male.

All health professionals covered by the policy will receive, and benefit from, regular clinical supervision regardless of their gender.

The policy intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

Where a supervisee raises concerns that relate to discrimination the supervisor will ensure that the matter is dealt with in line with the CCGs Conduct, Performance, Grievance & Absence Management Policy.

Sexual orientation

All health professionals covered by the policy will receive, and benefit from, regular clinical supervision irrespective of their sexual orientation.

The policy intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

Where a supervisee raises concerns that relate to discrimination the supervisor will ensure that the matter is dealt with in line with the CCGs Conduct, Performance, Grievance & Absence Management Policy.

Carers

The policy intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

Serving Armed Forces personnel, their families and veterans

The policy intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

Meeting psychological needs

The policy intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

Other identified groups

The policy intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

Involvement and consultation

For each engagement activity, briefly outline who was involved, how and when they were engaged, and the key outputs.

Q4 How have you involved stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?

Not applicable.

Q5 How have you involved stakeholders in testing the policy or programme proposals?

Not applicable.

Q6 For each involvement activity, please state who was involved, how and when they were engaged, and the key outputs:

Not applicable.

Equality statement

Positive impacts

The policy intends to have a positive impact for patients and carers who receive care and clinical support from nurses and AHPs. This is because clinical supervision will improve the quality of care provided, and help ensure clinical interactions are culturally sensitive.

In order to minimise potential negative impact, where a supervisee has a disability the supervisor will ensure that reasonable adjustments are put in place to ensure supervision sessions are accessible to that nurse or AHP.

Where nurses and AHPs work prat-time, or have child care or caring responsibilities, supervisors will try to arrange supervision sessions on days, times or at venues that do not create barriers to accessing sessions.

Where a supervisor does not feel confident to resolve cultural issues raised by a supervisee they will seek the support of a colleague or the equality and diversity lead

Where a supervisee raises concerns that relate to discrimination the supervisor will ensure that the matter is dealt with in line with the CCGs Conduct, Performance, Grievance & Absence Management Policy and the Equality, Diversity and Human Rights Policy.

Negative impacts

N/A

Health inequalities

N/A

Action planning for improvement, and to address health equalities and discrimination

Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.

Action	Person responsible	By date	Progress/ review (Add new actions if required)
1. Ongoing monitoring to ensure all nurses and AHPs can access good quality supervision and that supervisees' feedback is positive	Deputy Director of Quality and Nursing	Ongoing	To be considered at next policy review
2. We will work with Human Resources to gather data on the numbers, working pattern and protected characteristics of nurses and Allied Health Professionals	Equality and Diversity Manager and HR Advisor	31 December 2019	

For your records	
Person who carried out this assessment: Consultant Nurse: Safeguarding Adults	
Date assessment completed:	1 July 2015
Date to review actions:	
Responsible Director:	Deputy Director of Quality & Nursing
Date assessment was approved:	13 November 2019