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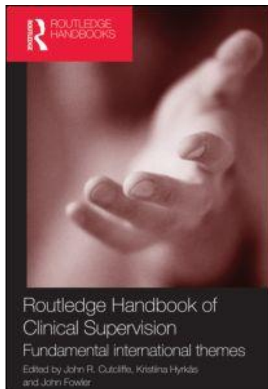

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Implementing clinical supervision in a National Health Service Community Trust

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Fundamental international themes

Edited by John R. Cutcliffe, Kristiina Hyrkäs and John Fowler

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11 Implementing clinical supervision in a National Health Service Community Trust

Sharing the vision

Jenny Bennett, Bob Gardener and Fiona James

This chapter outlines how a group of practitioners (lead professionals) facilitated the widespread implementation and development of clinical supervision within a NHS Community Trust. Drawing on the experiences of health visitors, general nurses and community psychiatric nurses, the authors describe the phases or stages of this implementation process. Furthermore, they describe their particular roles involved in the implementation and use case examples of the introduction of clinical supervision into each practice discipline. The chapter concludes with reflections on the implementation process and identifies some of the barriers to introducing clinical supervision.

The widespread introduction of clinical supervision within the NHS is not a development that can be introduced using a 'quick fix' technique. We believe that in order to bring about the widespread introduction, a shift in culture throughout the NHS may be required, a shift towards a culture that welcomes and encourages the examination of one's practice, the ventilation of any feelings, openness and transparency within practitioners, and views such endeavours as supportive, necessary and enabling.

Introduction

This chapter describes how a group of three lead professionals underwent the task of facilitating the implementation and development of clinical supervision (CS) within our Community Health Care Trust. Our organisation is a Community Trust including several community hospitals which serves a wide geographical area with both rural and urban locations with a population of 370,000. Our roles as lead professionals were new within our organisation and were part of the Quality and Professional Development Directorate, which took the lead on the clinical governance agenda. We had specific responsibility for the facilitation of professional and practice development within our nursing disciplines of community hospital nursing, mental health nursing and health visiting.

A central aspect of the role of lead professional for the first two years of the post was the promotion, implementation and development of CS. We were to focus on our own nursing disciplines but also to forward recommendations for the long-term strategic implementation of CS throughout the organisation. Our implementation plans were guided by:

- *The national United Kingdom picture* – responding to national policy documents on the health service and the development of nursing which highlighted the

need for lifelong learning and the role of CS in providing a quality service (UKCC 1996; Department of Health 1997, 1998).

- *Local picture* – within our organisation a comprehensive nursing review had recently been conducted, guided by the document *A Vision for the Future* (Department of Health and NHS Management Executive 1993). All of the nursing disciplines involved in our Community Trust identified a role for CS in supporting clinical practice and a major recommendation was to plan for its introduction.

Throughout this chapter we therefore describe how we worked in our own nursing disciplines to facilitate the implementation of CS. This involved working with community mental health teams, health visitors working within primary health care teams and the wards/departments of community hospitals.

Planning

Following our appointment as lead professionals we allocated time to enable all three of us to have a full discussion and debate on CS. This was guided by our experience of CS, our own beliefs about its value and limitations, discussions with other colleagues and the extant literature on CS. As a group we had a shared belief in the value of CS to be able to provide a pathway to improving the quality of services provided by clinicians. We debated the role, purpose and function of CS and adopted the three interactive elements of educative, supportive and personal management and monitoring, as the primary functions of CS depicted in Proctor's model (1991; see also Chapter 3 in this book). We found that this common understanding and agreement on the function of CS was essential in enabling us to share a vision of how we could facilitate the implementation and development of CS and communicate this to others.

We used the knowledge and understanding we had gained during our discussion to produce a project plan. The stages of the rational planning process, described in Box 11.1, guided the production of our project plan:

Box 11.1 Identified stages of the planning process

- What are we trying to do?
- What is the best way of doing it?
- What are we going to have to do?
- In what order?
- What resources will we need?
- Let's review it: is it going to work?
- Who is going to do what and when?

Through this planning process we were able to identify the practical tasks we would need to undertake and the personal, professional and organisational issues we would need to address. We set ourselves clear objectives with timescales for review. *A central tenet supporting the project plan was for us to openly express our enthusiasm for and belief in CS, inspiring others to be involved in developing a true shared vision of the*

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potential of CS in enhancing the quality of clinical practice. A shared vision has been shown to be an important element in achieving successful organisational change (Kouzes and Posner 1995; Poole *et al.* 2000). We would be seeking to develop relationships that encouraged others to become actively involved and inspired to participate in the change process. Bass and Avolio (1994) and Guastello (1995) describe how this approach can transform work areas to become more productive and more responsive to change.

In her discussion on introducing CS, Kohner (1994) highlighted the need for all staff (clinician, managers and administrators) to be involved in the local process of planning for its introduction. We wanted to engender an approach to change that encouraged commitment and used the strengths and creative ideas of practitioners. Therefore our approach to the implementation and development of CS was to encourage its introduction from the practitioner level in the first instance and was underpinned by the following principles:

1 To build on the good practice that was already taking place within the organisation with respect to CS.
2 To provide information, advice and support to practitioners that would facilitate individual areas to make informed decisions as regard to the implementation and development of CS.
3 To respond enthusiastically to the positive requests from individual areas within our organisation with regard to their desire to implement/develop CS.
4 Where available, to work alongside clinical leaders in individual areas to develop their knowledge base and experience, promoting local ownership and their role and strengths as change agents.
5 To use a flexible approach that was responsive and sensitive to practitioners' level of knowledge, experience and professional confidence.

Using these as our guiding principles we reflected on what our roles as leaders and facilitators in the implementation process should involve. We identified the following key elements:

1 *Change agent*
To act as key change agents with a formal responsibility for advising on the implementation and development of CS. Our leadership style would promote ownership and commitment by individuals in local areas, building on their strengths and talents.
2 *Partner*
To work alongside practitioners and managers to meet shared objectives.
3 *Educator*
To organise and deliver informal and formal training on the role, function and benefits of clinical supervision.
4 *Advisor and supporter*
To develop a resource library on CS and respond to managers' and practitioners' requests for information and support.
5 *Communicator*
To ensure managers and practitioners are informed of the local and organisational developments regarding CS.

6 *Networker and co-ordinator*
To promote the sharing of good practice across the organisation and the sharing of strategies to overcome difficulties.

Establishing a baseline

One of our first tasks on the project plan was to establish what CS was already taking place within our individual nursing disciplines and what practitioners' knowledge, thoughts and attitudes were regarding CS. We devised a comprehensive questionnaire, based on the issues identified in a review of the relevant theoretical and empirical literature, in conjunction with the clinical audit and research team and sent this to all practitioners in our disciplines. In total 377 questionnaires were distributed and there was an overall response rate of 55 per cent. This was an encouraging response and perhaps reflected a positive attitude towards CS which was evident in the qualitative sections of the questionnaire. The questionnaire covered areas such as: baseline provision, practitioners' level of knowledge and understanding and their views as to how CS should be developed further. The results highlighted an overall lack of knowledge and experience with regard to CS and therefore a high level of training needs. However, within community mental health teams, CS was established though its purpose and content was in need of review. Guided by the results we devised a flexible introductory training package on CS and decided to meet with all areas to give individuals within these the opportunity to be informed about CS and take part in its implementation.

Sharing the vision

We therefore visited individual areas and were enthusiastic to inspire others in our belief that CS had a valuable contribution to make in improving the quality of service we provide. We initially targeted receptive clinical leaders or teams that we had identified through meetings during our induction as lead professionals or by direct interest that we had received. *Working with individuals that had a positive interest enabled us to initiate a change process and these individuals were able to act as motivators and role models for others.* While we had a desire to share our enthusiasm it was important that during our initial meetings with individuals we actively listened to their beliefs and opinions about the functions of CS, the implementation process and their expectations of us. This proved essential to the development of shared and realistic implementation plans. Time was spent discussing and clarifying all aspects of CS that we had uncovered in our review of the literature/personal discussions. It was important that there was a shared understanding of the aims and functions of CS and its potential impact upon clinicians' practice and development. Our approach in supporting the development of local implementation plans was to empower clinicians/managers/administrators to reflect on their current situation and be enthusiastic about what could be achieved. Their central role in the implementation process was reinforced and we informed them that we were available to provide them with help, advice and formal training. When discussing the implementation process there was open and honest communication regarding the difficulties that could be encountered.

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Case study examples

Below are three examples that illustrate the implementation process in action in each of our respective disciplines. As discussed previously, to support this work we provided awareness-raising sessions across the organisation. These sessions were organised around individual areas' work patterns so that they were accessible to as many practitioners as possible. We also provided more in-depth supervisee and supervisor training as requested. The provision of a formal clinical supervisor's course for practitioners from all nursing disciplines was then purchased from a local university and following on from the success of this, a contract was agreed for them to provide further courses.

Example one: health visiting

The results of the baseline questionnaire highlighted that the majority of health visitors within the organisation did not, at the time of the data collection, give or receive CS. Of those that did report being involved in the process of CS, the results of the questionnaire suggested that there were different interpretations of the term amongst health visitors including confusion with 'mentorship' and 'child protection supervision'. It was identified that there was a need to clarify and clearly define what is meant by the term CS and, in addition, its aims and objectives, with 62 per cent of health visitors reporting that they had only an average knowledge of CS and 20 per cent reporting having a poor knowledge base. Overall, however, health visitors were positive about the concept of CS and welcomed its introduction into practice.

Within the organisation, health visitors worked in widespread geographical areas and many were based within individual Primary Health Care Teams. Initial discussions with health visitors across the district raised several key issues and concerns. These included how CS could be organised and resourced within each geographical area, in addition to who would co-ordinate this, as for many areas there was no designated team leader or health visitor with a practice development role. There was also a debate as to which health visitors would become clinical supervisors of others and whether one-to-one, group or peer supervision would be the most appropriate format for health visitors. There was also the issue that no one was trained as a supervisor. Reflection on these discussions highlighted that there was a diversity of opinions amongst health visitors as to a strategic way forward in health visiting and that there was no easy solution to these questions.

Returning to the principles that we had set in our initial discussions as lead professionals and a certain level of pragmatism proved to be the way forward. As lead professional, I wrote to all health visitors offering them the opportunity to become a 'pilot site' for CS with support and access to individual training. One group of health visitors who worked together in a clinic setting came forward requesting to undertake peer group CS. Within this group, one health visitor did have some previous experience of CS and a further health visitor had previously received some training. Two morning (half-day) workshops were spent exploring the concept of CS, models of reflection, contracting and documentation and how to conduct a group session. The health visitors were keen to proceed and began meeting on a monthly basis with regular review. Their continued interest and motivation was essential to the success of this pilot.

Simultaneously, four health visitors from different geographical locations were invited to attend the external clinical supervisor's course. Nominations were requested from individuals who would be prepared to undertake this role after completion of the course and act as champions for CS in their area. These health visitors formed a supportive group and it was arranged for them to receive group CS from an external supervisor for six months following the course. This gave the health visitors valuable experience in receiving CS and proved to be very successful in building up their confidence, particularly in CS. During these six months, I organised supervisee training workshops in each of the geographical locations and conducted these alongside the four 'champion' health visitors. The aim of these sessions was to support them in facilitating their colleagues' knowledge of and interest in CS and to encourage other health visitors to either receive CS or to attend supervisor training. The result of this was very positive as health visitors wanting to receive CS approached the four 'champion' clinical supervisors and they have set up both one-to-one and group CS, depending on what was requested, with a small number of health visitors in their area. In addition, the 'champion' supervisors continued to meet for peer group CS.

Through individual health visitors beginning to set up CS arrangements on either a one-to-one or group basis, more health visitors were becoming aware of the purpose and benefits of CS and were either requesting their own CS or attending clinical supervisor training. The implementation was therefore an incremental process and it evolved, flexibly, with input and participation from health visitors and in response to local needs.

Example two: community hospitals

This section describes three examples of how ward nurses introduced CS. They illustrate that a diverse approach to the implementation of CS was taken within community hospitals.

It is important to note that prior to implementing CS in the community hospitals, a selection of nurses from such facilities attended a leadership course. This acted as a catalyst for discussion on CS. These nurses identified that they would need to experience CS for themselves before being able to develop CS in/on their ward and day hospital areas. Monthly, one-to-one external CS was subsequently purchased by the organisation for a fixed period of six months. Several of the nurses who had experienced the external CS put forward formal plans to implement CS into their wards and day hospitals. They adopted different approaches, according to their view of local needs as shown by the following examples.

One ward manager decided to supervise all the qualified nurses on their ward for a fixed period of time and then review the whole process. As the lead professional for this clinical area, I made the ward manager aware of the constraints of hierarchical supervision: the ward manager put forward a logical reason for this approach. The ward manager felt it was a starting point, as initially there were no CS available and it would be a good way to demonstrate to ward nurses that dedicated time was available for them to reflect on their practice. The longer-term aim was to train nurses from the ward to become supervisors, then ultimately removing the hierarchical structure.

The second example involves a manager from another community hospital who allocated supervisors to all nurses. The rationale for this approach was, in the man-

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ager's words, 'to get CS started in our hospital'. As the lead professional for this clinical area, I discussed and challenged this approach making the manager aware that it was important that nurses should be actively involved and own the implementation process. However, the manager continued with this approach and I advised him that they should consider reviewing progress at an early date.

In the third example, a ward manager encouraged and supported two nurses from the ward to receive CS from the lead professionals. In time, one of the practitioners went on to facilitate group supervision for four ward colleagues. This approach to implementation has proved successful and it continues to meet.

Example three: mental health – community team

The lead professional for mental health nursing met with all the Community Mental Health Teams (CMHT) within our organisation. The following is a brief outline of the discussions with one specific team, which highlights the issues facing the majority of the teams. The key discussion points were guided by the results of the questionnaire, and the discussions occurred within meetings with the lead nurse within the CMHT and with all the CMHT nurses.

On a positive note, the majority of nurses reported that they were receiving CS on an individual basis, at monthly intervals. While there were nurses who reported they were not receiving CS on a monthly basis, this was the frequency they were aiming for. There was a history of CS taking place within the CMHT and it was valued and seen as 'much needed'. However, there were issues raised by the lead nurse and the nurses within the CMHT as to the way CS was organised and carried out.

The lead nurse within the CMHT, who had designated management responsibility for all the nurses, provided clinical and management supervision within one session, dividing the time between both areas. This structure of provision had developed in an unplanned way and was a response to a rapid increase in the number of nurses working within the CMHT, who needed both types of supervision. Interestingly, the nurses expressed (anecdotally) a positive view of the CS they received from the lead nurse. *However there was confusion between clinical and management supervision and concern that the sessions were dominated by management issues.*

Other issues that arose out of the discussions were that prior to commencement of CS there had been no contract drawn up between the clinical supervisor and supervisee, and that in the subsequent session, little or no documentation was used. It was also apparent that there was no choice of clinical supervisor. The lead nurse within the CMHT was motivated to further explore the issues raised by the discussions and the results from the questionnaires. I therefore continued to meet with the lead nurse, providing written information and offering guidance about the issues that had been raised. The lead nurse, after discussion with the nurses from the CMHT, decided to implement the following changes:

1. CS would be held separately from management supervision.
2. Management supervision would be termed caseload management.
3. The lead nurse within the CMHT would continue to be clinical supervisor for all the nurses but it had been openly acknowledged that there could be potential conflict in a line manager providing CS.

4 The supervisee would be responsible for setting the agenda within the CS sessions. The lead nurse had provided all nurses with a booklet in which to document the sessions. This was their property and they were encouraged to use it in support of their professional portfolio.
5 A contract would be drawn up based around the discussions that had taken place as to the aim and function of CS; sample contracts were available to the team.

While it should not be regarded as a formal evaluation, numerous positive verbal comments from the lead nurse and by some of the nurses from the CMHT were forthcoming, especially indicating that the changes allowed them to focus and reflect on their issues with regard to clinical practice.

In implementing these changes, the lead nurse within the CMHT has been able to promote clarity as to the function of CS and caseload management and as to how both processes can be used to support the nurses in their demanding role. The lead nurse dealt positively with the change process and educated his manager as to the need for and benefit of the changes made.

Finally two other points raised are worthy of mention. First, while most nurses had some experience of CS, very few had received any formal education/training. Second, some nurses identified a need for 'specialist' clinical supervision to enable them to practice a specific therapeutic approach i.e. Cognitive Behavioral Therapy.

Reflections on the implementation process

There are relatively few studies that specifically discuss the local implementation of CS (Fowler 1996). Authors have generally highlighted specific areas that need considering and/or potential problems that need to be overcome (Devine and Baxter 1995). Below are our reflections on the process of facilitating the local implementation of CS. Our aim during the first year of the implementation process within our organisation was to develop a culture that supported and valued CS. To add clarity to this, we have divided our discussion into the separate areas of: ownership; developing an organisational approach; and barriers to change.

Ownership

The importance we gave to the need for practitioners to own the implementation process, to value and want CS has proved to be successful. In areas where there are identified clinical leaders motivated to promote CS, the process of implementation moved forward. We have positive examples of areas where CS is now happening on a regular basis and is valued by practitioners. We have since built upon this success, in part by sharing the good practice and positive experiences of CS to other clinical and geographical areas. At an organisational level we are considering how we identify and develop future clinical leaders to progress the implementation of CS in areas where minimal supervision is taking place. The need to maintain local ownership will remain important as will the need to work in partnership with the managers of the service.

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Developing an organisational approach

As discussed in our reflections on ownership, in the first instance we were keen to promote individual practitioners' understanding of CS and their role in developing supervision locally. We became acutely aware that this needed to be supported by an organisational approach to CS. Practitioners have an important role in developing CS but they also need the support of managers and the organisation to do this. As we worked with practitioners they raised this issue. For example, practitioners were keen to know that they were entitled to CS and questioned whether there was an organisational policy to support this. They were also requesting standard guidelines for issues such as setting up contracts between the supervisor and supervisee and the documentation of CS sessions.

Throughout the first stages of the implementation process we worked with practitioners' line managers on an individual basis but we also led a formal session for managers on their role in supporting CS and the difference between CS and management supervision. The implementation of CS was seen to need a 'partnership approach' to be successful: both managers and nurses would need to see its value and be committed to its development. In order to promote an organisational strategy for CS, including the provision of resources to ensure that the implementation moved forward, we produced an interim report after 12 months in post. The report detailed current progress with the implementation process and put forward recommendations for a future organisational approach to implementation including resource and training implications. Together with the director and assistant director of nursing we presented the report to the senior management board and the senior nursing and professional advisory groups.

As a result of this process and significant background work, we have made progress in promoting practitioner involvement and local implementation supported by an organisational approach. We now have a written validated CS policy in addition to guidelines on the aims and function of CS; the role and responsibilities of supervisors and supervisees; and the use of documentation. Importantly we have agreement on the need to draw up contracts prior to commencing CS that cover the issues of confidentiality and information that needs to be disclosed/shared and the need for regular review. We have also set up a CS steering group that includes senior management and practitioner representation to strategically take forward the implementation of CS. We formulated a five-year implementation plan and monitored the status and progress of the plan via the CS steering group. This has produced evidence to indicate that local geographical areas have developed implementation plans and as they report on their progress, this evidence has been used to both underscore the benefits of engaging in CS and has also informed (and help revise) our continued implementation process.

Barriers to change

Implementing CS has involved a change process. As with any change process, as lead professionals we were aware that we might encounter barriers to change and resistance. Our leadership approach within our disciplines has aimed to minimise barriers and resistance, and has promoted a positive approach. Our approach of sharing a vision of the potential of CS for nursing practice and promoting

Box 11.2 Examples of barriers to change

- Resources: e.g. lack of clinical supervisors
- Individual resistance: e.g. some practitioners expressed that they did not need CS
- Workload factors: e.g. high caseloads, shortage of qualified nurses
- Concurrent change: e.g. other practice developments taking place
- Lack of knowledge: e.g. high level of training needs.

practitioner involvement, enabled practitioners to be committed to receive CS and finding realistic ways of achieving its implementation. It would be unrealistic to suggest that we have not encountered barriers. Examples of barriers to change that lead professionals and practitioners have identified are summarised in Box 11.2. These have ranged from individual factors to wider organisational issues.

We have openly recognised these barriers to change and through our ongoing discussions and support within the lead professional team we have developed the following strategies for addressing them:

1 developing supportive relationships with practitioners which encouraged them to identify potential problematic areas and develop creative approaches to deal with them;
2 the use of informal and formal training sessions in an environment that allowed practitioners to openly express their beliefs and concerns regarding CS;
3 developing implementation plans with individuals and their areas that were realistic, achievable and encouraged an incremental approach;
4 building on success and empowering practitioners to motivate their colleagues;
5 our use of self to provide ongoing positive support and encouragement through time of resistance and change.

Conclusion

As a result of our experiences, we would assert that the implementation of CS should not simply be seen as a task that staff need to be trained/educated and then to do; CS should be seen as part of an overall (overarching) framework that enables nurses and others to provide a quality health care service to clients and families. It needs to be introduced into the culture of the organisation, one that promotes individuals to maximise their strength, promotes autonomy and encourages reflection. In order to achieve this culture, managers and practitioners need to work in partnership and the organisation needs to be committed to being a learning organisation that aims to facilitate lifelong learning (Haire 1997). Planning for the implementation of CS therefore needs to include a long-term goal of aiming for it to be become a routine and valued practice.

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