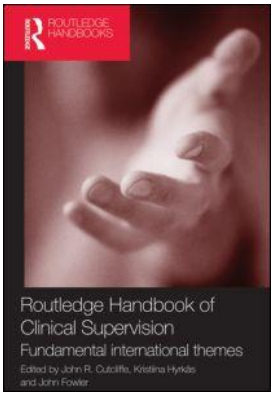

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Fundamental International Themes

John R. Cutcliffe, Kristiina Hyrkäs, John Fowler

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12 Clinical supervision in the United Kingdom – ten years on

A review of the United Kingdom clinical supervision literature

Graham Sloan

In *Fundamental Themes in Clinical Supervision*, Gilmore (2001) presented a summary of her comprehensive United Kingdom Central Council (UKCC)-commissioned literature review of clinical supervision for nurses and health visitors in the UK. As a logical follow up, this chapter presents a review of the nursing literature relating to clinical supervision which has been published between 1999 and 2009. After reminding readers of the UKCC's (now the Nursing Midwifery Council's) endorsement of clinical supervision, the chapter includes a critical appraisal of both the empirical and conceptual literature, including anecdotal accounts, expert opinion and position papers which have pervaded the nursing literature during the past decade. The chapter concludes with some recommendations on how clinical supervision can be further embedded into nursing practice.

Graham's chapter reminds the editors that while the consensus of the academe is that engaging in high quality clinical supervision brings about significant benefits for supervisees, supervisors, receivers of health care (e.g. clients/patients) and the health care organisations, there remains a high degree of resistance to operationalising clinical supervision in some organisations. This resistance can be underpinned by: economic concerns; inappropriate approaches to operationalising clinical supervision (e.g. top down, hierarchical, cascading models of supervision); a lack of understanding of the purpose and function of clinical supervision; and/or individual practitioner resistance. Clearly, a more developed evidence base is needed to help address some of these problems, as is more open mindedness on the part of some. While the editors are mindful of the economic climate in which health care operates, organisations (and the key individuals within them) might consider the long-term economic benefits of having a healthy and happy health care workforce; something which clinical supervision appears to be able to help bring about.

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Introduction

When consideration is given to the multitude of publications describing where and how clinical supervision (CS) has been implemented across the United Kingdom (UK) and the knowledge and experiences from further afield presented throughout some of the chapters of this text, there can be little doubt that familiarity with CS

within the discipline of nursing has expanded. In *Fundamental Themes of Clinical Supervision* (Cutcliffe *et al.* 2001), Gilmore (2001) presented a summary of her comprehensive United Kingdom Central Council (UKCC)-commissioned literature review of clinical supervision for nurses and health visitors in the UK. Given that this book is development from *Fundamental Themes in Clinical Supervision*, it is logical to follow Gilmore's original review with a review of the more recently published work, in the hope that this will help identify and enhance our understanding of how the knowledge base of CS has advanced during the intervening years. Accordingly, this chapter presents a review of the nursing literature relating to CS which has been published between 1999 and 2009. An important aim of the review was to develop an appreciation of the recently published literature and the associated knowledge of CS in nursing in the UK. In particular, this chapter focuses on a critical appraisal of both the empirical and conceptual literature, including anecdotal accounts, expert opinion and position papers which have pervaded the nursing literature during the past decade. The chapter will conclude with some recommendations on how CS can be further embedded into nursing practice. First, the UKCC (now the Nursing Midwifery Council's) endorsement of CS will be reiterated.

United Kingdom Central Council's position on clinical supervision

The UKCC (1996) delivered its much-anticipated position statement on CS, clarified the context within which it works and the principles which underpin its implementation. The Council argued that the potential impact on care and professional development for practitioners was enough to warrant investment. *Nonetheless, the UKCC also suggested that possible benefits are not limited to patients, clients or practitioners: 'A more skilled, aware and articulate profession should contribute effectively to organisational objectives' (UKCC 1996: 2).* The six key principles offered by the UKCC (Box 12.1) emphasised CS. Consequently, this fuelled the expectations of academics, managers and practitioners. Not surprisingly, CS has been implemented into a broad range of clinical settings in the UK.

Box 12.1 The UKCC's six key statements (UKCC 1996)

1 Clinical supervision supports practice, enabling practitioners to maintain and promote standards of care.
2 Clinical supervision is a practice-focused professional relationship involving a practitioner reflecting on practice guided by a skilled supervisor.
3 The process of clinical supervision should be developed by practitioners and managers according to local circumstances. Ground rules should be agreed so that practitioners and supervisors approach clinical supervision openly, confidently and are aware of what is involved.
4 Every practitioner should have access to clinical supervision. Each supervisor should supervise a realistic number of practitioners.
5 Preparation of supervisors can be effected using 'in house' or external education programmes. The principles and relevance of clinical supervision should be included in pre- and post-registration education programmes.
6 Evaluation of clinical supervision is needed to assess how it influences care, practice standards and the service. Evaluation systems should be determined locally.

Literature review strategy

A comprehensive search of the literature on CS published during the past decade was conducted. Literature was reviewed from a variety of sources. Keywords to locate literature on computerised databases – CINAHL, Medline, Psychlit and the British Nursing Index included 'supervision', 'clinical supervision', 'support', 'stress', 'relationship', 'evaluation', and 'benefits'. This provided the foundation for the literature search. Reference lists in the literature sourced were also scrutinised for any potentially unlisted or inaccessible sources. A manual scrutiny of more recent journals was conducted to ensure that potential sources not yet listed in the computerised databases had not been overlooked. This search strategy was supplemented by networking via email with researchers and educators from the international community. The Internet was also used to obtain useful resources related to the field of interest.

Clinical supervision: growing popularity in nursing

The increasing popularity of CS in nursing has been evidenced by the plethora of articles featured in the leading nursing journals and the publication of related texts and policy statements. Some of this work has attempted to demystify the concept (Lyth 2000). While its implementation appears to be widespread (Clough 2001; Spence *et al.* 2002), sizeable proportions of nurses claim never to have received CS (Davey *et al.* 2006). There have been descriptions of specific CS models (Sloan *et al.* 2000; Proctor 2001). While some have challenged the way in which CS is represented in nursing in the UK (Yegdich 1999), others suggest a multitude of alleged benefits.

Formats and frameworks

Reports of how CS has been introduced to district nursing, health visiting, mental health nursing, older adult mental health services, intensive care nursing, a day-surgery unit, a haematology nursing development unit, theatre nursing, occupational health nursing and practice nursing have been published (see, for example, Styles and Gibson 1999; Ashmore and Carver 2000; Clough 2001; Spence *et al.* 2002). Descriptions of its implementation into these nursing contexts reveal that CS can be delivered in a variety of formats.

CS delivered in a one-to-one format is probably the most common mode of delivery in nursing in the UK (Edwards *et al.* 2005; Sloan 2006; Ho 2007; Sines and McNally 2007). In this context, and in keeping with UKCC (1996) recommendations, the clinical supervisor is often a nurse. More often than not, the supervisor is also the supervisee's line-manager (Duncan-Grant 2003; Sines and McNally 2007; Sloan 2006; Rouse 2007), something according to Bishop (2006) that is contrary to initial policy spirit and professional ideals. Though less common, descriptions of group and triad formats have been published (Price and Chalker 2000; Sloan *et al.* 2000) as have examples of when the supervisor has been provided by another health care professional (Sloan *et al.* 2000).

Results from a validation study of the Manchester Clinical Supervision Scale support the view that supervision sessions should be of significant length to be effective, recommending that clinical supervision should be either monthly or bi-

monthly in frequency and, at the least, last for an hour (Winstanley and White 2003). For community staff there may be some benefit from extending supervision sessions to last longer than one hour. Similarly Edwards *et al.* (2005) highlighted that when sessions lasted longer than an hour and were provided monthly, clinical supervision was evaluated as being more effective. Achieving this goal, according to Edwards *et al.* (2005), will involve both organisational and cultural change. *Moreover, it will require significant investment and creativity in developing an adequate resource to enable the provision of effective clinical supervision. While it is encouraging to have such recommendations, when agreements between supervisee and clinical supervisor are established, consideration of the supervisee's work context, developmental level, complexity of clients, learning needs and the supervisor's availability should also be taken into account when establishing the duration and frequency of clinical supervision.*

Conceptual frameworks

Consideration has been given to the frameworks guiding the delivery of CS. There are few theoretical frameworks that specifically explain the processes of CS as adopted in nursing. However, some nurse scholars have suggested frameworks used by other professional groups to conceptualise the purposes and processes of CS. Proctor's model (1987) is probably the most frequently cited CS model in the UK nursing press (see for example, Davey *et al.* 2006; Buus and Gonge 2009). Using this model, supervisors can focus on all or any one of three areas at any time. In nursing's adoption of this model, the *formative* function is concerned with skills development and increasing the supervisee's knowledge; the *normative* function concentrates on managerial issues including the maintenance of professional standards and the *restorative* function is focused on providing support in an attempt to alleviate the stress evoked by doing nursing work. The original description of the three-function interactive model (Proctor 1987) did not provide any guidance on how a clinical supervisor might operate when working within any of its three functions. However, the supervision alliance model (Proctor 2001) clarifies how supervisors might provide helpful responses when guided by this framework.

Advancing earlier work (see, for example, Fowler 1996; Cutcliffe and Epling 1997), Driscoll (2000) described a model based on Heron's (1989) six-category intervention analysis. This model, as a CS framework, has been subjected to at least one study in the UK. Devitt (1998) explored the nature of the supervisory relationship and the labour of supervision through the eyes of the supervisor, using a grounded theory approach. Analysis of data from a focus group, self-reported reflective diaries and in-depth interviews highlighted that prescriptive and informative interventions (authoritative interventions) were used most frequently. This was inconsistent with an initial agreement that the use of Heron's framework should be limited to the use of four of the six categories, confronting, cathartic, catalytic and supportive (mainly facilitative interventions).

Another CS framework, taken from psychotherapy and adapted for nursing, is the cognitive therapy supervision model (Todd and Freshwater 1999; Sloan *et al.* 2000; Sloan 2006). While Todd and Freshwater (1999) illustrated the similarities between reflective practice and guided discovery, Sloan *et al.* (2000) clarified that while the approach was devised to help develop the therapeutic competence of cognitive therapists, its use in nursing contexts merits consideration.

This model differentiates between modes and foci (Padesky 1996). A supervision mode is the means by which supervisee learning and discovery occurs, for example, case discussion (nursing care), reviewing audio recordings of therapy sessions (nurse-patient interactions) or the provision of relevant educational material. The focus can include the mastering of new therapeutic skills (nursing interventions), conceptualising a client's problems (care plan), progressing the therapist's understanding of the client–therapist relationship (nurse–patient relationship) and working through the therapist's (nurse's) emotional reactions to their clinical work. These modes and foci appear relevant for the practice of CS in nursing where clinical practice has a therapeutic intention and it is recognised that knowledge and skills may develop as a result of practitioners reflecting on their interpersonal relations with clients. It has been argued that cognitive therapy CS, by addressing both the processes and content of CS, highlights its essential purpose: the development of the supervisee's therapeutic competence (Sloan *et al.* 2000).

There has been a gradual increase in the number of conceptual models described in the nursing press (Spence *et al.* 2002), but research investigating their utility and effectiveness is scarce. To date, nursing research has focused almost exclusively on Proctor's framework; future investigations should consider exploration and evaluation of alternative frameworks. Nonetheless, regardless of which framework has been adopted, and irrespective of an absence of research supporting its efficacy, CS is considered to have far-reaching benefits and potential outcomes. A great deal has been written about the expectations for CS and a plethora of anecdotal accounts are depicted in the literature.

Great expectations or a heavy burden?

By introducing formalised CS, anecdotal accounts and expert opinion suggest that nursing staff will develop their clinical competence and knowledge base (Ashmore and Carver 2000), experience less stress, burnout and sickness absence (Winstanley 1999). There has also been speculation that patient care will be improved (Jones 2006; Alleyne and Jumaa 2007) and that it provides opportunity for nurses to reflect on practice (Ashmore and Carver 2000; Jones 2006). Additional potential benefits of clinical supervision are its use as a risk management tool (Herron 2000) and the promotion of the clinical governance agenda (McSherry *et al.* 2002).

There is a dearth of published research evidence to support many of these claims (Gallinagh and Campbell 1999; Buus and Gonge 2009). In the UK, CS is considered an effective means of reducing nurses' experience of stress and burnout and that it facilitates knowledge development and skills acquisition (Butterworth *et al.* 1997). Since previous reviews have summarised these works (see, for example, Sloan 2006) this review concentrates on some of the contextual and process-focused investigations that have been conducted in the past ten years. Some studies have attempted to clarify factors that contribute to the effectiveness of CS.

Effectiveness literature

Using the Manchester Clinical Supervision scale, Edwards *et al.* (2005) reported from a sample of 260 (32 per cent) community mental health nurses that CS was more positively evaluated where sessions lasted for over one hour and took place

on at least a once-monthly basis. *Perceived quality of CS was also higher for those nurses who had chosen their clinical supervisor and where sessions took place away from the workplace. Time, space and choice emerge as important factors influencing the effective provision of CS.*

Following a survey of current CS practice with stakeholders in Northern Ireland, including all twelve mental health trust directors and all heads of education, Rice *et al.* (2007) formulated a number of best practice guidelines. All participants reported experiencing problems implementing the guidelines. A lack of information on the development and introduction of the guidelines contributed to fear and apprehension of engaging in CS among mental health nurses. However, respondents felt that implementing the following recommendations would be useful:

- A definition of CS should be agreed.
- Managers should ensure that practitioners are facilitated to participate in CS.
- Managers should ensure that robust operational policies are put in place in their organisations.
- Operational policies should include contracting arrangements between supervisor and supervisee.
- Organisations should provide appropriate time within the working day for CS.
- Supervisors must have sound clinical skills, a strong knowledge base and be a practicing clinical nurse.
- Supervisors should demonstrate clear commitment to the role of clinical supervisor.
- Supervisors should have the capacity to inspire supervisees to reflect on and evaluate their clinical and therapeutic work.
- Supervisors should complete recognised training.
- Trusts should evaluate and monitor impact of CS.
- Supervisors and supervisees should agree a mechanism for collecting data and information that would inform the evaluation.
- Though a difficult task, obtaining and including patient/client feedback may be worth considering.

Contextual and process-focused investigations

Aspects of the health care environment and its influence on how nurses receive CS have been generally overlooked. Nevertheless, there is a growing body of literature that has uncovered a number of organisational dynamics (barriers) affecting the successful implementation of effective CS.

Barriers to the implementation of clinical supervision

In the UK it is common for supervisory arrangements to be hierarchical (Cutcliffe 2000; Sloan 1999, 2006; Duncan-Grant 2000; Kelly *et al.* 2001; Bishop 2006; Davey *et al.* 2006; Rice *et al.* 2007; Sines and McNally 2007). While there is some support for a management-led model for the delivery of CS (Darley 2001), there are many others who suggest managerial supervision should exist parallel to, not concomitant with, clinical supervision (Yegdich 1999; Cutcliffe 2000; Cutcliffe and Hyrkäs 2006). It has been identified that management agendas pervade discussions during clinical

supervision (Sloan 1999, 2006; Duncan-Grant 2000; Kelly *et al.* 2001). Moreover, the hierarchical provision of CS appears to have had some negative influence on how nurses experience engaging in CS. According to O'Riordan (2002) staff withdrew from CS as a result of the supervisor being an insider to the unit and because it was hierarchical. Furthermore, CS was viewed negatively as it involved feeding back to management, was associated with a sense of being watched, and did not appear to be regarded by management as important (Rouse 2007). Sloan's (2006) investigation found that CS discussions were filled with talk about performance appraisals, professional development planning, annual leave and off duty and staff relations. Managerial agendas overshadowed clinical issues. *Such hierarchical provision is predetermined and therefore contrary to the notion that the supervisee should have some choice regarding a clinical supervisor.*

Duncan-Grant (2000) argued that hierarchy within the organisation in particular appears to poison the spirit and operation of CS for mental health nurses. It is suggested that this leads to an absence of ownership at all levels, tension between managers and staff and resistance among staff to a process that should, according to the literature, be to their benefit. More recently, Duncan-Grant (2003) proposed that problematic organisational dynamics will continue to undermine and threaten the successful implementation of CS.

As a result of the lack of acknowledgement having been given to the broader organisational and cultural context within which CS takes place, there has been a failure to appreciate how this may shape CS practice. Within the hierarchical cascading forms of CS, supervisees manage the supervision agenda by focusing on 'safe talk' (Duncan-Grant 2003). Consequently, discussions related to direct client care are overshadowed by other agendas (Sloan 2006). Ultimately this threatens any possibility of reflection on client care.

Following a systematic literature review of CS in psychiatric nursing, which included some of the empirical studies conducted in UK, Buus and Gonge (2009) argued that the lack of consensus on a definition of CS is the most serious obstacle for developing the field. *Perhaps the lack of an agreed definition delineating its core essence is the most significant barrier affecting the successful implementation of effective CS. It is suggested that absence of such clarity has and will continue to influence how CS is applied, the frameworks guiding its delivery, expectations on what it can achieve and ultimately the training programmes for its participants.*

Training practitioners for their engagement in clinical supervision

As described in Chapter 7 the content and methods of delivering sufficient or adequate training for CS in nursing in the UK remain elusive. There has been an absence of guidance on the content of training for CS; the published material varies considerably in its mode of delivery and duration. It is argued that developing the opportunities of CS training will contribute to increasing the availability of adequately trained clinical supervisors, its effective delivery, support a counter-challenge to the unhelpful dynamics that serve as a significant barrier to, and therefore the realisation of, useful practice-focused outcomes.

There are some who argue that the success of CS is greatly dependent on the clinical supervisor (Gilmore 2001). Consequently, training opportunities are often

confined to clinical supervisors. It is noteworthy that CS is not something done to the supervisee; rather it is a process to which both supervisor and supervisee can contribute. Interestingly, the supervisees' contribution to their CS, by endeavouring to prepare for it, having their own agenda items and attempting to introduce these into the discussion and, demonstrating knowledge of the issues discussed, was highlighted in a qualitative investigation (Sloan 2006). It is suggested that training opportunities should be made available to both supervisors and supervisees. Unsurprisingly, the supervisee–supervisor dyad has, to some extent, been overlooked.

The supervisory relationship

In nursing, the supervisory relationship is regarded as an important aspect of CS (Chambers and Cutcliffe 2001). There was little evidence in the empirical literature from the UK of any attention afforded to this specific aspect of CS in nursing. Nonetheless, a small quantity of work attempted to clarify helpful characteristics of the clinical supervisor.

Characteristics of a good supervisor

Unlike the research conducted in North America (Pesut and Williams 1990) and the Scandinavian countries (Severinsson and Hallberg 1996) which focused on the perceptions of the supervisor, research in the UK investigating the desirable characteristics of the clinical supervisor focused on the supervisee's perspective. Guided by Fowler's earlier (1995) study, Sloan (1999) conducted a descriptive investigation of the characteristics of a good clinical supervisor with staff nurses working in a mental health setting. The ability to form supportive relationships, having relevant knowledge and clinical skills, expressing a commitment to providing CS, and having good listening skills were perceived as important characteristics. Supervisees viewed their supervisor as a role model, someone whom they felt inspired them, whom they looked up to and had a high regard for their clinical practice and knowledge base. These perceptions are consistent with Fowler's 1995 findings.

Interpersonal interactions during clinical supervision

Sloan (2006), in turning attention to processes integral to CS, investigated the interpersonal interactions between supervisor and supervisee. It emerged that the work context within which CS was provided had a significant influence on how it was experienced. Aspects of the instructional system, particularly an NHS Trust document and description of a clinical supervision module, were unable to penetrate the rigid and inflexible routine hierarchical provision of CS. It emerged that when supervisors also assumed a line-management function, because of dual role incompatibilities, covert tensions impinged on the experiences of both supervisors and supervisees (Sloan 2006). These tensions were illuminated as the reciprocal interpersonal interactions between the supervisor and supervisee were brought into focus. Not surprisingly, unhelpful exchanges were apparent; discussion of client-related issues was infrequent and mental health nurses' emotional responses to their work were rarely discussed during CS. Similarly, participants in Ho's (2007) small scale study informed that while one-to-one CS was commonly experienced, very little

attention was paid to dealing with the emotions arising from mental health nurses' work with patients. Instead, participants coped with their emotional responses to their work through alternative means, mostly away from work, for example, going to church, talking to a loved one or playing sports.

Conclusion

This chapter presents a selective review of the CS literature pertaining to nursing in the UK. In closing the chapter, returning to the UKCC's (now the Nursing and Midwifery Council) position on CS is warranted and from which reflections and implications from the literature reviewed are presented (Box 12.2).

The increasing popularity of CS is obvious; nevertheless, there is considerable evidence informing that too few nurses are able to access it. While there is a plethora of guiding frameworks, there is too little research supporting their utility. The lack of an agreed definition, contributes to the burdensome expectations which perhaps detract from its core value. Clinical

Box 12.2 Revisiting the UKCC's six statements

1 Clinical supervision supports practice, enabling practitioners to maintain and promote standards of care.
The Nursing and Midwifery Council (NMC) should emphasise the significant purpose of clinical supervision for all nurses by making it a statutory requirement for registration.

2 Clinical supervision is a practice-focused professional relationship involving a practitioner reflecting on practice guided by a skilled supervisor.
Clarity from the NMC on the precise purpose of, and agreement of a definition for, clinical supervision for nursing is required.

3 The process of clinical supervision should be developed by practitioners and managers according to local circumstances. Ground rules should be agreed so that practitioners and supervisors approach clinical supervision openly, confidently and are aware of what is involved.
Guidance from the NMC, based on current empirical evidence, is required, which should facilitate the implementation of effective clinical supervision to local circumstances.

4 Every practitioner should have access to clinical supervision. Each supervisor should supervise a realistic number of practitioners.
The NMC should make it a statutory requirement that every nurse embraces clinical supervision.

5 Preparation of supervisors can be effected using 'in house' or external education programmes. The principles and relevance of clinical supervision should be included in pre- and post-registration education programmes.
Having clinical supervision as a requirement for the registration for nurses could contribute to the establishment of supervision competencies which in turn could provide guidance for supervision training programmes.

6 Evaluation of clinical supervision is needed to assess how it influences care, practice standards and the service. Evaluation systems should be determined locally.
Useful evaluation of the outcomes derived from clinical supervision will only become meaningful if supervision competencies are developed so that effective supervision provision can be evidenced and measured.

supervision is a gift, a golden opportunity. When embraced without apprehension and provided effectively it has the potential to enable high quality nursing care. It requires considerable investment and commitment: all stakeholders, supervisees, supervisors, management, educators and regulatory bodies can contribute.

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