

# MAKING A *Difference*

CLINICAL SUPERVISION IN PRIMARY CARE

June 2000

This update is one of a series being published to highlight issues raised in *Making a Difference*, the Government's strategy for nursing, midwifery and health visiting in England.

The paper describes the findings of recent Department of Health work on clinical supervision in primary care. It is based on the work of a group of practitioners with experience of implementing clinical supervision in primary care, and responses from over 400 people attending the first National Clinical Supervision conference.

The paper summarises some of the lessons learned about implementing and developing clinical supervision, which primary health care teams, and Primary Care Groups and Trusts, will find useful in integrating clinical supervision into their clinical governance programmes.

#### Background

*Making a Difference* highlighted the importance of clinical supervision for nurses, midwives and health visitors:

*'Their practice has been guided by professional self-regulation, supported by clinical supervision ... These activities need to be developed, strengthened and integrated into the wider clinical governance development programme and linked to annual appraisal and personal development planning ...' (page 46, para 7.5)*

A key commitment arising from *Making a Difference* was a re-launch of clinical supervision in primary care.

#### What this means for PCGs and PCTs

PCGs and PCTs should:

- find out what forms of clinical supervision are currently used by their primary health care teams, and whether there are any gaps in the availability of clinical supervision;

#### BOX 1:

#### Definitions of clinical supervision

'An exchange between practising professional to enable the development of professional skills' – Butterworth 1992

'Supervision is a meeting between two or more people who have a declared interest in examining a piece of work' – Wright 1989

'A term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations' – DoH 1993

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- ensure that the introduction or development of clinical supervision for all nurses, midwives and health visitors is part of their clinical governance plans.

#### What is clinical supervision?

Some definitions of clinical supervision are shown in Box 1. Statutory supervision for midwives (see Box 2) is a different form of supervision, and *must* be in place for all midwives.

Although research suggests that there is widespread acceptance that clinical supervision is a valuable tool in improving quality in clinical practice, some organisations have been slow to develop clinical supervision for their staff. In 1999, for example, an Audit Commission report on district nursing found that only half of district nurses had access to clinical supervision.

There are many different models of clinical supervision, and different approaches work better in some settings than others. The commonest forms are:

- One-to-one sessions *or* small group meetings, *involving*
- A trained supervisor *or* peers, *who may be*
- Chosen by the supervisees *or* allocated to them.

Whichever model is used, clinical supervision usually involves meeting regularly to reflect on practice with the intention of learning, developing practice and providing high quality care to patients. It is distinguished from more informal forms of staff support and development by a 'contract' between supervisor and supervisee(s), setting out ground-rules on issues such as confidentiality, commitment to attend and contribute, and format of sessions.

#### Finding out what works

The work commissioned by the Department of Health was intended to find out what makes clinical supervision work well in some places, and how to introduce and develop clinical supervision where it isn't already in place.

A small group of key individuals, all experienced at introducing clinical supervision in their organisations, were brought together to pool their experiences, and identify:

- key issues affecting the successful implementation of clinical supervision
- a framework for clinical supervision in primary care
- recommendations for key actions to support a 're-focus' on clinical supervision in primary care.

The group agreed that the factors which tend to militate *against* successful implementation are:

- inconsistent support for clinical supervision – for example, the exclusion of clinical supervision from the mainstream agenda of the organisation, such as clinical governance and human resource management; or, where there is good support from the Board, 'blocking' by managers (because of concern about time, resources and the impact on patient care), or a laissez-faire attitude which leaves practitioners to 'get on with it' unsupported.
- rural issues – particularly the problem of travelling time for practitioners working over large areas, who are isolated both

### BOX 2:

#### Statutory supervision for midwives

Statutory supervision of Midwives ensures the protection of the general public from malpractice by actively promoting a high standard of midwifery care. The statutory function of midwifery supervision and Local Supervising Authorities was first laid down in the Midwives Act of 1902 and has continued to be detailed in successive Acts of Parliament until the present time.

The focus of statutory supervision has changed overtime from a punitive and controlling system to that of a system of support and enabling the development of peer review.

### BOX 3: Training for clinical supervision

English National Board course R01: 'Clinical supervision skills for supervisors' – 10 day, University-based course, over 12 weeks. Enables suitably qualified registered nurses to extend, develop and integrate their knowledge and skills in the theory and practice of supervision.

Open University study pack: 'Clinical Supervision: a development pack for nurses'. Helps develop the skills needed to run effective clinical supervision sessions, and enhances personal and professional development.

geographically and professionally from colleagues.

- the need for evidence of positive outcomes of clinical supervision *on patients* – though some people question why there is a need to 'prove' this, believing that it should be supported in the knowledge that it is good for practitioners, relieves stress and increases confidence and competence.
- resistance from some practitioners –while some parts of the profession (such as community psychiatric nurses) have more experience of clinical supervision than others, there are still practitioners who believe that it is a managerial tool designed to find fault with practice.
- lack of a 'champion' –the absence of someone to steer or lead the process of implementation at team and organisational level often means slow progress, or a loss of momentum after the initial introduction.
- the difficulty of finding time – both for supervision sessions ( which often has to be 'justified' as it is not direct patient care), and for training.

However, all the group members had been involved in successfully implementing or developing clinical supervision in spite of these obstacles.

#### Training for clinical supervision

All those involved in the discussion firmly believed that:

- Quality training is essential to achieving real change in practice.
- Training for clinical supervision can be:
  - academic or skills-based
  - internal or external to the organisation

- the same or different for supervisors, supervisees and managers
- 'one off' or modular (including 'uplifts' for experienced practitioners).

Some examples of training courses are shown in Box 3.

#### Keys to success

The group produced a framework for high quality clinical supervision in primary care. It has to be viewed in the context of other changes and developments in primary care, including the development of new primary care organisations (PCGs and PCTs) and new systems for securing quality of services, such as clinical governance. The framework calls for:

- clinical supervision locally to be **linked to the national approach** – which sees clinical supervision as part of clinical governance
- **locally developed and supported implementation plans** – taking account of local agendas, the type of organisation, and the different groups of practitioners in the organisation
- **leadership** at organisational and team level – ideally with protected time for implementation, and the identification of '**champions**' at each level
- adoption of the **philosophy** of clinical supervision (that is, a common definition, and a framework for practitioners to work with), **rather than imposing one particular model on staff**
- the use of **evidence of positive outcomes** (see Box 4)
- clinical supervision to be **linked with systems of appraisal and continuing professional development**

**BOX 4:**  
**The University of Manchester's 'Manchester Clinical Supervision Scale'**

Is the first validated tool designed specifically to measure the impact of clinical supervision

Is quick and easy to complete; standard statistical tests can be used to establish significant differences in scores between staff groups

Is available for purchase with an instruction manual from the University of Manchester School of Nursing, Midwifery and Health Visiting

Contact: Helena Hall on 0161 275 5336 or email [Helena.Hall@man.ac.uk](mailto:Helena.Hall@man.ac.uk)

- Preparation of managers, supervisors and supervisees to ensure a **common understanding** of the purpose and the process of clinical supervision

Involving practitioners in the development of clinical supervision, rather than imposing it on them, is the most important success factor.

**What this means for PCGs and PCTs**

PCGs and PCTs should consider:

- Endorsing the principle of clinical supervision, as part of clinical governance activity, at Board level
- Finding a clinical supervision 'champion' amongst their staff

- Allocating some protected time to audit current provision of clinical supervision, and setting a target for involvement in clinical supervision
- Finding out from staff (e.g. through the nurse forum) what models of clinical supervision would be most practical and beneficial in each area of the organisation, and for each staff group
- Developing systems of clinical supervision, linked to clinical governance and CPD, where they do not already exist for staff
- Using the Manchester Clinical Supervision Scale to evaluate the effectiveness of clinical supervision in the organisation.

## Summary

Clinical supervision, as part of clinical governance programmes, forms part of the Government's strategy for nursing, midwifery and health visiting.

The numerous models in existence mean that organisations can choose the approaches which best suit their staff and their circumstances.

The keys to successful implementation of clinical supervision have been identified, and they can help organisations avoid mistakes and achieve effective systems. Commitment from the Board, from managers and staff, is essential. Involving staff in developing the process is also key to success.

A validated tool for evaluating the impact of clinical supervision on staff is now available, and gives essential information about the effectiveness of clinical supervision systems.

Further copies of this document can be obtained from:  
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or from the NHS Responseline on 0541 555 455