

Implementing Supervision  
in the South Eastern Health  
and Social Care Trust: A  
Report on Three  
Supervision Inquiry  
Workshops

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***Implementing Supervision in South Eastern Health and Social Care Trust: A Report on Three Supervision Inquiry Workshops held in the Region (February – March 2008)***

**1. Acknowledgements**

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## 2. Introduction

Whilst the notion of supervision is not a new concept, there are differences in the emphases or functions, of supervision in health and social care (Driscoll 2007 p4). From a policy perspective, clinical supervision within the nursing profession in the UK was first formally highlighted in 1993 and has continued to gather strategic momentum since this time (Barrowman 2000, Department of Health 1993; 1994a; Royal College of Nursing 1999; United Kingdom Central Council for Nursing and Midwifery (UKCC) 1996; Nursing and Midwifery Council (NMC) 2006). The importance of effective supervision (and the need for its development), has also been a recurring theme highlighted in a number of high profile national and regional Inquiries such as The Clothier Report (Department of Health 1994b), Lewis Review (2003), Shipman Inquiry (2005), Murtagh Review (2005) and the McCleery Inquiry Panel (2006).

Specifically within Northern Ireland, the Regulation Quality and Improvement Authority (RQIA) has recognised the importance of ensuring that staff have access to effective supervision and is reflected in Department of Health, Social Services and Public Safety published Quality Standards for Health and Social Care (DHSSPS 2006). In May 2006, the Chief Nursing Officer for Northern Ireland, commissioned the Northern Ireland Practice and Education Council for Nursing and Midwifery, (NIPEC) to undertake a review of clinical supervision across acute and community nursing (NIPEC 2007) in Health and Personal Social Services (HPSS), building on previously published surveys and resulting in *Best Practice Guidelines for Supervision* in mental health nursing (DHSSPS 2004) and learning disability nursing (DHSSPS 2005).

The NIPEC review of clinical supervision on behalf of the DHSSPS (NIPEC 2007) indicated that less than 33% of registered nurses in Northern Ireland were undertaking regular supervision. Substantial challenges to the implementation and long term sustainability of supervision were identified as being; a lack of

direction and definition as to what was meant by the concept, lack of effective leadership, inadequate resourcing, inappropriate training for supervisors, competing demands and a lack of evaluation of the long term benefits of clinical supervision for both staff and service users. Finally, most significantly to this report was that most Trusts (80%) had little or no current direction or leadership for clinical supervision. This last factor, lacking policy direction and leadership is not surprisingly cited as the biggest barrier in a major study when attempting to implement a successful supervision strategy (Lynch & Happell 2008a).

In response to the supervision review (NIPEC 2007), TWO regional standards for future supervision in Northern Ireland published by the Chief Nursing Officer (DHSSPS 2007) came into effect from April 2008 relating to;

1. The implementation of supervision
2. The governance of supervision

As a direct response to both of the above initiatives, THREE externally facilitated Supervision Inquiry Workshops were held in February and March 2008 to develop an organisational framework for supervision and support its implementation in South Eastern Health and Social Care Trust (SEHSCT).

### **3. Scope and Design of the Supervision Inquiry Workshop(s)**

THREE full day Supervision Inquiry Workshops (see Appendix 1) were held totalling 147 staff on;

- ❖ Monday 25<sup>th</sup> February 2008 at the Burrendale Hotel - Newcastle
- ❖ Wednesday 5<sup>th</sup> March 2008 at the Clandeboye Lodge Hotel – Bangor
- ❖ Monday 10<sup>th</sup> March 2008 at the Le Mon House Hotel – Belfast

From the outset whilst the development of supervision was viewed as an important policy initiative in SEHSCT, it was anticipated that the Supervision Inquiry Workshops would also be a vehicle for supporting a much broader agenda in managing change, following the realignment of two previous healthcare organisations into a single health and social Trust for the South Eastern area.

Following the submission of an outline proposal for funding to the DHSSPS and subsequent consultation within SEHSCT (including the Nursing and Midwifery Education and Learning Forum), the following **Aims of the Supervision Inquiry Workshops** (Appendix 1) were agreed, taking into account the published Supervision Standards (DHSSPS 2007);

- ❖ To obtain staff support for the development of supervision across SEHSCT
- ❖ To raise professional awareness of how supervision might work in everyday practice based on the experiences of those already engaged in the process
- ❖ To discuss the implications of committing to implementing supervision across SEHSCT and practical ways that it might be supported in practice
- ❖ To agree (in principle) a strategic 'way forward' that would include a shared vision of supervision in SEHSCT over the next 12 months based on available resources
- ❖ To actively support selected workshop participants expertise and commitment with supervision to act as 'champions' in its development across SEHSCT

As previously outlined in the introduction, there has been much supervision work in Northern Ireland that has included extensive fieldwork, case studies and widespread consultation. The Supervision Inquiry Workshops in addition to the

previously agreed aims had a threefold design to meet SEHSCT specifications that represented the different phases of the day(s) from which to collect data;

**Phase 1:**

- ❖ Build on best practice through acknowledging that firm (clinical), supervision foundations had previously been laid albeit in the guise of the former organisations that now comprised the newly formed SEHSCT

**Phase 2:**

- ❖ Present a sense of practical reality to participant practitioners within SEHSCT in relation to the 'doing' of supervision in everyday practice

**Phase 3:**

- ❖ Establish a positive working dialogue by participant practitioners in SEHSCT from which to move forward with the development of supervision.

Phase 1 began by examining participant / practitioner expectations of the day with the published workshop aims and identifying 'one thing' that had to be taken back to the workplace from the close of the workshop. An area on the gallery wall for 'Parked' issues that were too large to deal with in any depth on the day was also established. It was stressed at the beginning of the day that during Phase 1, 'supervision' was not being defined and participant / practitioners needed to consider how they interpreted supervision themselves. Phase 1 included paired interviewing to 'unlock the secrets of exceptional moments in supervision'. It concluded with a group plenary session examining 'where' and 'why' such exceptional moments in supervision occurred in practice and identification of the core factors that made that supervision exceptional.

This phase was a modified form of Appreciative Inquiry (Cooperrider & Whitney 1999, Watkins & Mohr 2001) that focused on identifying positive experiences of supervision activities generally, and examining 'what works', rather than the 'problems' often associated with implementing supervision in practice (Driscoll 2007 p209). The intention behind this approach was to engage participant / practitioners to describe 'positive' supervision ground in real experiences, rather than beginning the workshops from a more theoretical standpoint and was described in the introduction of the workshop as.... *developing supervision from inside out, rather than outside in.....*

Phase 2 began with a guided discussion on some of the key words and supervisory intentions, in the supervision definition by NIPEC for the DHSSPS (2007) that has been adopted by SEHSCT and contained in the supervision policy (SEHSCT 2008). The practical realities of implementing and sustaining supervision in practice were presented by those already engaged in the process. The regional 'snapshots of supervision from practice' outlined; a manager(s) experience in supporting the initiative, the view of a working supervisor(s), and the view of a supervisee(s) in practice. The presentations aside from being practical accounts by those with direct experience of supervision, was intended to demonstrate that supervision was possible to implement, using a variety of methods and ideas to suit the practice situation. The supervision accounts from practice also offered participants the opportunity to engage in a 'Question and Answer' session at the end. The phase pulled together key themes from the presentations, identifying ways in which supervision could meet the realities of the practice situation. The phase concluded by summarising the distinguishing features of professional supervision\*.

*\*The term 'professional supervision' is used for brevity throughout the remainder of this report to include any or all of the supervision activities described in the Trust supervision policy (2008 p6). Whilst the policy currently relates to 'all registrant nurses,' it is the intention that professional supervision will also be available to all non registered nursing staff in the future e.g. health care assistants.*

Finally, Phase 3 invited workshop participants to reflect and build upon the learning from the morning activities in relation to the development of professional supervision, supporting a 'culture of learning' identified as contributing to *The Quality Standards for Health and Social Care* in SEHSCT (DHSSPS 2006 p15). A 'force field' analysis (Driscoll 2007 p199) was instigated to identify relevant cultural factors through perceived 'pushing' and 'restraining' forces that existed in SEHSCT with plans for implementation of professional supervision. The 'force field' method has been positively evaluated as part of the overall strategy for large scale implementation of professional supervision (Lynch & Happell 2008 a, b, c,).

#### **4. Supervision Inquiry Findings and Discussion**

The Supervision Inquiry findings and discussion are examined from the three phases of the workshop(s) previously outlined and summarise participant / practitioner responses for all of the workshops. A limitation of this report is how representative a total of 147 participant / practitioners might be in relation to the development of professional supervision throughout nursing in SEHSCT. However, the findings do represent some of the good work already undertaken regionally in previous organisations in Northern Ireland and more recently within SEHSCT to move the initiative forward. The level of interest and (potential) commitment for developing professional supervision, is also evidenced by the willingness of 28 participant / practitioners from the workshops who self nominated themselves to act as 'champions' within SEHSCT for its future development.

**Recommendation 1: All participant/practitioners need to be acknowledged for their contribution and have access to this report and in particular, those who self nominated to act as 'supervision champions' need further direction and support to do so.**

### **Summary participant / practitioner response's to Phase 1;**

- *Workshop expectations and 'must have's' by the end of the day*

Participants were invited to 'post' statements at the beginning of the workshop outlining their general expectations of the workshop and ONE statement indicating a 'must have' on its closure. Workshop expectations included an increased knowledge, awareness and understanding of supervision principles, processes as well as different methods of implementation. For example; *alternatives to one-to-one encounters / how supervision might be organised in practice / roles and responsibilities in supervision generally, as well as in its implementation / what supervision is as well as what it is not / the evidence base for supervision methods as well as how to evaluate the initiative.* There was also a wish to be 'practical' in the implementation of professional supervision and to focus on solutions, rather than the 'problems' of implementation. There was an obvious willingness to participate in the Supervision Inquiry and disseminate ideas and experiences to support the development of a 'shared vision' for professional supervision in SEHSCT. Of particular note was an interest in SEHSCT's proposed direction for professional supervision including policy issues and how 'supervision' differed from 'clinical supervision' / 'clinical support' in operational terms.

Early workshop expectations offered an indication of supervision cultures based on previous experiences of implementation and personal involvement in practice that included the need to; *renew enthusiasm for supervision / get the batteries recharged / bring a new energy to the process / new motivation for supervision / less fear about supervision / reducing negativity associated with supervision.*

Focusing on 'must haves' by the close of the workshop, identified more specific supervision issues of a practical nature (and not in any order of priority), that will need to be considered in SEHSCT and recur as themes throughout this report;

- More **knowledge and understanding** about professional supervision and what this means to practitioners in SEHSCT e.g. **differences and similarities to 'clinical' supervision** experienced in previous organisations, a perceived increased legitimacy for **professional supervision 'now' compared to 'then'**
- The need for **consistent messages** outlining the **principles of professional supervision, how it is to be implemented** in SEHSCT and **ways of going about this**
- How to **'sell' professional supervision** as a positive idea in practice and **(re)motivate** and **involve staff at ward level** e.g. benefits, incentives
- **Acknowledge as well as challenge / support** previous organisational and cultural ideas / practitioner experiences of (clinical?) supervision in practice
- **Practical support** for engaging in professional supervision **as practitioners** at work and in **managerial roles** in its development in SEHSCT
- Ways of **evaluating the implementation** of professional supervision in SEHSCT as well as the **supervision process** itself

The quality of the responses made *before* the workshop had begun, demonstrated a diverse range of opinion, experience and support for the development of professional supervision in SEHSCT. There are high expectations for what can be achieved from future supervision workshops in general, as well as a strong sense of what is required for the development of professional supervision in a new organisation. Even at such an early stage of the workshop(s) there appeared to be a sense of anticipation about how the development of professional supervision might provide an opportunity to support broader organisational change. For example, through the establishment of new practitioner networks, combined with a general willingness to share and learn from experiences.

- *Unlocking the secrets of ‘exceptional supervision’ in practice ...‘where’ and ‘why’ does it happen and associated core factors;*

The focus for reflecting on ‘exceptional supervision moments’ was for participant / practitioners to consider positive elements of supervision based on their ‘lived’ experience(s) in practice, and examine with others, how and when this occurred. The interpretation of what ‘supervision’ was or meant to be, was intentionally omitted in phase 1, but included in the next phase of the workshop(s). The purpose of this was to reframe ‘supervision’ in a positive way and invite reflection on how such exceptional, or ‘extra’-ordinary supervision, might become a more ‘ordinary’ occurrence in practice. For instance, the nature of the supervision interviews / accounts in practice included sharing when did they happen and how? By identifying the core factors contributing to positive supervision as a group, a further intention was to consider whether it was possible to replicate, gain further ideas for supervision and (or), adapt such ‘moments’ as potential evidence for engaging in supervision in SEHSCT.

Figure 1 illustrates the broad range of supervision activities reported by participant / practitioners that formed the basis of ‘exceptional supervision moments’. They indicate the variable nature of supervision in practice and reflected in the policy direction taken by the organisation (SEHSCT 2008). It also illustrates different supervisory roles and of those being supervised. It should be noted that not all supervisory activities occurred in SEHSCT, but included worked examples of supervision experiences in previous organisations.

Clearly, ‘exceptional supervision’ from within practice can be both formal as well as of an informal nature. It can also be a planned activity, as well as an ‘ad-hoc’ or chance event. Whilst the ideal for the development of professional supervision

Figure 1:

The range of 'exceptional supervision' activities described by participant / practitioners in practice

**FORMAL**  
**(Supervision as the primary task)**

<p>During a CBT session Planned supervision meeting Within a Learning Set Within a Learning Set away from work Organised peer group supervision Planned group meeting During group supervision (for supervisors)</p>	<p>One-to One with Manager Feedback following a job interview A meeting after a group meeting</p>
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**PLANNED**

**SUPER  
VISION**

**AD-HOC**

<p>Lunch Break One-to One with Manager Lunch during a study day Staff tea room As part of a consultant's ward round In a ward bay at the patients bedside During a role play on a course</p>	<p>Lunch on a picnic bench One-to One with Manager Chance telephone conversation Over a coffee Private conversation Around a kitchen table (home) In the coffee shop Conversation sitting in a car</p>
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**INFORMAL**  
**(Service delivery continues)**

in SEHSCT might be towards the organisation of formal and planned individual and (or) group meetings, 'exceptional supervision' is reported as happening informally both in its timing and settings. Furthermore, as participant / practitioners reporting on such unplanned and informal events as being 'exceptional supervision' and (presumably) with tangible outcomes, how might this influence in a positive way, or interfere, with the delivery and implementation of professional supervision in SEHSCT? For instance, O'Riordan (2002) and Cleary & Freeman (2005) describe how the implementation of professional supervision can be perceived as a threat to informal support in practice, contributing to a culture of passive resistance in developing professional supervision.

For instance, some 'exceptional supervision' was reported as a form of personal support for individual practitioners immediately available to them in practice, with the focus often being a response to something that had happened or was happening in practice. For example; *able to lift a personal burden through sharing / getting things back into proportion / acknowledging that what was done was right / reassuring / reaching a shared understanding of a practice issue / feeling OK not to be perfect / to boost ones' confidence*

'Exceptional supervision' was also described in the group situation as being a response to situations happening within departmental, as well as meeting broader organisational concerns. For instance; *stressful time for the team / lack of support from management / a result of an ongoing problem / focus on improving the service / brought people together to reach a shared understanding on an issue / we needed to manage a change / an unfounded rumour in practice / due to a ward incident / the need to change practice due to pressure from staff.*

**Core factors** identified by participant / practitioners as contributing to 'exceptional supervision' in everyday practice included;

- The **knowledge and skills** of the supervisor
- **Trusting and confidential relationship** e.g. *non judgemental, acceptance, genuine concern and interest, honesty, non threatening, able to choose the supervisor*
- **Immediate access** to supervision in practice
- **Time protected** in which to do supervision in practice
- Perceived as a **positive experience by those engaged in supervision** e.g. *felt supported, improvement to practice as a result of supervision, constructive criticism, reassuring, relevance to practice, reduced stress*
- Having a **structure** within the supervision encounter

The core factors previously summarised, whilst offering some general principles for a range of supervision activities seen in practice, were valuable to build on

later in the workshop where comparisons were made for the development of 'professional' supervision in practice. Data summarised from phase 1 of the workshop appeared to demonstrate the quality of supervision generally, experienced by participant / practitioners (perhaps in previous organisations) and an ability to differentiate the key principles of what 'best practice' supervision might entail for its further development as professional supervision in SEHSCT.

### ***Summary participant / practitioner response's to Phase 2;***

Phase 2 began by inviting participant / practitioners to consider key words contained in the current policy definition of supervision (SEHSCT 2008);

*“Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety”.*

Further facilitated questioning (in preparation for the presentations from practice), briefly examined differing agendas for developing professional supervision in SEHSCT based on this definition. The discussion also provided a focus for what questions might need to be asked of the presenters.

The importance of the presentations was to demonstrate that professional supervision was possible in practice, how challenges were overcome and sharing that learning to a wider audience. Each presenter considered supervision from the practical perspectives of a) a manager b) a supervisor c) a supervisee. The three workshops in total offered a range of supervision possibilities and expertise from within practice;

<b>Workshop date:</b>	<b>Manager</b>	<b>Supervisor</b>	<b>Supervisee</b>
25 <sup>th</sup> Feb 2008	Ray Kendall Charge Nurse	June Cairns Ward Manager	Neill Hand Staff Nurse
Work area / Organisation	Care of the Older Person Ulster Hospital Dundonald	Rehabilitation Unit Lagan Valley Hospital	Care of the Older Person Ulster Hospital Dundonald
<b>Workshop date:</b>	<b>Manager</b>	<b>Supervisor</b>	<b>Supervisee</b>
5 <sup>th</sup> March 2008	Dawn-Heather White	Dawn-Heather White	Bette McMullan
Work area / Organisation	Community Mental Health Services Manager Downshire Hospital Downpatrick		Senior Manager (Mental Health In- patient Unit) Ards Hospital Newtownards
<b>Workshop date:</b>	<b>Manager</b>	<b>Supervisor</b>	<b>Supervisee</b>
10 <sup>th</sup> March 2008	Maggie Parks	Helen Walkingshaw	Shirley Jones
Work area / Organisation	Clinical Manager Surgical Directorate Ulster Hospital Dundonald	Clinical Co-ordinator Surgical Directorate Ulster Hospital Dundonald	Ward Sister Surgical Directorate Ulster Hospital Dundonald

It is interesting to note that the notion of professional supervision often stereotypically thought of as predominantly for junior staff, had been led by managers who themselves were directly engaged in the process, in addition to actively supporting its implementation in practice.

**Recommendation 2: The practice of senior nursing staff actively engaging in professional supervision provides a positive role model and legitimacy for the activity and be regarded as ‘best practice’ in SEHSCT.**

The three workshop presentations offered differing perspectives and insights on the organisation of professional supervision ranging from Care of the Older Person, Mental Health and a Surgical Directorate in an acute hospital that may, or may not, be able to be generalized or even applicable in the diverse practice arenas across SEHSCT. Issues raised by the presentations for the implementation of professional supervision based on personal experience can be summarised as;

*The emergence of professional supervision in clinical practice*

Implementation was often in response to 'a need' for its development in practice e.g. *pressure to implement from 'top down' or from 'on high' had previously resulted in supervision being a 'paper exercise' or 'ad-hoc' events; a need to implement a suitably costed model, to challenge and change a culture of poor performance through reflective practice; previous positive experiences of supervision by a manager (as a supervisor and a supervisee) from a different discipline (social work) e.g. development of a culture of supervision challenging nurses attitudes of supervision as being a managerial tool,*

Professional supervision began in different ways e.g. with a *pilot scheme in two areas of practice*; before more widespread implementation; as a form of *informal peer clinical support* before that then became formalised in practice and included provision of protected group time; as a *supervisee peer group for managers who were acting as supervisors* before being rolled out to ward sisters within an *action learning set* (as part of formalised Away Days); by *formalising the process using documentation*; the development of supervisors was based on a *leadership programme in which participants were motivated and enthusiastic about supporting patient centred care*

Specific learning from practice based on presenters' experiences when implementing professional supervision were;

- The need to **keep trying** and not giving up
- Learn from the team about their perspectives of supervision when implementing, **recognising different skills and interests**
- **Start small**, seek champions
- **Supervision should be led by the supervisee** not the supervisor otherwise it could become a *dumping ground* in which the supervisor simply gives solutions
- Supervision must have an **agreed contract and boundaries** from the start
- **Supervisees need to prepare for supervision** beforehand

- **Monitor and evaluate supervision** development as it happens....but **sometimes difficult to evaluate**
- In multidisciplinary environments **establishing quarterly professional supervision and monthly supervision for the team** is helpful before then merging such meetings over time
- Supervision development happens when **managers actively support the process themselves**
- There is **not a 'right' and 'wrong' way of doing** supervision
- **Group supervision works best in group sizes of 6-8** participants that includes a **range of grades** offering a wider supervision experience; working in groups helps to share problems and see not just your own unique problems but others as well
- **Managers can act as supervisors** provided that the supervisee is given a choice
- There need to be **clear guidelines for staff** participating in supervision
- For supervision to work there needs to be **trusting relationships**, that can influence positive working relationships
- There needs to be a **range of methods** for doing supervision
- **Confidence grows in supervision by getting started** and experiencing it...perhaps as a supervisee first
- **All supervisors should also be supervisees**

Many of those messages for the development of professional supervision are also supported in the SEHSCT supervision policy (SEHSCT 2008) e.g. the need to formalise professional supervision through agreeing boundaries, the need to monitor and evaluate supervision activities and having a range of methods for supervision. However, the need for 'champions' as distinct from other roles and responsibilities in Section 8 of the policy is not recognised and will need differentiating from that of assumed roles rather than a self nominating role.

**Recommendation 3: The self nominating supervision 'champions' role as distinct from other roles outlined in the draft supervision policy (SEHSCT 2008) needs further clarification and support for the new role in practice.**

*Challenges posed by the development of professional supervision in clinical practice*

From the descriptions and discussions around the practical implementation of professional supervision in practice, a number of challenges were posed for its wider implementation in SEHSCT that recurred as 'restraining forces in phase 3 of the workshop;

- **Protecting the time** for supervision and building into the working day
- The need for **new supervisor support** with role and including the *development of a larger pool of supervisors* for supervisees to choose from
- **Limited supervisor development** e.g. *dropped into role* (1 day training) before then expecting to act as a supervisors, *whilst theory days are OK there is a need to learn supervision by doing it*
- **Having a range of supervision methods** to meet the demands of the service / *supporting remote geographical areas*
- Questioning **whether managers could act as supervisors** and whether *everybody is suitable to become a supervisor*
- **Sustaining group supervision** over time (9 months) with changes in staff
- Evaluating and **communicating the benefits of supervision** in practice to others
- Combining the development of professional supervision **with a 'top down' and 'bottom up' approach** in practice

Although the intention of all the workshops was to inquire about the positive elements of supervision with a view to building on these for wider implementation in SEHSCT inevitably 'problems' surfaced. Whilst not dealt with directly at the time, they were acknowledged and 'parked' as issues that will need to be considered within the design of a professional supervision implementation strategy for the Trust. **Parked issues** included;

- How will **professional supervision differ from other forms of supervision** in SEHSCT?
- How will **time for professional supervision** be found?
- Where is the **evidence that professional supervision** can (or will) **contribute to more effective patient / client care?**
- **What is effective** (as opposed to non effective) **professional supervision?**

- What might be the **legal implications** of engaging in professional supervision?
- **Will professional supervision become mandatory** and if not **what will happen to those not engaging in professional supervision?**
- Will **professional supervision** also become available for **'non' registrant staff?**
- **What sort of training** in professional supervision will be required?

A prominent theme arising from the parked issues and emerging as a 'strong restraining force' (Appendix 2) in a later activity in the workshop, was practitioner confusion with how professional supervision might differ from other forms of supervision available within SEHSCT. As stated previously in this report (p8), the term professional supervision is a generic term used in this report to encompass all those activities contained in the supervision policy (SEHSCT 2008 p6) that includes;

- supervision for *clinical purposes*
- supervision for *supportive purposes*
- supervision for *professional development purposes*
- supervision for *managerial purposes*

Therefore practitioners might need to access a range of supervision in SEHSCT, but will need to be able to differentiate those supervision activities as well as individually demonstrate evidence that it has occurred.

**Recommendation 4: A 'Professional Supervision Briefing Paper' for practitioners be published differentiating ways that practitioners can demonstrate evidence of engaging in 'supervision activities' outlined in the Trust policy (SEHSCT 2008 p6).**

Further ideas for moving forward with the identified challenges for implementation of professional supervision and associated recommendations are discussed later in the report. Phase 2 closed by bringing together the mornings' activities and examining through guided discussion what participant / practitioners thought might be the distinguishing features of effective supervision;

## Some distinguishing features of effective supervision in SEHSCT

- Planned and **protected use of time**
- Will have a **range of methods** depending on the needs of practice areas
- Requires **commitment and support from managers** to legitimise the process in practice as well as the involvement of supervision participants
- Can be **formal / planned** but **might begin as also informal and** ad-hoc meetings / sessions
- Involves a **choice of supervisor**
- Is **intended to meet supervisee needs** / their agenda
- Will involve a **'top down' as well as 'bottom up'** approach for its development and more **widespread acceptance** in practice
- Provides **individual practitioner evidence** of Continuing Professional Development
- **Confidential process**...with exceptions

This stage appeared helpful in discussing what to aspire towards with the development of professional supervision in SEHSCT against the practical realities faced by those presenters who were actively engaged in the process and a useful preparation for phase 3 activities;

### ***Summary participant / practitioner responses to Phase 3;***

The final phase of the workshop brought together the learning and insights from phases 1 & 2, in which participant / practitioners were invited to identify strong and weak **Driving** and **Restraining** forces to support the implementation of supervision in SEHSCT. Driving forces were described as the pushing forces or strengths already within SEHSCT that supported the implementation of professional supervision. Restraining forces were described as those factors that would either slow down, or significantly interfere with the implementation of professional supervision. Together, data from both sets of Driving and Restraining forces represented an 'organisational cultural assessment for the

development of supervision' (Lynch & Happell 2008a) albeit by a small cross section of participant / practitioners in SEHSCT.

The afternoon activities described ways in which the representative participant / practitioners (acting on behalf of other colleagues in SEHSCT), viewed how existing **Driving forces for professional supervision could be strengthened** and **Restraining forces** once identified, **might become minimised if not completely eradicated**. Inevitably with any intended change, there will be resistance (and was), but the afternoon activities provided what was referred to as *a bonfire of responses* making a valuable contribution to ideas for the development of professional supervision in SEHSCT.

A number of themes were identified from participant / practitioner perceptions about what constituted **Strong and Weak Driving Forces**;

- Governmental influences and leadership
- Organisational leadership and direction
- Communicating professional supervision ideas in a consistent way across SEHSCT
- Current available expertise and experience with professional supervision (including from previous organisations):
- Positive practitioner attitudes towards the development of supervision in SEHSCT (that may have also come from previous organisations):
- Support for education and training opportunities with professional supervision:

A more detailed description of participant / practitioner responses in relation to perceived Strong and Weak Driving Forces with some additional comments for further clarification is contained in Appendix 2. Some discussion issues arising from the responses to Strong and Weak Driving Forces were that a major barrier

to successful implementation of professional supervision is when there is an obvious lack of a clear policy direction from government and organisational leadership (Clifton 2002, Cutcliffe & Proctor 1998, Rice et.al 2007). Clearly strong forces are at work in SEHSCT with the published Standards on Supervision (DHSSPS 2007), the publication of best practice guidelines for supervision (DHSSPS 2005, 2004), and the supporting NIPEC review (NIPEC 2007) and Development Framework (NIPEC 2006).

Despite strong driving force's for the implementation of professional supervision, communicating this in a consistent way across SEHSCT requires further strengthening (Appendix 2). Whilst a policy and an organisational infrastructure for professional supervision are critical for its development in SEHSCT, an effective implementation strategy also has to consider ways of 'winning the hearts and minds' of practitioners to engage in the process. Such elements of an implementation strategy includes the need to communicate what professional supervision is (and is not), through raising awareness and specifically identifying what the benefits (and incentives) are to encourage practitioners to get started and how to go about accessing supervision in practice.

**Recommendation 5: Convene a meeting with those identified as having responsibility for implementing professional supervision (including self nominating supervision 'champions'), to generate ways that a consistent supervision message can be communicated to practitioners in target sites in SEHSCT.**

**Recommendation 6: Clearly identify for practitioners in any agreed communication strategy what professional supervision is (and is not), the specific benefits for practitioners and where to access local information for getting started with professional supervision.**

There was undoubtedly active and positive support by participant / practitioners who attended the workshop(s) for the development of professional supervision in practice. Whilst active supervisors are an obvious resource in SEHSCT (as well as the supervisees already in the process) they will need to have further support

and updating to continue their work effectively. Although perhaps obvious, the launch of professional supervision in SEHSCT will increase the demand for working supervisors requiring further training programmes to increase the 'pool' of supervisors, as well as increase supervisee choice of supervisor.

**Recommendation 7: An audit of current working supervisors is undertaken identifying what support might be necessary to effectively supervise others in practice and ways that new supervisors will be supported in their new role.**

**Recommendation 8: The number of working supervisors in practice will need to be increased and a suitable training programme devised and agreed, followed by publication of a Trust wide list of active supervisors.**

For the majority of registrant nurses employed by the Trust, undertaking a supervisory role will already be part of their job description suggestive of 'topping up' their existing skills and experience for use in professional supervision. As part of attracting new supervisors (perhaps including managers), a criteria for becoming a supervisor will need to be agreed and disseminated. The selection of a supervisor might also include a peer nomination process e.g. practitioners put forward those they think might be suitable supervisors in practice who then go on to undertake training. Whilst perhaps viewed as a lengthy process, new supervisors who have been nominated by their peers are likely to increase the uptake of professional supervision by those same supervisees' (Lynch & Happell 2008b).

**Recommendation 9: The criteria for being a supervisor in practice needs to be agreed and disseminated, to include whether a process of peer nomination might yield an increased number of supervisors and subsequent uptake in practice**

Finally, whilst training resources including publication of a comprehensive *Learning & Development Strategy for Supervision* (DHSSPS / NIPEC 2008) is available in SEHSCT, the self evaluation tool needs wider dissemination (perhaps as an appraisal item), in order to assess the training and development

needs of supervisees as well as supervisors. It was not clearly outlined by participant / practitioners whether is a preference for combined or separate programmes for supervisors and supervisees as a way of strengthening supervision training as a strong driving force for the development of professional supervision in SEHSCT. However there would seem to be scope for using both working supervisors and supervisees experiences to support future supervision training initiatives.

**Recommendation 10: A self evaluative assessment (perhaps included as an appraisal item), needs to be made to gauge the potential for the development of new supervisors and supervisees within anticipated target sites based on the work of the regional *Learning and Development Strategy for Supervision* (DHSSPS / NIPEC 2008)**

As a counterbalance to the Strong and Weak Driving Forces, participant practitioners were additionally asked, based on their previous supervisory experiences to identify Strong and Weak Restraining Forces that might interfere with SEHSCT's goal for the widespread implementation of professional supervision. A number of competing organisational ideas emerged about the development of professional supervision based on differing managerial and practitioner responses and perceptions. The themes identified about what constituted **Strong and Weak Restraining Forces** were;

- Practical reasons for not being able to develop professional supervision in SEHSCT:
- Negative practitioner attitudes for the development of professional supervision in SEHSCT (that may have also come from previous organisations):
- Implications for future training and education for the development of professional supervision:

A more detailed description of participant / practitioner responses in relation to perceived Strong and Weak Driving Forces is contained in Appendix 3. It would appear that poor experiences of (clinical?) supervision, whether as a result of engaging in the process or, being involved with previous implementation strategies in other organisations may present a major challenge to its successful development within SEHSCT. In addition and just as significant, would seem the timing for the implementation of professional supervision when practitioners are also facing major organisational change and uncertainty.

**Recommendation 11: Ways need to be actively sought to identify how, and build on, the constructive dialogue and networking demonstrated during the Supervision Inquiry Workshops and where possible, replicated or adapted, to support further organisational change in SEHSCT.**

As previously alluded to in this report, further work also needs to be guided towards developing a shared understanding of professional supervision by practitioners in SEHSCT. This will include assessing the quality of what professional supervision is already happening in SEHSCT and prioritising further training needs and requirements in conjunction with the self development reports outlined in Recommendation 10.

**Recommendation 12: A Trust wide ‘supervision mapping’ exercise should be undertaken within SEHSCT to examine what supervision activity is already happening, its effectiveness and implications for targeting further training and implementation efforts.**

Whilst many of the practical reasons cited for not being able to develop professional supervision are perhaps not surprising e.g. the need to build professional supervision into the working day, lack of understanding, poor staffing etc. However, the negative practitioner attitudes outlined by participant / practitioners do present a strong and significant restraining force. Although this may have surfaced from within previous organisations, it will have implications

not just for implementing professional supervision, but the management of change generally in SEHSCT.

**Recommendation 13:**

**Those identified as having responsibility for implementing professional supervision in SEHSCT (including self nominating supervision ‘champions’), work with target groups to generate, and report on ways that professional supervision can be adapted into the working day based on Figure 1 (p.13 of this report) and the *Purposes of Supervision Activities* (SEHSCT 2008 p6).**

**Recommendation 14: Clearly identify for practitioners in any agreed communication strategy how professional supervision links to Clinical Governance, clearly outlining organisational, as well as individual, roles and responsibilities for its development in practice.**

**Recommendation 15: Departmental managers to include the uptake of professional supervision as an area of discussion during individual appraisal meetings and the setting of agreed objectives with practitioners.**

**Recommendation 16:**

**Those previously identified as having responsibility for implementing professional supervision in SEHSCT actively promote (in conjunction with senior managers), ways of devolving responsibility and foster ownership for its development by practitioners in practice.**

Despite strong and weak restraining forces outlined in Appendix 2, participant / practitioners demonstrated an ability throughout the workshops to examine implementation issues in a constructive way producing a feasible **Summary Action Plan** for the development of professional supervision in SEHSCT (Appendix 4) that included some initial ideas for evaluating the initiative. These have been themed as;

- Further clarification on professional supervision
- Managerial and departmental issues
- Disseminating professional supervision
- Education and training issues
- Monitoring and evaluation

Although far from a consensus view of nursing practice and perhaps even a minority view, collectively, the findings represent a valuable insight for the development of professional supervision in nursing from inside the 'real' world of SEHSCT practice'.

**Recommendation 17: The diverse range of issues raised by participant / practitioners to this Supervision Inquiry (Appendices 2 & 3), the Summary Action Plan (Appendix 4) and the Recommendations in this report be reviewed and inform the development of professional supervision initiatives in SEHSCT.**

### ***Supervision Inquiry Workshop(s) Evaluation***

At the end of each of the Supervision Inquiry Workshop(s) an optional self report questionnaire was administered (Appendix 5) to participant / practitioners. Despite a long day(s) with an enormous amount of participant / practitioner effort and completion being optional, the response rate for questionnaires was 85%. Such a high response was a further indicator of the interest generated for the development of professional supervision in SEHSCT. The vast majority of practitioners felt that the aims of the day(s) had been met and just as importantly, individually stated hopes and expectations were also achieved. All of the evaluative responses for the Supervision Inquiry Workshops for any future cross referencing are held by Dr. Bob Brown - Assistant Director of Nursing (Learning and Development). The selection of comments below seemed to crystallise what happened during the workshop activities, offering a rich source of narrative feedback for the development of professional supervision;

- *“It’s good to know that the purist model can be parked in favour of a range of supervision activities”*
- *“I appreciated the focus around turning the issue of protected time into a more positive slant on the importance of building supervision into daily practice”*
- *“Supervision can be carried out anywhere – not just formal sessions”*

- *“The level of information has inspired me to establish supervision within my workplace – both formal and informal”*
- *“I particularly enjoyed the group work – much food for thought in how to get supervision established”*
- *“The supervision martini effect – anytime, anyplace, anywhere!”*
- *“I found out for the first time that there are multiple ways of doing supervision – not necessarily a right or wrong way, as long as we stick to the principles around facilitating reflective practice”*
- *“I enjoyed meeting with other colleagues and realising they have the same issues around supervision and the opportunity of working together to think of ways to overcome these”*
- *“For supervision to be effective it must be supervisee led”*
- *“I feel this workshop has made me feel more confident as a supervisor and encourages me to keep the momentum going”*
- *“Feel that I can be more competent and confident when doing supervision either individual or group”*
- *“I am now really positive that we can make it work in a meaningful way in practice. I would be interested in becoming a champion for supervision in the Trust”*

## **5. Conclusion**

One of the challenges for the implementation of professional supervision is that there still remains a lack of literature specifically addressing how to establish and monitor a successful strategy beyond the initial implementation plan (Lynch & Happell 2008b). This would seem an opportunity for SEHSCT with its supervision experience and expertise, to address the dearth of literature, in addition to instigating a feasible implementation plan for professional supervision. Furthermore, Lynch & Happell (2008c) argue that assessing the supervision culture of an organisation e.g. using a force field analysis, should not be a one off event, but needs to be continually reviewed and reflected upon in the light of changes and progress made. The spectre

of 'implementing clinical supervision' 'then', (and in previous organisations), as opposed to the development of professional supervision 'now' in SEHSCT, presented a number of significant challenges outlined in this report. Based on the responses to the three Supervision Inquiry Workshop(s) there is not just an active support, but a genuine willingness by participant / practitioners to tackle the challenges posed evidenced by the quality of responses underpinning this report.

The main aims of the Supervision Inquiry Workshop(s) were to obtain staff support for the development of professional supervision using a variety of methods and workshop activities. Whilst this seems the case in relation to the 147 staff who participated in the workshop(s) and anecdotally, the effort and enthusiasm in responding to the workshop activities (including identifying a total of 28 potential supervision 'champions'), further work will need to be undertaken in communicating a consistent professional supervision message across SEHSCT.

The willingness not simply to participate, but the sharing of both positive and negative ideas, experiences and expertise required trust on behalf of those taking part and a readiness to disclose, as well as offer constructive feedback to SEHSCT. In this respect, the Supervision Inquiry may have also been what Playle & Mullarkey (1998) refer to as a 'parallel process' in professional supervision. In other words, what happened in the workshops being a mirror of what is happening (and thought about) by those working in practice. The supervision presentations provided a valuable insight, as well as a positive role model, for those considering setting up professional supervision in practice despite its challenges.

The Supervision Inquiry was a frank and open discussion on some of the key issues concerning the development of professional supervision in SEHSCT. Based on the authors' experience and the available literature, to be successful the implementation of professional supervision needs to be managed on TWO fronts; a) winning the hearts and minds of staff to become engaged in the process as a legitimate activity in practice, whilst

meeting service delivery demands and b) developing a robust infrastructure for professional supervision across SEHSCT.

Whilst implementing professional supervision within nursing might seem yet another 'change hurdle to straddle', Wilkins et. al. (1997) remind us when describing their experiences of implementing professional supervision in nursing;

*....within the paradox that change is the only thing likely to remain constant in healthcare lies the irony that the object of resistance....professional supervision, could actually provide some relief from the pressures such changes have created.....*

The professional supervision landscape has now become even more evident in SEHSCT following the Supervision Inquiry Workshops. However, just as importantly in this report has been the ability of participant / practitioner's (acting on behalf of other colleagues in the Trust), to work collaboratively to generate their own solutions to the development of professional supervision. In doing so, SEHSCT has been actively supported to make the leap from simply believing that professional supervision *is needed* in practice, to facilitating a process in which practitioners have now discovered that professional supervision is now *wanted* by them in practice.

## 6. References

Barrowman, L. (2000) *Clinical supervision: the future imperatives* The National Board for Nursing, Midwifery and Health Visiting for Northern Ireland (NBNI), Belfast, Northern Ireland, UK.

Cleary, M. Freeman, A. (2005) 'The cultural realities of clinical supervision in an acute inpatient mental health setting' *Issues in Mental Health Nursing* (26):489-505.

Clifton, E. (2002) 'Implementing clinical supervision' *Nursing Times* 98 (9): 36-37.

Cooperrider, D. Whitney, D. (1999) *Appreciative Inquiry* Berrett-Koehler, San Francisco, CA, USA.

Cutcliffe, J. Proctor, B. (1998) 'an alternative training approach to Clinical Supervision' *British Journal of Nursing* (7): 280-285.

Department of Health (1994a) *Clinical supervision for the nursing and health visiting professions* (CNO Letter), 94 (5), HMSO, London, UK.

Department of Health (1994b) *The Clothier Report: Independent inquiry relating to the deaths on the children's ward at Grantham and Kesteven General Hospital* HMSO, London, UK.

Department of Health (1993) *A Vision for the Future: Report of the Chief Nursing Officer* HMSO, London, UK.

Department of Health, Social Services and Public Safety (2007) *Standards for Supervision for Nursing* (CNO Letter), July, DHSSPS Belfast, UK.

Department of Health, Social Services and Public Safety (2006) *The Quality Standards for Health and Social Care* DHSSPS Belfast, UK.

Department of Health, Social Services and Public Safety (2005) *Clinical supervision for Learning Disability Nurses in Northern Ireland: Best Practice Guidelines* DHSSPS, Belfast, UK.

Department of Health, Social Services and Public Safety (2004) *Clinical supervision for Mental Health Nurses in Northern Ireland: Best Practice Guidelines* DHSSPS, Belfast, UK.

## 6. References continued.

Department of Health, Social Services and Public Safety / Northern Ireland Practice and Education Council (2008) *Supervision Project Learning and Development Strategy* (March), DHSSPS / NIPEC, Belfast, UK.

Driscoll, J. (2007) (ed.) *Practising clinical supervision a reflective approach for healthcare professionals* (Second Edition), Bailliere Tindall, Elsevier, Edinburgh, UK.

Lewis, R. Cole, D. Williamson, A. (2003) *Review of Health and Social Services in the case of David and Samuel Briggs* DHSSPS, Belfast, UK.

Lynch, L. Happell, B. (2008a) 'Implementing clinical supervision: Part 1: Laying the ground work' *International Journal of Mental Health Nursing* (17): 57-64.

Lynch, L. Happell, B. (2008b) 'Implementation of clinical supervision in action: Part 2: Implementation and beyond' *International Journal of Mental Health Nursing* (17): 65-72.

Lynch, L. Happell, B. (2008c) 'Implementation of clinical supervision in action: Part 3: The development of a model' *International Journal of Mental Health Nursing* (17): 73-82.

McCleery Inquiry Panel (2006) *Executive summary and recommendations from the report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board* [online]

<http://www.ehssb.ni.nhs.uk/EBWEB.NSF/32b4770d2885ca9380257103004e0c92/12741c5c2cf2d8ee8025717a00390db2/> accessed 01/05/08.

Murtagh Review (2005) cited in: Regulation & Quality Improvement Authority *Review of the Lessons Arising from the Death of Mrs Janine Murtagh* [online]

[http://www.rqia.org.uk/cms\\_resources/Murtagh.pdf](http://www.rqia.org.uk/cms_resources/Murtagh.pdf) accessed 29/04/08.

Northern Ireland Practice and Education Council (2007) *The Review of Clinical Supervision for Nursing in the HPSS 2006 on Behalf of the DHSSPS NIPEC*, Belfast, UK.

Northern Ireland Practice and Education Council (2006) *Learning Activities List* [online] [www.nipecdf.org/learn/actList.asp](http://www.nipecdf.org/learn/actList.asp) accessed 14/05/08.

## 6. References continued.

Nursing and Midwifery Council (2006) *Guiding Principles for Clinical Supervision* NMC, London, UK.

O’Riordan, B. (2002) ‘Why nurses choose not to undertake clinical supervision – the findings from one ICU’ *Nursing in Critical Care* 7(2):59-66

Playle, J. Mullarkey, K. (1998) ‘Parallel process in clinical supervision: enhancing learning and providing support’ *Nurse Education Today* (18): 558-566.

Rice, F. Cullen, P. McKenna, H. Kelly, B. Keeney, S. Richey, R. (2007) ‘Clinical supervision for mental health nurses in Northern Ireland: formulating best practice guidelines’ *Journal of Psychiatric and Mental Health Nursing* (14): 516-521.

Royal College of Nursing (1999) *Look back move on: clinical supervision for nurses* RCN, London, UK.

South Eastern Health and Social Care Trust (2008) Policy for Supervision in Nursing (January), Lisburn, Northern Ireland, UK.

Shipman Inquiry (2005) Sixth Report – Shipman: The Final report [online] <http://www.the-shipman-inquiry.org.uk/finalreport.asp> accessed 29/04/08.

United Kingdom Central Council for Nursing and Midwifery (UKCC) (1996) *Position statement on Clinical Supervision for Nursing and Health Visiting* United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London, UK.

Watkins, J.M. Mohr, B.J. (2001) *Appreciative Inquiry – Change at the Speed of Imagination* Jossey Bass Pfeiffer, San Francisco, CA, USA.

Wilkin, P. Bowers, L. Monk, J. (1997) ‘Clinical Supervision: Managing the resistance’ *Nursing Times* 93(8):48.

## **7. Summary of Recommendations:**

### **Recommendation 1:**

All participant/practitioners need to be acknowledged for their contribution and have access to this report and in particular, those who self nominated to act as 'supervision champions' need further direction and support to do so.

### **Recommendation 2:**

The practice of senior nursing staff actively engaging in professional supervision provides a positive role model and legitimacy for the activity and be regarded as 'best practice' in SEHSCT.

The practice of senior nursing staff actively engaging in professional supervision provides a positive role model and legitimacy for the activity and needs to become standard practice particularly in areas new to its development.

### **Recommendation 3:**

The self nominating supervision 'champions' role as distinct from other roles outlined in the draft supervision policy (SEHSCT 2008) needs further clarification and support for the new role in practice.

### **Recommendation 4:**

A '*Professional Supervision Briefing Paper*' for practitioners be published differentiating ways that practitioners can demonstrate evidence of engaging in '*supervision activities*' outlined in the Trust policy (SEHSCT 2008 p6).

### **Recommendation 5:**

Convene a meeting with those identified as having responsibility for implementing professional supervision (including self nominating supervision 'champions'), to generate ways that a consistent supervision message can be communicated to practitioners in target sites in SEHSCT.

### **Recommendation 6:**

Clearly identify for practitioners in any agreed communication strategy what professional supervision is (and is not), the specific benefits for practitioners and where to access local information for getting started with professional supervision.

### **Recommendation 7:**

An audit of current working supervisors is undertaken identifying what support might be necessary to effectively supervise others in practice and ways that new supervisors will be supported in their new role.

## **7. Summary of Recommendations continued:**

### **Recommendation 8:**

The number of working supervisors in practice will need to be increased and a suitable training programme devised and agreed, followed by publication of a Trust wide list of active supervisors.

### **Recommendation 9:**

The criteria for being a supervisor in practice needs to be agreed and disseminated, to include whether a process of peer nomination might yield an increased number of supervisors and subsequent uptake in practice

### **Recommendation 10:**

A self evaluative assessment (perhaps included as an appraisal item), needs to be made to gauge the potential for the development of new supervisors and supervisees within anticipated target sites based on the work of the regional *Learning and Development Strategy for Supervision* (DHSSPS / NIPEC 2008)

### **Recommendation 11:**

Ways need to be actively sought to identify how, and build on, the constructive dialogue and networking demonstrated during the Supervision Inquiry Workshops and where possible, replicated or adapted, to support further organisational change in SEHSCT.

### **Recommendation 12:**

A Trust wide 'supervision mapping' exercise should be undertaken within SEHSCT to examine what supervision activity is already happening, its effectiveness and implications for targeting further training and implementation efforts.

### **Recommendation 13:**

Those identified as having responsibility for implementing professional supervision in SEHSCT (including self nominating supervision 'champions'), work with target groups to generate, and report on ways that professional supervision can be adapted into the working day based on Figure 1 (p.13 of this report) and the *Purposes of Supervision Activities* (SEHSCT 2008 p6).

### **Recommendation 14:**

Clearly identify for practitioners in any agreed communication strategy how professional supervision links to Clinical Governance, clearly outlining organisational, as well as individual, roles and responsibilities for its development in practice.

## **7. Summary of Recommendations continued:**

### **Recommendation 15:**

Departmental managers to include the uptake of professional supervision as an area of discussion during individual appraisal meetings and the setting of agreed objectives with practitioners.

### **Recommendation 16:**

Those previously identified as having responsibility for implementing professional supervision in SEHSCT actively promote (in conjunction with senior managers), ways of devolving responsibility and foster ownership for its development by practitioners in practice.

### **Recommendation 17:**

The diverse range of issues raised by participant / practitioners to this Supervision Inquiry (Appendices 2 & 3), the Summary Action Plan (Appendix 4) and the Recommendations in this report be reviewed and inform the development of professional supervision initiatives in SEHSCT.

## APPENDICES:

1. Supervision Inquiry Workshop Aims and Programme Outline
2. Perceived Strong and Weak Driving Forces supporting the implementation of professional supervision by workshop participants
3. Perceived Strong and Weak Restraining Forces challenging the implementation of professional supervision by workshop participants
4. Summary Action Plan for the development of professional supervision in SEHSCT
5. Workshop Evaluation

## Appendix 1: Supervision Inquiry Workshop Aims and Programme Outline



### *Implementing Supervision in the Workplace From Practical Inquiry to Practical ACTIONS!*

Monday 25<sup>th</sup> February 2008

Burrendale Hotel, Newcastle

09.30 – 16.00

A Workshop with: John Driscoll

#### *Intended workshop outcomes;*

- To obtain staff support for the development of supervision across South Eastern Health and Social Care Trust
- To raise professional awareness of how supervision can work in everyday practice based on the experiences of those already engaged in the process
- To discuss the implications of committing to implementing supervision across South Eastern Health and Social Care Trust and practical ways that it might be supported in practice
- To agree (in principle) a strategic 'way forward' that will include a shared vision of supervision in South Eastern Health and Social Care Trust over the next 12 months based on available resources
- To actively support selected workshop participants expertise and commitment with supervision to act as 'champions' in its development across South Eastern Health and Social Care Trust

## Appendix 1: contd.

*Implementing Supervision in the Workplace  
From Practical Inquiry to Practical ACTIONS!*

Monday 25<sup>th</sup> February 2008

0915 – 0930	COFFEE / REGISTRATION & NETWORKING	
0930 – 0945	Welcome and setting the scene...for the development of supervision in SEHSCT	Bob Brown
0945 - 1000	Just like supervision...agreeing the intentions (and perception) of the workshop	John Driscoll
1000 – 1100	Unlocking the secrets of best practice supervision in practice (Activity 1)	John / Bob / All
1100 – 1120	COFFEE & NETWORKING	
1120 – 1215	Defining supervision and supervisory practice in SEHSCT Supervision Snapshots from practice: (Activity 2) -supervision from a managerial perspective -supervision from a supervisee perspective -supervision from a supervisor perspective	John / Speakers  TBA
	Guided Discussion and Question Time	All
1215 – 1245	Pulling it all together: Key issues to consider when implementing supervision in practice	John / All
	Reflection on morning	John / Bob / All
1245 – 1330	LUNCH & NETWORKING	
1330 – 1500	FROM IMAGE TO ACTION: Co-creating a shared vision of supervision in SEHSCT and ways of making implementation a practical reality over the next 12 months (Activity 3)	John / Bob / All
1500 – 1520	TEA & NETWORKING	
1520 – 1545	Learning review and feedback Supervision 'champions' review Verbal evaluation of the day	All
1545 – 1600	Closing remarks....Closure & written evaluations	Bob

## **Appendix 2:**

### **Perceived STRONG and WEAK DRIVING FORCES (*weaker forces in italics*) supporting the implementation of professional supervision by workshop participants**

#### **Governmental influences and leadership:**

- Government led changes supporting supervision
- Published CNO Standards on Supervision
- Regional Inquiries
- NIPEC Supervision Review for DHSSPS
- NIPEC Development Framework including guidance on supervision and reflective practice
- Leadership for supervision from ex Director of Nursing / Chief Executive
- NMC Guidelines for supervision

#### **Organisational leadership and direction:**

- Draft SEHSCT Policy on Supervision
- Key individuals in SEHSCT already skilled in facilitating groups and supervision
- Senior management commitment towards Clinical Governance
- Support for self nominating supervision 'champions'
- Development of a 'new' organisation and an expectation for a 'new' way of working
- *More robust supervision policy and guidelines*

#### **Communicating professional supervision ideas in a consistent way across SEHSCT:**

- *Disseminate supervision policy in different ways (unclear... roadshows, whole day events, in-house literature, supervision policy guidance or consultation?)*
- *Increase supervision awareness*

## **Appendix 2 continued:**

- *Lead person in clinical area to encourage / motivate staff to take forward* (unclear...whether a lead differs from a champion, how motivation will occur e.g. incentives?)
- *Staff to be able to demonstrate gains (benefits) from being in supervision* (unclear...how will this be monitored and by whom, just who benefits by being in supervision?)
- *A variety of supervision methods / approaches already exist but more need to be developed* (as previously outlined in phase 1, different methods of supervision may need wider dissemination from those described in SEHSCT supervision policy)
- *Build in to existing staff meetings* (unclear..as a form of supervision, information about supervision and its implementation?)
- *Reduce the jargon associated with supervision*

## **Current available expertise and experience with professional supervision (including from previous organisations):**

- Committed (and accessible) supervisors already working in practice
- More confident and competent practitioners (unclear... if this was in implementing or 'doing' supervision in practice)
- *Maximise use of (self nominated) champions in SEHSCT* (the term 'champions' does not currently appear in the SEHSCT supervision policy...role differences and responsibilities between champions, supervision leads, managers, supervisors?)
- *Willingness by staff to develop supervision / promote ownership* (unclear...staff who attended Supervision Inquiry Workshops, others in practice not yet identified...who and what staff?)
- *More support for working supervisors in practice e.g. support groups*

## Appendix 2 continued:

- *Possibility for adapting more formalised and planned approaches to supervision from informal and ad-hoc supervision already happening in practice*
- *Raise awareness through workshops that supervision is already working well in some areas*

## Positive practitioner attitudes towards the development of supervision in SEHSCT (that may have also come from previous organisations):

- Not alone in supporting the development of professional supervision e.g. strong leadership and supervision expertise
- Motivation for re-starting supervision
- Younger workforce in SEHSCT (unclear...to concentrate supervision resources? ...will just take up supervision as a 'normal' aspect of practice? ...raised expectations for supervision through education?)
- *Consider a multi-professional approach in supervision* (unclear...as in supervision groups...and or its implementation....cost effectiveness as an organisation?)
- *Promote own level peer group (supervision) to get started*
- *Informal peer support for its development* (unclear...as a supervision method...as a way of implementing in departments, challenging the concept of formalised supervision?)
- *Identify and communicate what incentives for becoming supervisors or getting involved in supervision* (unclear...what incentives might be available for supervisors...perhaps it might also be useful to identify what happens if practitioners do not uptake at least two annual sessions of supervision when there is an organisational infrastructure in place?)
- *Use of group supervision as less threatening than individual supervision*

## Appendix 2 continued:

### Support for education and training opportunities with professional supervision:

- *Education / Training already available from within BMC? (unclear...Beeches Education Centre?)*
- *Influence of supervision / reflective practice in student nurse training*
- *Promotion of learning from others' supervision experiences*
- *EP (Education Practitioner?) practice... (unclear what this means...skills of facilitation, guided reflection, managing change, source of support?)*
- *Ensure staff access to supervision training (unclear....existing expertise, updates etc. what sort of training needs to happen?)*
- *Increase supervision expertise of staff*
- *Increased knowledge and skills in better use of managing time (for and in supervision)*

### **Appendix 3:**

#### **Perceived STRONG and WEAK RESTRAINING FORCES challenging the implementation of professional supervision by workshop participants**

##### **Practical reasons for not being able to develop professional supervision in SEHSCT:**

- Poor staffing levels
- Lack of protected time
- Inadequate physical environments in which to do supervision *increase environments conducive to supervision*
- Lack of IT resources to access remote areas
- The term 'supervision' rather than others cited e.g.. '*clinical support*', '*reflective practice*', '*practice support*'.. *reflecting changing views / opinions of staff*
- Geographical distances to now travel in SEHSCT for supervision
- General resistance to change with so much change already happening / feelings of insecurity
- Poor timing with other changes happening in practice for example... RPA? Needing to meet Government targets, *Agenda for Change* e.g. outstanding banding issues / winners and losers /its impact on practitioners
- Lack of supervision knowledge and training needs
- Lack of clarity and understanding about supervision and ability to choose a supervisor (or be allocated a supervisor)
- Conflict over what the priorities are for change in SEHSCT e.g. concerns about jobs, loss of Practice Development roles etc.
- *Work commitments*

##### **Negative practitioner attitudes for the development of professional supervision in SEHSCT (that may have also come from previous organisations):**

- Strong inequalities in amalgamation of other organisations into SEHSCT
- Not part of the nursing culture (social work perspective)

### **Appendix 3 continued:**

- Lack of interest / apathy / poor motivation / unwillingness to participate in supervision / cynicism / scepticism
- Weak management commitment to supervision development
- Being put into a role e.g. supervisor or supervisee that would not be your choice
- Lack of co-ordination of resources for supervision / resources
- Concerns about the legal implications of participating in supervision
- Perceived as a managerial tool
- Some people might not want it e.g. ageing workforce... 'why now?'
- *Supervision as meaning too many things e.g. 'Martini time' ...any place, any where, any time*
- *Dual role of being a manager and also acting as a supervisor*
- *Fear about exposing poor practice in supervision situation*
- *No acknowledgment of (existing) supervisors work*

### **Implications for future training and education for the development of professional supervision:**

- Prioritise supervision training needs...analysis / mapping exercise?
- More clarity on supervision methods / development of alternative methods for supervision
- In-house preparation for supervision and use of external sources to manage a negative culture
- Challenging the work culture to begin to take an interest in each other as nurses and best practice initiatives e.g. learning from patient centred care initiatives, shared learning where supervision is working well
- Adequate preparation of supervisees to use supervision effectively
- Clarification of legal issues re: documentation/confidentiality
- Exploring what might be harmful or ineffective supervision and how will this can be recognised or monitored
- Managing the complexities of supervision
- Ways in which practitioners can be more proactive at work rather than simply reacting to situations...developing thinking space either alone or with others?

## Appendix 4: Summary Action Plan for the development of professional supervision in SEHSCT

### Further clarification on professional supervision:

- Clearer direction and further information about regional; policy and standards for supervision in SEHSCT e.g. **develop a communication strategy** for professional supervision implementation
- Further **guidance on how to document and evidence** professional supervision in practice
- **Lessen confusion** for who is responsible for what and when with professional supervision e.g. roles and responsibilities

### Managerial and departmental issues:

- Review SEHSCT **policy** on supervision e.g. roles, expectations, getting started
- Promote the **networking** amongst staff at supervision workshops and in SEHSCT e.g. contact points, expertise ...intranet, email addresses?
- **Shadow opportunities** with people already doing supervision well
- Use ways of promoting **practice development initiatives on patient centred care** into the supervision situation e.g. focus for supervision, methods used to implement change etc.
- Appoint a **supervision co-ordinator** for each Directorate
- Establishment of Trust wide **supervision implementation groups** utilising different staff from previous organisations
- **Use of professional supervision to act as a catalyst for organisational change** e.g. can also act as a team building activity, involvement in reviewing draft supervision policy / documents / briefing guidelines
- **Managerial support for protected time** for professional supervision as a legitimate activity in practice alongside ideas about how to evidence this
- **Support for being creative** in the development of supervision and in use of different methods – **‘soup’er vision** an eclectic blend of different methods and approaches e.g. from informal to formalised supervision

#### **Appendix 4: continued.**

- Review **current infrastructure for professional supervision** and establish **feedback loops**
- Through organisational leads and supervision 'champions' in practice **promote practitioner ownership**, combined 'bottom up' and 'top down' approaches to implementation
- Develop a **list / network / pool of available supervisors** to allow choice
- **Agree a model** for implementing professional supervision in the Trust...**just one way or promoting diversity** of methods and approaches to meet needs?
- Embed supervision in **new practitioners** through mentorship and clinical education facilitation....**target group?**
- Start **implementation of supervision in a small way** in practice
- **Rotate supervision locations** rather than one venue or site
- **Promote engaging in supervision as an appraisal objective** to be met as part of individual performance reviews
- Begin by **formalising group reflective practice in practice with a focus** e.g. patient centred care, evidence based practice (journal club?), debriefing following critical incident
- Consider ways of **'marketing' professional supervision** to practitioners e.g. 'growing together' slogan / logo etc.

#### **Disseminating professional supervision:**

- Follow up and clarify role with **self nominating supervision 'champions'** identified during workshops e.g. commitment, expectations etc.
- Supervision Inquiry **information based on workshops** to be made available to all staff and in particular those in attendance
- Use of **Assistant Director** to speak to staff about development of supervision
- Use of **Trust Intranet to disseminate supervision information** e.g. staff involved / training programmes / road shows

#### **Appendix 4: continued.**

- **Utilise experienced supervisors (and supervisees)** within the Trust that have already been trained and are practising to act as 'supervision champions or ambassadors for supervision e.g. road shows, in training workshops etc.
- **Increased use of IT** to communicate to **remote geographical areas** in SEHSCT
- **Sell supervision** as being supporting rather than inflicting, promote benefits
- Development of **SEHSCT newsletter / brief guidelines on supervision**

#### **Education and training issues:**

- Promote **NIPEC Development Framework** – supervision / reflective practice resources
- **Promote sharing / learning** of current supervisory practice and expertise in SEHSCT
- Develop a **co-ordinated Trust wide training/preparation programme** for supervision e.g. for supervisees, manager, supervisors etc. ....Learning & Development Framework? (DHSSPS & SEHSCT 2008)
- Development of **workshops for professional supervision** to clarify and increase understanding e.g. roles, **legal implications**, methods and including separate workshops for managers e.g. managing dual roles of supervisor / manager
- Development of a 1 page sheet as **evidence for documenting informal supervision** in practice
- **Supervision training for supervisors** and **develop ideas for supervisor support** e.g. away days, ensuring all working supervisors have access to supervision / are supervisees
- Explore **use of alternative methods for supervision** e.g. telephone supervision, internet, blogs network groups etc.

#### **Monitoring and evaluation:**

- **Baseline audits** prior to implementation of professional supervision that monitor **staff performance** e.g. sickness absence, complaints, incidents etc.
- Promote the **benefits of being in supervision** – advertise these

#### **Appendix 4: continued.**

- Consider ways of **benchmarking supervisory practice** or **developing standards** in professional supervision
- Obtain **feedback on the benefits** of professional supervision **audits / mapping** what is happening
- Use of **focus groups to evaluate** the effectiveness of supervision / implementation
- Develop audit tools to monitor the effectiveness (or not) of the supervision experience e.g. satisfaction surveys

## Appendix 5: Workshop Evaluation



*Implementing Supervision in the Workplace  
From Practical Inquiry to Practical ACTIONS!*

Monday 25<sup>th</sup> February 2008

### WORKSHOP EVALUATION

Please take a few minutes to complete this questionnaire and indicate by ticking the appropriate boxes the statements that most accurately reflects your opinions about the day and enter your comments in the boxes to help plan for future events

STATEMENTS ABOUT THE WORKSHOP	Strongly Agree	Agree	Disagree	Strongly Disagree
The intentions for the workshop were made clear at the beginning and closely resembled what actually occurred				
The venue was a good place to hold the workshop				
The inputs were helpful in achieving the outcomes of the workshop				
The group work was helpful in realising the aims and intentions of the day				
The overall facilitation of the day was of a high standard				
The quality of the hospitality arrangements was of a high standard				
I am leaving the workshop knowing more about supervision than when I started				
I have left the workshop with some definite things to do towards the development of supervision				
The workshop was well worth attending				

PLEASE GO TO NEXT PAGE

**Appendix 5: contd.**



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**WORKSHOP EVALUATION**

WHAT I LIKED BEST ABOUT THE WORKSHOP:

WHAT I LIKED LEAST ABOUT THE WORKSHOP:

ONE KEY THING I LEARNED ABOUT SUPERVISION TODAY WAS:

Thank you for completing this