

Coaching for clinicians

The value of professional coaching to improve performance for senior staff in the NHS is now recognised.

John Driscoll and Rachel Cooper examine its potential to enhance clinical supervision

CLINICAL SUPERVISION (CS) continues to be promoted across the UK as a legitimate work based activity for nurses, midwives and health visitors who work in the NHS. It also receives attention from allied health professions.

It is enshrined in the clinical governance framework as a continuing professional development activity beyond registration (McSherry and Pearce 2002) that demonstrates evidence of lifelong learning in meeting statutory regulatory requirements (Nursing and Midwifery Council 2002).

It is described as 'essential' for the role expansion of nurses (Department of Health 2002) and has recently become an auditable support mechanism in NHS organisations (Healthcare Commission 2004).

Despite the high hopes for it, and some progress made over the past decade, CS remains difficult to implement effectively across organisations (Howatson-Jones 2003). Establishing a standard for best practice on which it can be evaluated has also proved to be difficult.

There may be a suspicion that the term 'clinical supervision' is a management tool to monitor practitioners' work. 'Coaching' on the other hand, though it is linked to personal performance and sometimes instigated by managers, is a holistic term for the support of continuing personal and professional development.

Coaching and clinical supervision

Professional coaching in the NHS is currently provided almost exclusively to senior managers and executives and involves individually tailored personal and professional development meetings or sessions intended to improve organisational performance.



According to a study by Arnott and Sparrow (2004), involving more than 100 UK organisations including eight NHS trusts, there will be a significant increase in professional coaching in the near future.

It is the authors' contention in this paper that, while obvious differences exist between coaching and CS, the skills used in coaching senior executives are equally as applicable to those who undertake CS.

The nature of professional coaching

Coaching is usually associated with competitive sports: nurturing potential, maximising individual or team performances and, above all, achieving results. Perhaps unsurprisingly, such coaching techniques and other processes used in competitive sports have been applied to businesses, and now to health care.

West and Milan (2001) identify three specific types of coaching for leadership that illustrate different coaching relationships: skills coaching, performance coaching and developmental coaching (Fig. 1).

Skills coaching can be distinguished from training in that it is delivered on a one-to-one basis rather than in large group situations. It encourages highly individualised and intensive relationships between coaches and clients that focus on the specific learning needs of clients and, because their purpose is to fill gaps in clients' knowledge, are usually short term.

Performance coaching is wider in scope. Its function is to examine specific performance issues or targets and assist in the development of particular behaviours that will enhance performance. The results achieved by performance coaching relate to organisational objectives or job descriptors, often defined and planned as part of annual appraisals or personal development reviews.

Development coaching, like CS, is a more evolving process than skills coaching, and requires longer term relationships between coaches and clients.

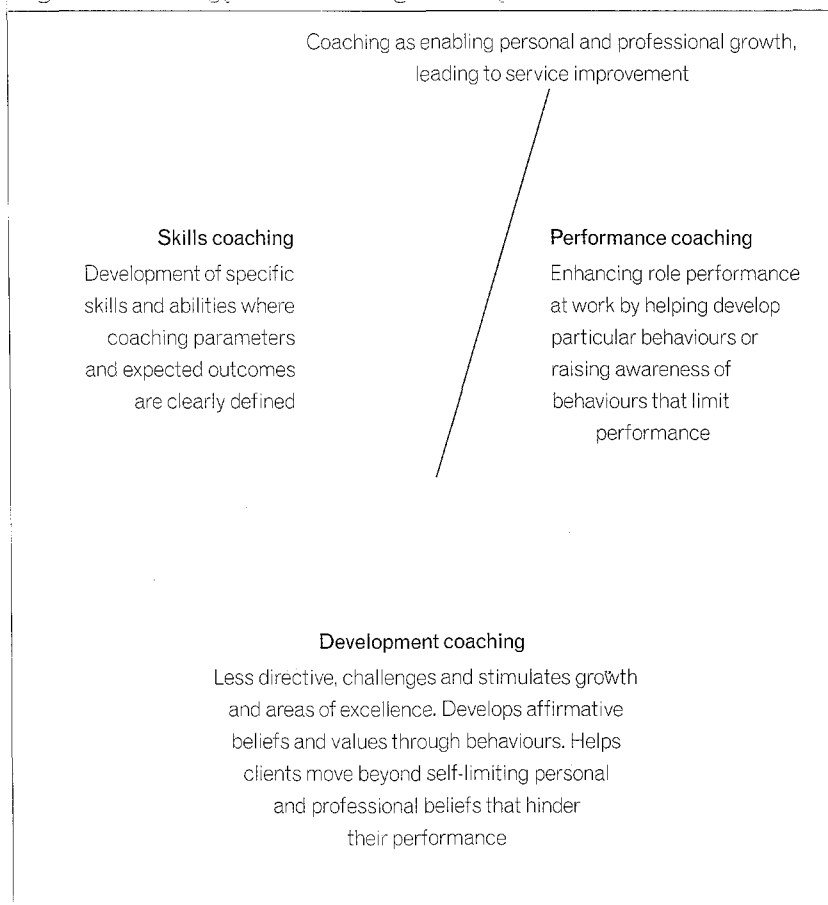
The process creates conditions for reflective learning by providing safe psychological spaces that allow coaches and clients to stand back from the workplace in confidential but challenging environments.

Adding and subtracting

Gallwey, a major influence on the origins of developmental coaching, based his 'inner game' thesis (Gallwey 2000) on the realisation that people's peak performance is often marred by their own 'self-interference'.

Self-interference might take the form of self-doubt or fear of failure so that a client's potential, let alone peak performance, cannot be attained. Gallwey suggests that development coaching requires coaches not to 'add' new

Fig. 1. Different types of coaching and emphases with clients



skills or behaviours to clients, but to 'subtract' whatever prevents clients from unlocking their potential.

In this respect, the task of development coaches does not only involve facilitating clients' learning but also enabling their 'unlearning'.

All three types of coaching outlined here – skills, performance and developmental – present two basic coaching models that can be categorised as either directive in nature, in that they 'show and tell', or non-directive, in that clients retain more control of the learning process.

The two extremes of directive or non-directive coaching activities occupy either end of the coaching continuum (Table 1) depending on clients' experience and needs. This continuum is similar to that of supervision (Driscoll 2000) in UK health care.

Clinical supervision practice

The UK International Coach Federation (ICF) is a professional organisation that promotes minimum standards and ethical guidelines for coaches, and accredits the quality of coaching training programmes.

Table 1. Coaching continuum dependent on client experience and need

Coaching type	Skills coaching	Performance coaching	Development coaching
Objectives	Finite and concrete	Often set in association with organisational parameters	Complex and emergent
Coaching style	Directive, teacher or expert imparting knowledge and skills	Induction programme, ongoing training and updates, meeting job descriptors, appraisal and performance review, 360° feedback, disciplinary, meeting targets, study days, academic learning, peer review, mentoring, management supervision, gaps evident from training needs analysis	Non-directive, gaining commitment to make lasting change, releasing potential, enabling more positive psychological states, client driven, holistic
Duration	Short term	Medium term	Long term

It describes the 'what' of professional coaching as 'a professional partnership between a qualified coach and an individual or team that supports the achievement of extraordinary results, based on goals set by the individual or team'. It also describes the 'how': 'through the process of coaching, individuals focus on the skills and actions needed to successfully produce their personally relevant results' (ICF 2005).

In explaining what is expected of coaches, this description helps us to consider whether coaching skills would be useful in CS encounters. In particular, the concepts of professional partnerships, setting goals, achieving results and being applicable in one-to-one or group situations are applicable to the principles and ideas underpinning CS.

As part of the standardisation of professional coaching work, the ICF (2002) identifies four key clusters that underpin the work of professional coaches, and 11 associated core competencies that are individually assessed in theory and practice before candidates can become accredited members or professional coaches (Table 2).

Unlike coaching, training to become a clinical supervisor for UK nurses, midwives and health visitors is extremely variable in length, and the content of training courses often depends on locally available expertise.

Clinical supervisors are rarely assessed or followed up after in-house or externally facilitated supervisory programmes to find out whether they are competent. It is small wonder therefore that many 'trained' supervisors fail to supervise in practice.

Moreover, a lack of regulated minimum standards in CS leave them open to individual interpretation and

personal preference, and, while an advantage of this is that it does not limit the development of CS, there remain unanswered ethical questions about the effects of this less prescriptive stance on clients and supervisors, as well as issues concerning the effective use of resources. The four key coaching clusters and 11 associated core competencies cited previously also help to identify some of the key differences between coaching and CS. These are summarised in Table 3.

In the literature, a distinction is drawn between coaching and CS on the one hand and therapy in any form on the other, with descriptions of coaching and CS beginning invariably in clients' or supervisees' 'present' practices.

As O'Donovan and Martin (2000) assert: 'Unlike therapies, coaching focuses on where you are now and where you want to get to, and the only place you can start from is where you are now.'

Professional coaching is an eclectic discipline that draws on a wide knowledge base from the social sciences: counselling, neurolinguistics, management and business consulting, philosophy, and motivational psychology (Hadikin 2004, Peltier 2001, Starr 2003, West and Milan 2001).

It adopts an appreciative or positive approach with clients, and concentrates on creating solutions and results with them. It does this by identifying what currently 'feels right' for clients, then makes this the basis for clients' future development. It looks for areas of achievement that can be cross fertilised with others areas and suggests that, when problems exist, it is not always necessary to look ever deeper into them in order to find solutions.

In contrast, reviews of CS theory (Sloan and Watson 2002, Winstanley and White 2003) are limited to the advancement by academics of various psychological, counselling and reflective frameworks that appear relevant for professional practice but with little input by practitioners themselves.

Perhaps unsurprisingly, CS remains largely a 'problem' orientated intervention, not dissimilar to medical models in which problems are identified, or diagnosed, before treatment plans are agreed upon between supervisors and supervisees.

A further major difference between professional coaching and CS is that the latter is seen as an additional part of the practitioner role, subsequent to some rudimentary training. In other words, supervisory roles are often expected in practice, yet practitioners are not granted additional time, and are not relieved of any of their clinical responsibilities accordingly. Most coaches, on the other hand, have undergone long experiential training to become accredited before practising.

It is interesting to note that, while coaching is perceived to add value to organisations through the individualised development of staff and subsequent service improvement, CS, which has a similar philosophy and is legitimised through clinical governance, is often perceived as inconvenient in busy practices.

Whichever type of coaching relationship is used, its essence should be a supportive and reflective alliance between coach and client that is future focused rather than problem orientated.

The external nature of coaches from immediate work situations is also significant and, as part of the contractual agreements made with clients, sessions take place in ways that encourage reflection on practice, whether as telephone conversations or as meetings away from the work environment.

Advancing clinical supervision

As previously stated, coaching draws on many differing sources of psychological literature.

Based on the authors' 'coaching as CS experience', key areas that can be further developed in CS training include the use of powerful questions, active listening, facilitating learning, and designing with supervisees ways to recognise and achieve outcomes from sessions.

Coaches often appear less concerned than their clinical supervisor counterparts about embracing holistic and non-therapeutic approaches that takes account of personal as well as professional lives.

The authors do not suggest that coaching should replace CS, but argue that some key elements of, in

Table 2. Four clusters of coaching and 11 associated core competencies

Clusters and competencies	Abilities needed
Setting the Foundation	
Meeting ethical guidelines and professional standards	Understanding coaching ethics and standards and applying them appropriately in all coaching situations
Establishing coaching agreements	Understanding requirements of specific coaching interaction and agreeing with prospective and new clients about coaching processes and relationships
Co-creating the relationship	
Establishing trust and intimacy with clients	Creating safe, supportive environments that produce ongoing mutual respect and trust
Coaching presence	Creating, and being fully conscious of, spontaneous relationships with clients, and employing an open, flexible and confident style
Communicating effectively	
Active listening	Focusing completely on what clients say and do not say, and understanding the meaning of what is said in the context of the client's desires, and supporting self-expression
Powerful questioning	Asking questions that reveal information of maximum benefit to coaching relationships and clients
Direct communication	Communicating effectively during coaching sessions, and using language that has the maximum positive impact on clients
Facilitating learning	
Creating awareness	Integrating and evaluating accurately multiple sources of information, and making interpretations that help clients gain awareness and thereby achieve agreed upon results
Designing actions	Creating with clients opportunities for ongoing learning during coaching and 'work-life' situations, and taking new actions that will most effectively lead to agreed upon results
Planning and goal setting	Developing and maintaining effective coaching plans with clients
Managing progress and accountability	Attending to what is important for clients, and leaving responsibility for action with clients
(ICF 2002)	

particular, development coaching can be adapted to situations in which CS would otherwise be used and that these need not benefit only senior healthcare practitioners.

It is also worth examining just how committed supervisees and supervisors are to CS, which is a process 'given freely' in the NHS, compared to clients or senior executives who pay for individual sessions or are sponsored by their organisations.

Table 3. Key differences between coaching and clinical supervision using the four key clusters of coaching competencies

Coaching	Clinical supervision
Setting the foundation	
Incremental levels of coach training based on experiential learning and coaching	Often short and variable introductory training given in-house or by external provider
Established knowledge from counselling, management and business consulting, motivational psychology and philosophy	Establishing knowledge base from counselling, psychology and reflective frameworks
Mutual contractual agreement made after detailed first interview matching methods and expertise	Mutual contractual agreement based on practitioner experience and expectations
Coaches expected to have ongoing supervision as required by their ethical code (European Mentoring and Coaching Council 2004)	Clinical supervisors expected to have ongoing supervision themselves as best practice
Coaching may soon be regulated so that supervision will be a professional requirement	No regulation of clinical supervisors although clinical practice by healthcare professionals is regulated
Coaching is an emerging and valued profession in its own right	Supervision viewed as additional part of practitioners' roles
Always emphasises client solutions and results for the immediate future	Often emphasises 'problems' and 'problem solving' in practice
Co-creating the relationship	
Client and coach agree terms and fees	Free at point of delivery for all practitioners
Process based on delivery through multiple communication systems	Process mainly based on face-to-face encounters, either one-to-one or in groups
Coach often outside client's organisation	Supervisor often inside client's organisation
Coaching viewed as adding value to the organisation in developing key staff	Clinical supervision aimed at all healthcare professionals particularly inexperienced staff
Communicating effectively	
Coach tends to be non-directive and seeks permission to offer guidance	Tendency to be more directive as supervisor but dependent on supervisee need
Client is expert in conversations, because of their situation	Tendency for supervisors to be an experienced practitioners and offer expertise in conversation
Clarity with coaching role and expectations	Sometimes confusion with supervisory role and expectations
Facilitating learning and results	
Always emphasises client response- 'ability' during and after session	Often emphasises on supervisee professional accountability during and after session
Emphasis on the organisational performance in conjunction with 'work-life' balance	Emphasis on supervisee professional performance at work
Coaching evaluated through outcomes, results defined by client as part of contractual agreement	Difficulty in evaluating effectiveness of supervision in practice

By implication, development coaches could be employed as clinical supervisors unless they are acting already as 'surrogate clinical supervisors' to senior executives in health care while acting as coaches.

The use of telephone conversations as a complementary method of CS outside busy practice arenas has yet to be explored in the CS literature. They are convenient, familiar and easy to record. Such CS sessions can be followed up by email communication to encourage actions that were previously agreed upon.

At present, CS usually depends on a face-to-face encounters. Yet, as patient care takes priority and time is at a premium, one wonders why.

We find anecdotally that embracing a development coaching approach in CS encounters is transformational. It has as its main purpose demonstrable improvement and change in the behaviour of supervisees. By formally agreeing actions, and documenting them at the end of each session, coaches or supervisors enquire periodically about actions taken between sessions. Supervisees are expected to review the outcomes that have or have not been achieved by forwarding pre-session documentation. This transparency in development coaching, with its emphasis on documenting and following up agreed individual outcomes, makes the process easier to evaluate.

Finally, CS, like coaching, relies on sessions being productive for supervisees or clients. This is best achieved when clinical supervisors impose a framework or structure to sessions to help them navigate their ways through.

There are many frameworks described in the coaching literature from which clinical supervisors can choose, but the most widely used is a model known as GROW (West and Milan 2001), which stands for Goal, Reality, Options, Way Forward. It was published by Whitmore (1992) in his seminal coaching text, *Coaching for Performance*.

By the following definition, 'growth' in clients is a critical element of coaching and, it would seem, CS: 'Coaching is about performing at your best through the individual and private assistance of someone who will challenge, stimulate and guide you to keep growing.' (O'Donovan 2004)

Influencing clinical supervision encounters
In the author's view, CS has been established long enough to have become understood as a support mechanism for continued professional development in health care. This article has presented some of the ways in which elements of professional coaching can influence the continued integration of CS into practice.

The theory and knowledge underpinning the core competencies and codes of ethics in professional coaching can help provide a consistent framework to promote the effectiveness of CS in UK health care.

The role of professional coaching in improving individual and organisational performances offers an encouraging prospect of CS.


There are distinct advantages in professional coaching when setting clearly defined and measurable outcomes with clients in the business and health care sectors. For example, all parties are left with no doubt that, as in sports coaching, there will be emphasis on outcomes and results applicable to the work setting.

The authors believe that, like professional coaching, CS has the potential to support good management practices by offering role clarity and formal support if it is embraced by healthcare organisations, particularly supervisors and supervisees.

Clinical supervisors are expected to engage in regular supervision of their practices (European Mentoring and Coaching Council 2004) because, without formal support, they can rapidly become overwhelmed and discontinue their supervisory roles. The expectation in professional coaching is that learning is lifelong, with coaches often remaining coached or 'supervised' no matter how senior or experienced they are.

Coaching, and development coaching in particular, adds scope to the actual and potential benefits of CS as a supportive and learning intervention.

For healthcare managers, promoting coaching skills in CS can offer such benefits as raised internal accountability of all parties engaged in the CS process and an enhanced ability for supervisees to respond – their 'response-ability' – in the interests of their own personal and professional development, and in those of the practice. Applying a coaching approach can enhance CS not only by supporting practitioners but in helping to sustain service improvements, and increase motivation and performance.

In this respect, professional coaching clearly has the potential to enhance the continued development of CS by providing clarity of purpose and enabling practitioners and supervisees to discover their untapped potential 

John Driscoll BSc (Hons), DPSN, CertEd(FE), RGN, RMN is a professional development consultant and healthcare coach based in Sudbury, Suffolk

Rachel Cooper BSc (Hons) is a personal development coach and cultural transformation consultant working in the private and public sectors. She is based in Melton Mowbray, Leicestershire

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