In 1993 the Department of Health published *A Vision for the Future* which included a target related specifically to clinical supervision. Subsequently, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting approved its initial position statement on clinical supervision for nursing and health visiting (UKCC 1995). According to the statement, the aim was to ‘provide practitioners with the key principles on which to build systems of clinical supervision in the wide variety of clinical settings that exist within the health services’.

This level of explicit commitment to clinical supervision is supported by evidence of its benefits (Johns 1997), and the launch of the clinical governance strategy in the White Paper *A First Class Service* (DoH 1998) confirmed the benefits of clinical supervision in order to regulate, support and lead practice. These benefits lead to better patient outcomes (Webb 1997), although Yegdich and Cushing (1998) argue there is a ‘lack of measurable evidence’ to support the benefits claimed for clinical supervision. Nevertheless, there is qualitative evidence to show how nurses value supervision personally and its contribution to improving patient outcomes (Johns 1997, Webb 1997). In order to meet these benefits Webb and Wheeler (1998) suggest that the implementation of clinical supervision requires preparation, resources and training.

In this article, the authors explain how theory was put into practice during the implementation of clinical supervision. Implementation took place over one year and involved nurses of different grades in an NHS health care trust.

Preparing the ground

A project team was formed to begin implementation, led by the trust’s head of nurse education and professional development. This role was essential to the project’s success (McCallion and Baxter 1995); it guaranteed that a coordinator was available and gave the project team direct access to resources, so confirming the trust’s support.

The project team comprised senior nurses who volunteered for the work.

The first steps to be taken were to devise a clinical supervision policy and raise awareness among all staff, because the term clinical supervision is often ‘misconceived’ by nurses (Butterworth and Faugier 1994).

A trust policy was written to provide guidelines for clinical supervision. McCallion and Baxter (1995) recommend that a policy should be devised taking into account the organisational...
tion as a whole. It should also be sufficiently flexible to suit local directorate needs (for example, in deciding on the type of clinical supervision model used), allowing choice without losing the core requirements of the policy. The content of the trust's policy included issues such as restrictions on the number of supervisees, roles and responsibilities of the supervisors and supervisees, and a contract agreement. Workshops were arranged and delivered by the local college to educate staff in and promote clinical supervision.

Six pilot sites were agreed, to include a range of specialties and clinical staff including: clinical nurse specialists; special care baby unit; medical admission unit; rehabilitation unit; a private ward; and a gynaecological ward. The membership of each pilot group ranged from two to eight members for each team. From a resource and motivational point of view it seemed impossible to co-opt whole teams as members. It was agreed, therefore, that the staff groups involved in the pilots would cascade clinical supervision in the future.

Next the project team decided that further training and support was required. We, external nurse consultants from Parallel, were recruited to meet this need. Our remit was to:
- work with representatives from the pilot areas to assess their needs/expectations
- assist with planning the clinical supervision process
- provide education to support and reinforce the previous clinical supervision training sessions
- lead and facilitate groups involved in the pilot
- problem solve issues to enhance the smooth running of the pilot programme
- promote the benefits of clinical supervision.

We were invited to attend a team meeting early in the project to meet members of each of the pilot groups and get their ideas about the training and support they felt they would need. It was an opportunity to agree the format of the programme and arrange follow up on a one-to-one basis. Ideas for the content of the training and education plan were also canvassed. The plan agreed consisted of:
- two training days for all six pilot areas
- four two-hour, one-to-one coaching sessions for teams in the individual pilot areas
- an evaluation day.

Meetings with the project team leader were arranged at interim periods throughout the pilot for feedback and progress reports.

Training days

According to Bartle (2000): ‘Successful implementation of clinical supervision will depend on staff’s understanding on what clinical supervision is.’ With this in mind, it was important that the content of the initial days focused on the fundamentals of clinical supervision. These included:
- what clinical supervision is, and what it is not
- the benefits of clinical supervision
- the skills/responsibilities of the supervisor/supervisee; their role and the supervisory relationship
- use of models/frameworks
- modes of supervision
- hospital policy and contracts
- steps to introducing clinical supervision.

The mode of supervision favoured by the pilot groups was group supervision. They practised it in their individual sessions to enhance skills and develop learning needs. However, following education and discussion, one-to-one supervision was preferred for their own individual needs. McCallion and Baxter (1995) support this, stating that, although one-to-one supervision seems costly, it is likely to be more effective as reflection is more frequent and staff can discuss personal feelings or insecurities about job roles in private. This may make it more cost effective in the longer term.

Staff in the pilot groups now had to choose their own supervisors and commence supervision. The first step was to complete contracts agreeing ground rules and documentation for the sessions, agree the format and aims of the sessions, and plan dates for supervision.

Once individual supervision was in place for each member of each pilot group, the one-to-one groups sessions were arranged. Subjects covered in the sessions included:
- pitfalls of the supervisor and supervisee relationship
- communication and skills (for example, listening and using open-ended questions)
group reflection using real critical incidents
self-awareness exercises
preparing supervisees for supervision
use of models in action
reflecting on sessions
resistance to supervision.

Discussion of the pitfalls of the supervisor and supervisee relationship and listening skills helped the groups to recognise the importance of understanding and using the skills effectively, something, it was agreed, that would come with experience. Concerns over ‘damaging’ supervisees within sessions (through mishandling them) started to surface. But through discussion the staff realised that, as nurses, they already possess many of the skills required for supervision and that it was a matter of refining these skills. The groups were also reassured to discover that clinical supervision was not counselling. Initially, clinical supervisors could only be expected to be prepared to start somewhere and simply do their best (Bond and Holland 1998). With experience the supervisors found they were able to deepen the reflective process and become more effective.

The general preference was at first to use John’s structural model for supervision (1997). Later, the groups realised the need to be flexible with models and be able to change the model in use according to the subject matter raised in supervision. In nursing, according to Van Ooijen (2000), one model of supervision is unlikely to fit all activities. The introduction of problem-solving spirals, force-field analysis models, and skills assessment cycles gave supervisors more tools to use which, potentially, provided more options for supervisees to take away at the end of sessions.

One-to-one group sessions, used to gain experience of clinical supervision, were supplemented with problem solving sessions dealing with issues that may have been hindering team members as they worked with their own supervision plans. Teams agreed that supervisors with both relevant clinical knowledge and good supervisory skills would be ideal, but they were not always available.

It became obvious to the groups that sound supervisory skills were more important in a supervisor than simply having clinical knowledge, which could be gained to help the supervisor understand the clinical setting, whereas poor supervisory skills could not be overcome. The supervisor, however, does need to have a clinical background of some sort with more or equal general experience and should not come from a management background alone (Bond and Holland 1998). In addition, supervisors were expected to be flexible, providing supervision in settings outside their own directorate. This made it easier for individuals to find supervisors based in clinical areas.

Finding time for supervision was a problem for some groups. This was solved by effective forward planning (booking dates for meetings well ahead of staff work rotas being drawn up); introducing flexi-time within existing rotas to create a longer handover period on days for supervision; creating time within existing routines by looking at more efficient ways of working such as at patient handover time; and thinking about the time of day booked for supervision (for example, it is not always effective at the end of busy shifts). The pilot group members were given direction on how to obtain further support from their managers with these operational issues.

According to Butterworth (1996), employers should recognise and capitalise on the benefits of supervision by providing time and resources. He also stated that in order for managers to support clinical supervision, trust boards should ensure that their business plan contains a strategy to support its development. Planned discussions with the project team leader throughout the pilot project helped to address some of the operational issues and gain further support at trust board level.

Other difficulties that arose related to issues such as understanding contract writing and having more information on the fundamentals of clinical supervision. A follow-up training

Recommendations from the pilot project
Clinical supervision opportunities are cascaded to give other units a chance to benefit
Similar input/support is provided for the future in order to help new teams to implement clinical supervision
Resources are made available to the pilot groups to help the smooth implementation of clinical supervision for their colleagues
The need for leadership involvement at ward sister/charge nurse level for future projects to support and lead the implementation of clinical supervision
Follow-up for the initial pilot groups
Results from the post-pilot questionnaire are to be analysed and taken into account for the future
day was arranged for all pilot groups to deal with these problems.

Follow-up training
A follow-up event was arranged halfway through the pilot project and the main aims were to:
- evaluate how the pilot was progressing
- give the groups the opportunity to share experiences
- problem-solve general issues
- give further input on the theory of clinical supervision, for example, how clinical supervision fits into the clinical governance framework.

It was clear at this stage that all of the pilot groups were progressing well with their knowledge and understanding of clinical supervision. Also, all group members had found a supervisor and entered into a supervisory relationship for themselves. Reported benefits included:
- improved self-esteem, motivation and patient care
- increased support
- increased confidence
- enjoying a positive experience
- gaining an opportunity to discuss important issues in a confidential setting, which helps to reduce stress.

Further one-to-one group sessions were planned to continue education, support and learning through reflection. An evaluation day was held at the end of the pilot project, which was to summarise feedback about the implementation of clinical supervision.

Evaluation day
The pilot groups presented their experiences/understanding of the following subjects:
- the hospital policy for clinical supervision
- the theory of clinical supervision
- the use of documentation for sessions
- the benefits of clinical supervision
- the skills learnt for the role of supervisor/supervisee
- the steps to clinical supervision
- how the pilot groups overcame operational issues
- general feedback on the input received from external sources
- how the pilot groups move forward.

These presentations showed how team members had moved on in terms of their knowledge and commitment to clinical supervision. A questionnaire, compiled by the project team, was distributed to the pilot groups to allow them to evaluate issues such as:
- whether supervision is in place
- the type of supervision chosen
- how useful the policy was for defining roles and responsibilities
- whether contracts were used, if so whether this was helpful
- knowledge on the theory of clinical supervision
- what the benefits of supervision have been
- how clinical supervision has benefited practice
- what difficulties were experienced?

Recommendations were discussed and agreed by the team members, the project team and the external support nurses, along with results from the evaluation day (Box 1).

Conclusion
The pilot programme proved to be successful in implementing clinical supervision. The team members from the pilot groups reported positive experiences throughout the programme and since. Evaluation of the pilot programme has shown the definite need for education and support for implementing clinical supervision. Wider implementation of clinical supervision in the trust will take into account the recommendations from the pilot project. Investment in staff when introducing new subject matter clearly raised morale and enthusiasm for clinical supervision. It is this enthusiasm, along with the knowledge gained by staff, that will lead to successful and effective implementation of clinical supervision. This, in turn, will fulfil one of the clinical governance requirements which is to ensure the regulation, support and leading of clinical practice.

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References

Further reading