Clinical supervision is important to help maintain and promote high-quality healthcare. It has been advocated as a requirement for all registered staff by all professional regulators in healthcare, such as the Nursing and Midwifery Council. The NMC states: “Clinical supervision should be available to registered nurses and allied healthcare professionals to support the provision and maintenance of high-quality care. In 2012, we developed new guidelines for nurses and AHPs on supervision, incorporating a clinical supervision framework. This offers a range of options to staff so supervision accommodates variations in work settings and individual learning needs and styles.

Clinical supervision in a community setting

In this article...

- The benefits of clinical supervision
- Developing an organisation-wide clinical supervision system

Clinical supervision must fit around work settings and individual learning needs and styles

Protected time for reflection should be prioritised by practitioners, managers and the organisation

Learning should bring about change and improve care

Learning needs identified in supervision should feed into appraisals

Organisational commitment is crucial to the success of clinical supervision

Keywords: Clinical supervision/
Multidisciplinary/Reflection/Learning/Development

This article has been double-blind peer reviewed

5 key points

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Clinical supervision is a formal process of professional support, reflection and learning that contributes to individual development. First Community Health and Care is committed to providing clinical supervision to nurses and allied healthcare professionals to support the provision and maintenance of high-quality care. In 2012, we developed new guidelines for nurses and AHPs on supervision, incorporating a clinical supervision framework. This offers a range of options to staff so supervision accommodates variations in work settings and individual learning needs and styles.

Clinical supervision is important to help maintain and promote high-quality healthcare. It has been advocated as a requirement for all registered staff by all professional regulators in healthcare, such as the Nursing and Midwifery Council. The NMC states: “Clinical supervision should be available to registered nurses throughout their careers so they can constantly evaluate and improve their contribution to the care of people. Along with the NMC’s PREP (continuing professional development) standard, clinical supervision is an important part of clinical governance.” (NMC, 2008).

The new NMC code requires nurses to “gather and reflect on feedback from a variety of sources, using it to improve practice and performance” (NMC, 2015).

In April 2016, the NMC will introduce a system of revalidation, in which nurses and midwives will have to show evidence of having undertaken continuing professional development, as well as other activities, when they come to re-register every three years. It is likely that clinical supervision will be recognised as a suitable CPD activity that registrants can use to demonstrate their continuing fitness to practise.

Likewise, standards of proficiency for registered AHPs include the requirement for formal supervision and emphasise the importance of critical reflective practice. For example, physiotherapists must be able to audit, reflect on and review practice, and understand the value of reflection on practice and the need to record the outcome of such reflection (Health and Care Professions Council, 2013a; 2013b).

It is clear that clinical supervision, as a tool to help maintain and improve practice, should be integral to CPD activities that clinicians undertake to maintain their competence and registration.

First Community Health and Care is a not-for-profit social enterprise established in October 2011 to provide community healthcare services to people living in East Surrey and parts of West Sussex. It recognises the importance of clinical supervision in the development of all practitioners and demonstrates its commitment to providing clinical supervision by building on inherited processes and practice to establish a robust and formal system of professional support, reflection and learning.

Evidence for change

A group-facilitated model of clinical supervision was introduced for community nurses in East Surrey in 2002. Subsequent surveys and evaluation have demonstrated that the model is highly valued as a method of reflection and support.

Box 1. FUNCTIONS OF CLINICAL SUPERVISION

Normative – maintaining appropriate standards of care and monitoring quality.

Formative (educational) – developing knowledge, skills, research awareness and understanding. Done through problem solving, with the supervisor sharing knowledge and expertise, identifying training needs, reflection and exploring other perspectives.

Restorative (Supportive) – creating a therapeutic relationship that nurtures and cares for the person being supervised. It facilitates self-awareness through critical analysis and exploration of events and feelings.

Source: Proctor, 2000
However, in addition to community nursing and health visiting, First Community provides a range of inpatient and out-patient therapies. We recognised that each professional group had its own arrangements for clinical supervision, and the launch of the new organisation provided the perfect opportunity to bring these models under one umbrella.

We also identified the need to review existing clinical supervision practice within First Community, as attendance at groups had fallen and a number of surveys, audits and anecdotal evidence indicated some staff were not engaging and others were not benefiting from it.

A clinical supervision survey conducted in East Surrey indicated that line managers were inconsistent, not only in asking about attendance at clinical supervision, but also in identifying learning needs emerging from practitioners’ reflection on their practice through supervision. There appeared to be no safe or effective way to show evidence of reflective practice for individual practitioners; if captured, this evidence could be used to inform:

- Practitioners’ personal development plans (PDP);
- The organisation’s learning and development programme;
- Reviews of clinical incidents to prevent recurrence.

It was clear that the organisation needed a more flexible approach in providing clinical supervision to provide assurance for external assessors - such as the Care Quality Commission, which requires healthcare organisations to ensure staff receive “appropriate training, professional development, supervision and appraisal” and keep records of this (CQC, 2010) – and to promote learning and development for all clinical staff through protected time for reflection on practice.

Developing the framework
In the development process we reviewed several clinical supervision models from a cross-section of healthcare providers and the academic literature; it was clear that the three functions of clinical supervision outlined by Proctor (2000) were crucial to the development of clinical supervision practice within First Community (Box 1).

Fowler (2011) suggested that there is no single way to undertake clinical supervision so we felt it was important to take into account the experiences of clinical staff as well as best-practice evidence. A consultation process, involving all nurses and AHPs, was therefore conducted through surveys and focus groups.

Organisational commitment is vital to the success of supervision (Burns and Bulman, 2013); First Community’s Quality Account 2012-13 identified it as a key priority with a commitment to “support all registered clinical staff… to access clinical supervision... in their preferred format, time and place from a menu of options”.

The menu in practice
Staff choose their preferred method of supervision from group-facilitated supervision, reflective logs, clinical specialist/peer supervision, peer review and action learning sets. They select mixed methods from the menu, subject to agreed parameters, to enable them to reflect and develop through supervision.

Our launch week in July 2012 included introductory workshops for clinical staff. Staff were asked to choose from the menu in agreement with their line manager, then clinical supervision groups were allocated for those choosing that option (more than 50% of staff choices at the time of writing).

All clinical staff are encouraged to attend one introductory workshop, which continues to be offered bi-monthly. After initial training, group facilitators are supported in their role through allocation to a self-facilitating supervision group for facilitators. This offers support and a safe environment in which to discuss and reflect on issues relating to the management of the group they facilitate as well as

### Table 1. Problems and Solutions

<table>
<thead>
<tr>
<th>Problems encountered</th>
<th>Solutions</th>
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<tbody>
<tr>
<td>Staff engagement: non-attendance at groups, limited use of reflective logs to record learning</td>
<td>Development of supervisee log books and reporting/follow up of non-attendance with line managers</td>
</tr>
<tr>
<td>Line manager engagement: discussing clinical supervision, attendance and learning, in one-to-ones or appraisal</td>
<td>Introduced new appraisal framework and training</td>
</tr>
<tr>
<td>Training resources: to ensure enough facilitators for groups and all staff have access to the half-day workshops</td>
<td>New facilitator training and ongoing introductory workshops</td>
</tr>
<tr>
<td>Records of attendance and learning themes in facilitated groups</td>
<td>Development of a facilitator log book and online reporting template</td>
</tr>
<tr>
<td>Inadequate reporting from line/service managers regarding learning from options other than groups</td>
<td>Presentation to the senior management team and introduction of quarterly reporting schedule</td>
</tr>
</tbody>
</table>
clinical issues relating to their role. These groups are highly valued by facilitators.

The learning from clinical supervision and staff members’ commitment to their chosen supervision option is monitored through the appraisal process, while quarterly analysis and reporting of attendance and learning themes emerging from group-facilitated clinical supervision inform First Community’s learning programme. Problems and solutions are outlined in Table 1 on page 17.

**Outcomes**

An online staff survey in 2013 enabled us to review our progress in achieving some of the standards on clinical supervision set out by the NMC (2008), other professional bodies (HCPC, 2013a; 2013b) and the CQC (2010). It also provided an insight into how the menu of options was working for staff. The survey had three aims:

- To measure progress against recommendations arising from an audit of appraisals completed in 2011;
- To identify any training or support needs for group facilitators;
- To find out how the new guidelines and menu of options were working for staff and identify development needs.

The group-facilitated model was particularly valued by staff as a method of reflection, support and learning. Other options were less likely to be accessed and line managers were not routinely monitoring evidence of learning. This identified a need for managers supporting staff to bring back their learning from clinical supervision into practice.

All staff participating in clinical supervision are encouraged to use reflective logs to facilitate and record learning. We wanted to find out how those opting to use reflective logs as a specific choice had used them to ensure external challenge, support and learning. Survey responses indicated that 56% of staff using reflective logs had discussed their learning with their manager, a peer or their team or supervision group. To increase this, a supervisee logbook has been developed for use across all the options.

When staff were asked how clinical supervision helped them in their practice, the supportive and reflective elements of clinical supervision were most highly valued, although all elements were valued by at least 39% of respondents.

Group facilitators complete an online survey to capture attendance and learning themes from facilitated group supervision. This information is collated and analysed to form part of the quarterly reporting to First Community’s Clinical Quality and Effectiveness Group.

To ensure all staff have an opportunity to evaluate their experience of clinical supervision we plan to hold evaluation events on 30 June and 9 July.

**Conclusion**

Common barriers to effective clinical supervision include lack of time, lack of management support, staffing resource and service inflexibility. It is therefore vital that access to supervision is both adaptable and tailored to individual staff and service needs. In practice, this is challenging but must not be a barrier to the provision of clinical supervision. First Community has found that clinical staff are more likely to engage in the clinical supervision process if they have a menu of options because they can access supervision at a time convenient to them and in a format that suits their individual learning needs and style.

**References**


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Health and Care Professions Council (2013b) Standards of Proficiency, Chiropodists/Podiatrists. Bit.ly/NThoopodistsStandards


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