REPORT OF THE REVIEW

OF CLINICAL SUPERVISION FOR

NURSING IN THE HPSS 2006

ON BEHALF OF THE DHSSPS

NIPEC

In May 2006, the Chief Nursing Officer for Northern Ireland, Professor Martin Bradley, asked NIPEC to review current guidance on clinical supervision in the HPSS, to evaluate current supervision systems and establish an action plan for ensuring that clinical supervision systems are in place. The CNO placed the importance of this review in the context of DHSSPS Quality Standards for Health and Social Care, published in March 2006, which set out five key quality themes for the development of standards. This Report is the product of that Review.

Review of Clinical Supervision for Nursing in the HPSS 2006

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Acknowledgements

NIPEC would like to thank a range of stakeholders who have contributed to this review. We would particularly like to thank the Review Group and Chair, Mrs Hazel Baird, for their time and dedication to this project.

Thank you also to the Directors of Nursing and senior nurses from the eighteen Trusts, who took part in the fieldwork undertaken.

We are indebted to the service colleagues who submitted their case study initiatives, took part in the workshops and facilitated the analysis of the findings that contributed to the action planning phase.

Finally, we give thanks to other colleagues who attended the Consultation workshop and contributed to further development of the guiding principles and action plan.

Executive Summary

In May 2006, the Chief Nursing Officer for Northern Ireland commissioned NIPEC to undertake a review of clinical supervision for nursing, across the Health and Personal Social Services (HPSS). A regional Review Group was formed (see Appendix 2 for membership) with a remit for reviewing current guidance and relevant literature on clinical supervision, to describe and evaluate current supervision systems, develop a set of guiding principles for future supervision, and report the review findings and a recommended action plan for improvement.

This report provides an analysis of the work of the Review Group between June and November 2006. A review of the literature on the topic indicates that despite having been prominent in health care for well over a decade, clinical supervision continues to be poorly defined, often misunderstood and is under evaluated from the perspective of both its processes and outcomes.

Methods used to undertake the fieldwork for this review included structured interviews with Directors of Nursing and Senior Nurses from each of the eighteen HPSS Trusts. Each of the interview transcripts was thematically analysed, and barriers to as well as enabling factors for establishing and sustaining supervision were generated. In addition, case-studies of valued supervision models were selected using a pre-determined set of criteria. At a workshop in

August 2006, barriers to and enablers for effective supervision within these case studies were also identified.

Feedback from both the interviews and case studies were considered by the Review Group, and a draft set of guiding principles and recommended actions for supervision across the HPSS were developed. These draft principles and actions were presented to a wide range of stakeholders in a Consultative workshop. The Review Group then produced this final report and action plan.

This Review has indicated that there is limited evidence of widespread implementation of effective systems of clinical supervision across nursing in Northern Ireland, however some examples of exemplary models and approaches have been analysed during this review and reported on. In response to this, the Review Group has offered a modernised definition for Supervision in Section 7 of this report.

Recommendations for implementing effective models of supervision are offered, underpinned by the modernised definition for supervision and emphasising the importance of linking supervision to appraisal, governance systems and performance management. Supervision should therefore be the responsibility of every nurse as integral to their practice, and for every organisation must be embedded within a culture of learning and development that focuses on delivering safe and effective care.

SECTION 1 - INTRODUCTION

1.1 In May 2006, the Chief Nursing Officer for Northern Ireland, commissioned NIPEC to undertake a review of clinical supervision across acute and community nursing in the Health and Personal Social Services (HPSS). Mrs Hazel Baird (Executive Director of Nursing, Homefirst Health and Social Services Trust (HSST) and NIPEC Council Member) was invited to Chair a Review Group whose membership was composed of colleagues from across the HPSS with related expertise in this area and who were representative geographically and from across all areas of nursing.

The terms of reference for the review group were as follows:

1. To review current guidance and relevant literature on Clinical Supervision in the HPSS

2. To describe and evaluate current Supervision systems

3. To develop a set of guiding principles for Supervision

4. To report (by November 2006) the review findings and a recommended action plan for improvement, for presentation to the Department of Health, Social Services & Public Safety (DHSSPS) for implementation.

1.2 The Review Group agreed at its first meeting, that for the purpose of this review, the term 'clinical supervision' would

include a wide range of activities that have 'supervision' impact, and thus have the intention of developing practitioner competence and the enhancement of their practice. These include formal one-to-one or group clinical supervision, action learning, reflective or work-based learning groups, critical companionship, professional and peer supervision, particularly where such activities are formally identified as having similar principles to or being undertaken for supervision purposes.

1.3   This report provides an analysis of the work of the Review Group between June and November 2006, to meet the above terms of reference through fieldwork with colleagues and teams undertaking supervision across the HPSS, and culminating with a set of guiding principles and recommended actions for future supervision practice.

SECTION 2 - BACKGROUND

2.1 From a policy perspective, clinical supervision within the nursing profession in the UK was first formally highlighted in 1993 and has continued to gather policy momentum since this time (Department of Health 1993; United Kingdom Central Council for Nursing and Midwifery (UKCC) 1996; Barrowman 2000; Nursing and Midwifery Council (NMC) 2006). In offering one of a number of definitions, the NHS Management Executive (1995) defined clinical supervision as,

> *'…a formal process of professional support and learning which enables individual professionals to develop knowledge and competence, assume responsibility for their own practice, and enhance consumer protection and safety of care in complex situations.'*

2.2 In supporting the establishment of clinical supervision as an important part of clinical governance, and in the interests of maintaining and improving standards of patient/client care, the NMC issued guiding principles for underpinning any system of clinical supervision, in use nationally (NMC, March 2006). These are available in Appendix 1. According to the NMC (2006) clinical supervision allows registrants to develop their skills and knowledge, and helps them to improve patient/client care.

Clinical supervision enables registrants to:

- Identify solutions to problems
- Increase understanding of professional issues
- Improve standards of patient care
- Further develop their skills and knowledge
- Enhance their understanding of their own practice.

2.3   National and regional inquiries have increased interest in and recognition of the importance of effective clinical supervision, for example The Clothier Report – The Allitt Inquiry (1994), The Bristol and Liverpool Inquiries, Shipman and more locally and recently, The Lewis Review (2003), Murtagh Review (2005) and McCleery Report (2006).

2.4   The Regulation and Quality Improvement Authority (RQIA) in Northern Ireland also recognises the importance of ensuring staff have access to effective supervision, and these are reflected in DHSSPS published Quality Standards for Health and Social Care (DHSSPS, March 2006) under five key quality themes:

- Corporate leadership and accountability of organisations;
- Safe and effective care;
- Accessible, flexible and responsive services;
- Promoting, protecting and improving health and social well-being; and

- Effective communication and information.

2.5 The Quality Standards recommend that an effective system for clinical supervision across the HPSS can help organisations to meet each of the above Clinical and Social Care Governance standards, and specifically by:

- Having in place appraisal and supervision systems for staff which support continuous professional development and lifelong learning (p11);

- Promoting a culture of learning to enable staff to enhance and maintain their knowledge and skills (p15);

- Ensuring that clinical and social care interventions are carried out under appropriate supervision and leadership, and by appropriately qualified and trained staff, who have access to appropriate support systems (p15).

(DHSSPS, Quality Standards, 2006)

2.6 In addition to the above policy recommendations and in recognition of the challenges faced by many organisations in their establishment of supervision systems this review is clearly justified. There is also an apparent lack of robust monitoring on the number of registrants undertaking supervision as well as limited evidence of evaluation of effectiveness of preparation for supervision, the experience itself and its impact on professional development and quality of practice.

2.7 In Northern Ireland, the DHSSPS undertook a survey and analysis of clinical supervision in mental health and learning disability nursing, before issuing best practice guidance (DHSSPS September 2004; DHSSPS November 2004). The current review has in part been commissioned to evaluate the impact of this guidance and review the range of supervision systems across general and specialist hospital and community nursing. A review of the literature on clinical supervision regionally, nationally and internationally would be a natural starting point for this work.

Review of relevant literature on Clinical Supervision

2.8 Despite having been prominent in health care for well over a decade, a review of the literature indicates that clinical supervision continues to not be clearly defined, is often misunderstood and is under evaluated from the perspective of both its processes and outcomes. Described by the U.K nursing pioneers of clinical supervision as,

> *'an exchange between practising professionals to*
> *enable the development of professional skills'*
>
> (Butterworth and Faugier, 1992)

2.9 Clinical supervision aims to provide a supportive service for nurses to help them reflect on their actions or possible inactions

in the provision of patient care. Despite this, a continuing lack of understanding combined with underlying mistrust by nurses can still result in obstacles for those attempting to provide supervision for nurses (Bush, 2005).

2.10 Two further, widely used definitions provide an indication for how clinical supervision has been understood and applied in a number of areas nationally. The Department of Health's definition explains how supervision,

> *'provides a support system for practitioners to ensure the provision of high-quality treatments and services through the evaluation of practice and by encouraging practitioners to learn from their experiences'*

> (DoH, 1999)

The RCN (1999) states that clinical supervision,

> *'involves the meeting of one or more nurses regularly to discuss aspects of work in order to think critically about practice, check procedure and deal with emotional issues arising from work'.*

2.11 Reviewing the existing literature on clinical supervision reveals that implementation is advanced in many parts of the U.K, however much more evidence is needed on the impact of the process in supporting practitioners during their work, promoting

learning and improving patient care through enhanced competence. Likewise, a range of other learning processes, closely aligned to the principles of clinical supervision are growing in popularity, for example, action learning, reflective learning groups, peer supervision, peer support, interprofessional supervision, professional-management supervision and critical companionship. Each of these activities hold similar values to clinical supervision and are utilised across a range of practice settings in Northern Ireland, however all require a stronger evidence base to understand and provide justification for the range of investments required to effectively establish their processes.

2.12 Gilmore (1999) conducted the largest evaluative review of clinical supervision to-date, commissioned by the UKCC in order to inform their continuing programme of work on clinical supervision. The majority of evaluations were found to be on the process of clinical supervision with evidence on the focus and quality of the clinical supervision provided. A number of issues were highlighted, including availability of clinical supervision, barriers to uptake, training of supervisors, record keeping, and confusion around the amalgamation of clinical supervision with managerial supervision. A range of studies have been published since this review within the UK, which have addressed the issues of effectiveness and clinical supervision (for example, Draper et al, 1999; Green 1999;

Jenkins, Rafferty and Parke, 2000; Cheater, 2001; Kelly et al 2001; Teasdale et al 2001).

2.13   Despite the above work, there is still a lack of knowledge on what makes clinical supervision effective. During the last three years however, a range of studies has begun to emerge that are providing clearer indication of the factors that impact upon the success of clinical supervision (for example, Freshwater et al 2003, Hyrkas et al 2003; Rafferty, Jenkins and Parke, 2003; Edwards et al 2005; Hyrkas et al, 2006). These factors for success relate to ensuring there is careful focus on the appropriate use of time, the environment for supervision, relationships, interventions to facilitate learning, organisational support, recording, evaluating effectiveness and competence (accountability).

2.14   In Northern Ireland, a range of evidence sources has provided an indication that over 80% of community psychiatric nurses were receiving regular supervision (Brooker and White, 1997); a high proportion of mental health nurses viewed clinical supervision as important, valuable, and highly beneficial (Kelly, Long and McKenna, 2001) and as outlined earlier, with reference to mental health nursing, Department guidelines have outlined a framework for guiding implementation of the process regionally (DHSSPS, 2004). There is however, very little evidence supporting the effectiveness of clinical supervision across the wider range of hospital and community nursing

services. In contrast to this, other models have emerged and are increasingly being reported in the literature, for example the benefits of reflective practice group sessions (McGrath and Higgins 2005), action learning as a means towards developing a nursing strategy (O'Halloran, Martin and Connolly 2005), the role of clinical education facilitators' in promoting work-based learning (McCormack and Slater 2006); group telephone supervision (O'Driscoll and Brown et al 2006) and critical companionship as a learning and development process aimed at supporting a culture of critical inquiry (Gribben and Cochrane 2006).

2.15 During 2005 NIPEC carried out a Workforce Development Survey of the registrant nursing and midwifery population of Northern Ireland as part of the design of the various components of the Development Framework project. A questionnaire was issued to the total registrant population (approximately 21,500) in February 2005 resulting in a 35% (n = 7,500) response rate. The survey provided valuable information in relation to registrant learning and development experience including formal and informal learning, appraisal activity, career development, personal development planning, supervision and participation in learning and development activities.

2.16 In relation to the above survey, when asked if they had undertaken 'supervision' sessions to support their role, 67% of

respondents said that they had no supervision (n=4754). Of those who did undertake supervision (33% of respondents to this question n=2273), 70 percent felt the experience was beneficial or very beneficial. There was strong evidence to suggest that those employed in midwifery (including hospital and community), mental health (including specialist roles in hospital and community) or organisation wide specialist posts are more likely (over 50%) to have supervision sessions to support their roles than those employed in other areas. Those employed within emergency nursing, intensive care and theatres, including specialist roles, surgical including surgical specialisms and specialist roles, or children's including specialist roles are the least likely (only around 20%) to have supervision sessions

Conclusion

2.17 From the relevant literature and survey information it is clear that there is limited evidence of widespread implementation of effective systems of clinical supervision or similar support and learning structures across nursing in Northern Ireland, thus the present review is timely and much needed. Firmer information is required on the number of practitioners undertaking clinical supervision (and similar models), the critical indicators of what organisations are calling clinical supervision, and evidence on the quality and impact of the supervision experience itself. In addition, evaluation is required on the training being undertaken

in preparation for supervision, policies and documentary reports guiding the process and enabling factors, as well as barriers to effective supervision.

SECTION 3 - PROJECT METHODOLOGY

3.1   In aiming to gain maximum insight to the range and impact of various clinical supervision models, it was agreed by the Review Group, that there would be two main aspects to the review approach, as follows:

1.   The development of a structured interview schedule to be administered by NIPEC with Trust Nurse Directors (July 2006)

2.   A stakeholder workshop to explore and analyse the impact of a range of supervision case studies from across the HPSS (August 2006)

3.2   The aim of this approach was to gather information on the extent and nature of supervision practice and to inform potential areas for further recommended action. It was agreed that the fieldwork process would focus on the level of supervision activity across the HPSS, what activities are currently going well, the barriers to effective supervision, what evidence there is of appropriate training, policy guidance, and the effectiveness of different models of supervision, and evidence for how supervision improves registrants' competence and practice.

3.3 The benefits of the above approach were agreed by the Review Groups as follows:

- A partnership approach would ensure that a clear service based focus informs the review process and promotes ownership of the review recommended action plan;

- Key informants will be directly involved in contributing to the review;

- Best practice exemplars will be identified and presented to inform enhancement of current supervision arrangements;

- Use of the Review Groups as a reference group to agree and validate the findings of the review and proposed action;

- The review objectives can be achieved in the tight timescale;

- The approach can provide focus that may continue beyond the life of the project.

SECTION 4 - INTERVIEW ANALYSIS

4.1 This section will provide a thematic overview of the main findings drawn from the interviews, with a particular focus on the barriers to establishing and sustaining supervision, as well as the enabling factors for effective supervision. Directors of Nursing were consulted regarding the review methodology and project plan, as well as the communication process to be followed throughout the review (see Appendix 3). Each of the eighteen HPSS Directors of Nursing agreed to be interviewed, either on a one-to-one or group basis. The majority preferred a group interview that included their senior team.

4.2 The full questioning framework followed in each interview is provided in Appendix 4. Each interview was undertaken by Bob Brown (Senior Professional Officer), recorded and transcribed verbatim by the interviewer. Having been transferred from the tape to a Microsoft Word document, the file was then sent to the relevant Director to validate the content of the transcript. A full question by question analysis summary is provided in Appendix 5.

Findings

Different models of supervision

4.3   Interviews with senior nurses suggest that HPSS Trusts recognise a wide range of learning, support and professional development activities, each of which were said to fall under a 'supervision' umbrella term. These include, formal clinical supervision (one to one and group); informal clinical supervision which might take place at the bedside, at a team meeting, or in the staff room; professional and managerial supervision; peer and clinical support supervision; action learning; mentorship, staff induction and development programmes; problem based learning; critical companionship; and through maintaining a reflective journal/diary:

> *'We use a multi-method approach to supervision, including one to one and group, action learning, mentorship and preceptorship, away days, 'live issues' model, ward managers steering group approach and strategic planning   i.e. through a reflective strategy group'.*
>
> **(Trust C)**

> *'Our methods include one to one and group clinical supervision, action learning, critical companionship, reflective diaries and problem-based learning. In our*

experience a multi-method approach that recognises diversity of interest, works best'.

(Trust A)

Defining Clinical Supervision

4.4 When asked to define clinical supervision, from their organisational perspective, around half of Trusts were working with the traditional definition of clinical supervision (similar to those offered earlier in this report). Some Trusts follow no definition and have not been successful in establishing extensive supervision, while other Trusts have moved away from the term clinical supervision, and now favour terms such as 'critical inquiry framework' to recognise the breadth of activities that come under an organisational framework for learning, support and development.

'We define clinical supervision as a range of processes aimed at supporting practitioners to deliver safe and effective care for clients within a clinical governance framework. It is aimed at improving standards of care being delivered, while identifying weaknesses in practice, as well as risks that clients or staff are exposed to'.

(Trust J)

Organisational framework and policy

4.5   When asked about the level of robustness regarding supervision as part of a wider organisational framework for learning and development across the organisation, several Trusts were clearly able to articulate and evidence this, whereas the majority are working to address this. Around one third of Trusts however, appear to be somewhat behind in terms of an apparent lack of organisational impetus around supervision activity.

4.6   It is clear from the interview analysis that there is wide disparity regarding the development of policy for supervision activities. 60 percent of Trusts either have no operational policy for clinical supervision, or introduced one 'years ago' and this may or may not be functional. Some Trusts are currently revising their guidance on clinical supervision, while others are focusing their attention on a framework of supervision activities, embedded within a broader strategic directive set by the Director of Nursing.

> *'We have a trust policy from seven years ago, which now has to be updated to reflect the range of supervision activities'.*
>
> **(Trust E)**

'We are currently developing our clinical supervision policy, as part of a learning and development framework that includes a focus on clinical support'.

(Trust M)

'All of these activities are underpinned by the Nursing and Midwifery Research and Development strategy'.

(Trust Q)

4.7   Evidently there is a need for regional direction to ensure there is both a corporate and operational understanding of clinical supervision as one of a range of possible supervision models offering support, learning, contributing to practice development and linked corporately to the organisational governance infrastructure.

Leadership

4.8   Skilled leadership is often considered to be an essential prerequisite for facilitating and driving clinical supervision successfully. This study would suggest, however, that in around 25 percent of Trusts, there is no designated leader for this work. In the remainder of Trusts, supervision activities are being led either singly by the Director of Nursing, through a specialist role such as a Practice Development Facilitator/Clinical Education Facilitator, or by a specific team, such as a Nursing and Midwifery Development Team.

Numbers undertaking supervision

4.9　Regarding the number of staff said to be undertaking one or more supervision activities, the majority of organisations have no accurate or complete method for monitoring this work, whereas in a small number of Trusts there is a process in place for collecting this important information on a routine basis. The need to strengthen this process is therefore apparent, and will increasingly be so as part of governance requirements.

Enthusiasm for clinical supervision

4.10　An open-ended question regarding levels of enthusiasm for clinical supervision was asked, and opinion varied from limited or mixed interest in a few areas to statements by the majority of Trusts that there has been a renewed and growing eagerness for this form of learning, support and development. It was of interest to note that in some organisations, the term 'clinical supervision' is no longer used, in preference for an awareness of a wider range of activities that have supervision intent. Terms such as 'clinical support and learning', a 'framework for critical inquiry' or 'methods of reflective practice' are now being used in some cases. The following quote is representative of the experience in the small number of Trusts who are successfully developing this work:

'My experience is that people welcome supervision activities. A model of consultation allows protected time for managerial and practice issues to be discussed in a learning environment. The name, whether it is supervision or consultation isn't important, it is the process that counts. In the areas where it is not currently successful, a supportive framework for these activities is emerging'.

(Trust F)

4.11 There is concern in some areas that clinical supervision is being seen as of less importance due to an increased emphasis being placed on appraisal and the NHS Knowledge and Skills Framework. It may therefore be that greater recognition and awareness is required for how supervision activities can help a practitioner to demonstrate their learning and development individually as complementary to and integrated with appraisal and continuous professional development processes, thus promoting learning and development, as well as quality and safety of care.

'Roles are changing, services are modernising and staff are responding to the challenge and recognising that clinical supervision is a means of helping them to do this effectively'.

(Trust L)

Time for clinical supervision

4.12 The issue of 'protected time' is often perceived as a barrier to establishing clinical supervision effectively. In some areas (30-40 percent of Trusts), lack of time is seen as the main reason for not implementing widespread supervision, and it is suggested that a greater recognition of this requirement at a policy and commissioning level is needed to assist Trusts to move forward. It is interesting to note however, that a growing number of Trusts are 'getting on' with this type of learning activity without additional resource attainment because their focus is on enabling all staff to recognise the value of supervision as embedded in and essential to their everyday practice:

> *'Protected time isn't an issue, people want to do this and we have enabled a framework to be in place to help them to do so – it is integrated in everyday practice'.*
> **(Trust G)**

4.13 There are a number of models of supervision across the HPSS that do offer regular and protected time, such as in relation to staff nurse induction and development programmes, specialist roles such as in child protection, and in some areas of mental health. It would seem however, that widespread awareness is required at all levels of nursing to change the way many senior nurses manage the issue of 'time' for supervision activity. To

focus on the issue of 'protected' time is increasingly seen to be inappropriate, and instead attention is being given, at least in the areas where supervision appears more successful, to facilitate a greater awareness of this as an essential activity and to enable staff to use their time more effectively.

> *'Rather than focusing on the barrier of protected time, we are drawn towards developing new and creative ways of learning that become accepted and embedded in practice'.*
>
> **(Trust C)**

Evaluation of clinical supervision

4.14 Evaluation of clinical supervision models has been a topic of much consideration in the literature, however much of the focus has been on evaluating the process of the supervision experience, rather than on the outcomes of this in relation to improving practice. Another area receiving insufficient attention to-date has been the lack of evaluation on the connection between preparation for supervision and an effective supervision experience, as well as little attention being given to competency monitoring that would help to ensure that supervisors and supervisees maintain up-to-date skills in this area. When Directors were asked whether or not clinical supervision had been evaluated in their Trust 50 percent had no or very limited evidence of evaluation to offer. A few Trusts

have audited models of supervision and process evaluated other activities such as action learning, problem-based learning and critical companionship, however it was openly acknowledged that in most cases an evaluation strategy for supervision activities is only beginning to be established. One Trust has undertaken a lot of work in this area and created an evaluation framework to monitor the range of supervision activities they offer. This approach has been in place for several years and would provide a useful approach for other Trusts to utilise, as it is clear a lot of regional direction is required in this important area.

> *'Our action learning sets are being process evaluated, however as a result of this review we hope there will be recognition and guidance on developing a framework for evaluating the impact of action learning and other models of supervision'.*
>
> **(Trust A)**

Training for clinical supervision

4.15 Preparation for undertaking clinical supervision has tended to be through a programme delivered by the in-service education providers, with around 60 percent of Trusts utilising these short programmes to train supervisees and supervisors. There appears to be recognition, however, that these programmes alone do not adequately prepare registrants for undertaking

clinical supervision, and it has become apparent that more creative and integrated approaches to preparation for supervision are required than those currently available regionally:

'We use the in-service approach and as far as I understand it, training has been positive, but overall there are serious gaps about training and the promotion of clinical supervision among the services'.

(Trust O)

'The in-service training approach is somewhat narrow and hasn't moved on from many years ago. It needs to focus more on developing reflective practice, supporting and enabling people as they embark on supervision and for a period of time after this as they develop their skills'.

(Trust D)

4.16 Around 40 percent of Trusts are recognising the importance of providing practitioners with a range of training opportunities and in line with the growing number of supervision models on offer. Both universities offer post-graduate facilitation in learning modules, the RCN Practice Development School has been introducing the concepts relevant to practice development, including facilitation, for a number of years. Some Trusts are providing in-house supervision and facilitation training and ensuring this is part of leadership development programmes.

Analysis of the Trust interviews reflects the fact that training for supervision should not be time-limited to the preparation stage, thus opportunities for training in practice and for developing the wide-ranging skills of various supervision activities over time are recognised and should be encouraged. An increase in opportunities for accredited training, linked to individual portfolio development and which monitor competence for undertaking supervision throughout a registrants career could provide the kind of innovation required. This would offer the range of opportunities a number of senior nurses have been advocating regarding ways of ensuring supervision activities become embedded in practice, as a means of contributing reflective evidence that would then be used by a practitioner as part of their ongoing appraisal.

Recording supervision sessions

4.17 When interviewees were asked what records were kept to evidence the range of supervision taking place, e.g. proformas, and action plans etc, the majority of Trusts either had no record or were depending on the use of a record that was part of a supervision policy introduced some time ago. In around 40 percent of Trusts however, there is a record in place for one or more activities, and this may be used for evaluation or monitoring purposes. While there it limited evidence regionally to show how supervision records display an audit trail from the

supervision experience to a generated improvement in practice, this is the intended outcome for most Trusts.

'There is a gap between the final supervision action plan and the communication of this to managers, and lack of a mechanism to deal with ways of working in a focused way on action plans'.

(Trust N)

'We would welcome guidance on the formality and content of records for supervision activities'.

(Trust I)

Barriers to establishing clinical supervision

4.18 Trusts were then asked to indicate the 'barriers' they had experienced when implementing clinical supervision. Many barriers were offered and have been thematically analysed into the following areas:

1. Negativity, cynicism, lacking acceptance and lacking commitment to the concept of supervision.

2. Confusion and misunderstandings around what clinical supervision is about.

3. No one leading or championing the process.

4. No organisational framework, strategic direction or strong value base for supervision activities.

5. The sheer number of nurses across an organisation who would be required to avail of these opportunities.

6. Lack of a resource infrastructure to enable staff to engage in supervision i.e. funding to protect time for work-based learning, and the demands of service that make it difficult to find time for supervision activities.

Barriers to sustaining clinical supervision

4.19 A wide range of barriers to 'sustaining' clinical supervision were also offered in response to a separate question asking interviewees to outline the factors that prevent them from mainstreaming this activity throughout their organisation. These have been thematically analysed as follows:

1. Lack of a big enough pool of experienced and well trained supervisors/facilitators.

2. Increasingly integrated and cross-boundary working and the potential impact of organisational re-structuring may affect sustainability of these activities.

3. Increasing expectations on experienced nurses to mentor, teach, assess and supervise practitioners at a range of levels.

4. Failure to evaluate supervision activities through not creating a strong monitoring framework, and therefore not fulfilling the need to prove through evaluation that there are benefits to these activities.

5. Failing to recognise the importance of placing the wide range of learning and development activities under a single and well resourced organisational framework.

6. Lack of apparent value being placed on supervision activities at a commissioning level, and the need for appropriate funding streams if all forms of experiential learning are to work alongside formal classroom learning.

7. Lack of continual and ongoing leadership, drive and commitment.

Enabling factors for effective supervision

4.20 The final question invited Trust Directors and senior nurses to reflect on the factors that enable supervision activities to work effectively and become sustainable. This question was particularly directed to those Trusts that are experiencing success in one or more activities. A wide range of enabling

factors for effective clinical supervision was offered, and these have also been thematically analysed as follows:

1. Organisational commitment and gifted leadership.

2. Developed from the bottom up and driven from the top down.

3. Having a clear vision that becomes a strategic plan and supervision framework.

4. A strong professional value base that recognises the usefulness of these activities.

5. A critical mass of people who have the skills in this way of working and facilitation.

6. Integrated processes, flexibility of approach and working across professional groups.

7. Specific strands of project work and a range of developing tools and processes to underpin critical inquiry.

8. Modernising learning and building up the importance of experiential learning and the time for these activities.

9. Reciprocity in that all involved understand and share the benefits of supervision.

10. Robust evaluation of the processes and outcomes of supervision activities.

Conclusion

4.21 The findings of the eighteen interviews with senior nurses from each Trust have provided a comprehensive and detailed analysis of supervision experience, as it currently stands, across the HPSS. This evidence was then scrutinised by the Review Group, and combined with the workshop case-study analysis that follows, to develop a set of Guiding Principles and an Action plan, to be submitted to the DHSSPS for consideration.

SECTION 5 - CASE STUDY ANALYSIS

5.1 A workshop was held on 21st August 2006, to enable service colleagues to engage with the Review Group to share their supervision activities and reach consensus on the factors that enable effective supervision processes. The aim of the workshop was to appreciate the best of what is currently available across the HPSS on the subject of clinical supervision (and related models of reflective practice that include support, challenge and learning). The methodology guiding the workshop was one of an Appreciative Inquiry (Bushe, 1995), which is about appreciating what is good in relation to something and exploring this further.

> *"Appreciative inquiry, as a method of changing social systems, is an attempt to generate a collective image of a new and better future by exploring the best of what is and has been".*

(Bushe, 1995 p. 14)

5.2 Appreciative Inquiry has its roots as a methodology in action research and organisational development and is increasingly used to understand change processes in relation to the complexity of organisational systems, through encouraging stakeholder engagement, in a way that brings people together to develop practice in a specific area of concern. It is a collaborative approach that focuses on facilitating organisational learning. The method followed at the workshop

involved understanding the strengths of each model, developing consensus regarding what is required to enable each supervision activity to be successful, and to produce 'statements of intent' that could be used to inform future regional work in this area.

5.3   The criteria developed by NIPEC to be used by Directors when considering offering a model of supervision for the workshop is contained in Appendix 6, as well as an overview of the workshop programme (Appendix 3). Twenty-five submissions were received from across Northern Ireland, with most Trusts offering at least one model for consideration. These were assessed against the set criteria by a group of Review Group evaluators, and twenty-one models of supervision were then invited to the workshop. At the workshop four broad models of supervision activity were represented – one-to-one clinical supervision, staff nurse induction and development programmes, health visiting and child protection models and action learning (further information is contained in Appendix 3 and examples of each of the above models are contained in Appendix 7). The format of the workshop followed three cyclical stages. In stage one each of the groups discussed the following questions and fed back the work they had completed on flip charts:

1.   What works about this example of a model of clinical supervision? i.e. what is effective

2. For whom does it work? i.e. individuals, team, organisation

3. Why does it work?

4. In what circumstances? i.e. we were looking at context here, such as the enabling factors and barriers to implementation etc.

5.4 As the group fed back their discussion on the above questions, an observer from each of the five groups noted key themes from the feedback session. The group of observers met over lunch to thematically analyse their notes and reached consensus on the key themes that had emerged from the 1st analysis cycle (see Appendix 3). The five groups then reconvened to discuss the thirteen factors and produce a series of 'provocative propositions' (statements of intent). Provocative propositions (Hammond, 1998) are challenging statements of goals developed in the Appreciative Inquiry process e.g. 'Everyone in the organisation will understand everyone else's role regarding clinical supervision'.

5.5 Once each group had reached consensus on their statements, the whole group met again to share feedback by reading out their statements. Following discussion it was agreed that the group of observers would negotiate a consensus on which statements would be taken forward, as a means of informing the next stage of the review. These were agreed as follows:

- There will be a shared commitment to supervision in each organisation.

- There will be an organisational framework that identifies structures and processes for supervision.

- Every member of staff will engage in supervision activities that demonstrate learning on and in practice.

- Organisations will develop a critical mass of skilled facilitators to enable the operationalisation of supervision activities.

- Individual champions of supervision activities will be recognised, nurtured and enabled to take this forward.

- There will be appropriate organisational wide preparation for engaging in supervision.

- Organisations should focus on the development and valuing of workplace learning cultures that aim to facilitate and develop person-centred care.

- At all levels within the organisation there must be strong leadership and commitment for supervision, with clear lines of responsibility and accountability.

- Development of robust monitoring and evaluation frameworks to identify the benefits of supervision for those involved and on the quality and safety of care will be a priority.

- Organisations and individuals will recognise the value of all types of learning and development, recognising that different situations require different types of learning (i.e. a blended approach).

5.6 The above statements were then considered by the Review Group in September 2006, and after comparing these with the analysis of the interviews, a set of Guiding Principles and Recommended Actions were developed and reported on, at a consultative workshop with senior nurses in October 2006.

SECTION 6 - CONSULTATION WORKSHOP ANALYSIS

6.1 A workshop was facilitated by NIPEC on 27th October 2006 to present to service colleagues the interview and case-study analysis, and through a group work approach to discuss the draft guiding principles and recommended actions that the Review Group had produced as a result of this work. The workshop was attended by forty-eight people and the majority of Trusts were represented at Director of Nursing, senior nurse, education facilitator or practice development level.

6.2 Following a presentation of the interviews and case-study workshop analysis by Bob Brown on behalf of the Review Group, participants attending focused on the following questions in their groups:

1. Do the guiding principles and recommended actions seem reasonable?

2. Having considered the guiding principles and recommended actions, does there appear to be any missing?

3. How easy would it be to implement the recommended actions?

Feedback from Groupwork

In response to the above questions, an intensive and wide-ranging discussion was undertaken by those attending the workshop and is summarised as follows:

6.3 It was considered important to share agreement on the difference between a guiding principle and a recommended action. A 'Guiding Principle' is a shared belief about something that should be achieved, whereas a 'Recommended Action' is the act(s) that must take place to ensure the guiding principle is achieved.

6.4 There was widespread agreement that we should be using the term 'Supervision' rather than Clinical Supervision, to reflect the range of activities and responsibilities and thus highlight that Supervision can have professional, managerial or clinical intent and be undertaken using a wide range of approaches.

6.5 It was suggested that the Guiding Principles should be fewer in number (eight had initially been offered), and not overly prescriptive. Thus the onus is on organisations to find the 'best fit' for this range of activities in their locality, through interpreting the guidance and actions in a meaningful and productive way. It was agreed that the recommended actions should have clear focus by stating what is required and be targeted at specific groups.

6.6 Emphasis is clearly placed on creating an organisational infrastructure for supervision activity, as part of a growing learning and development culture in each area, and facilitated by champions of supervision who display strong leadership qualities in this area, and through doing so, help registrant nurses to value this experience much more. Clearly, individual registrants have a personal responsibility to seek out opportunity for supervision, particularly when a strong infrastructure is in place.

6.7 There was concern about the practicalities of a recommended action that suggests supervision must be mandatory and that 'every nurse has the equivalent of 1-2 hours of supervision experience at least quarterly'. It was generally agreed that the focus should be on ensuring that a modernised approach to supervision activity is part of each organisations infrastructure, embedded in practice through strong leadership and facilitation and valued over time as essential by every registrant nurse. Employers and registrants have a shared responsibility to ensure effective supervision is available for all. Opportunities to fully integrate supervision with appraisal as an ongoing learning process and through individual career planning should help to emphasise and develop this ethos.

6.8 Monitoring of supervision activity across each organisation and implementation of a robust and systematic evaluation process

is seen as crucial, and must be linked to internal governance mechanisms and accountability review. It was agreed that emphasis must be placed on ensuring that supervision activities are evaluated in a range of ways, including the impact of training, on competence, quality of the supervision experience and the resulting impact on individual development, performance and ultimately quality and safety of care.

6.9   There was widespread agreement that to receive the attention it requires regionally, supervision needs to be accepted and embedded in the DHSSPS and HSSA/Trust performance management framework as a Priority for Action target.

SECTION 7 - RECOMMENDATIONS AND CONCLUSIONS

Context

7.1   This section provides recommendations for future supervision activity, by offering a series of Guiding Principles and an Action Plan to assist the establishment of effective models of supervision across nursing in the HPSS. As a result of the work of the Review Group, through carrying out interviews with senior nurses in every Trust, facilitating a case-study workshop of 'best-practice models' of supervision, and a consultation workshop with key stakeholders to create the action plan for approval, a modernised definition for supervision will also be offered.

7.2   As noted in the previous section, the Review Group understand a 'Guiding Principle' to be a shared belief about something that should be achieved, whereas an 'Action' is the act(s) that must take place to ensure the guiding principle is achieved.

7.3   In recent years there has been increasing recognition of the role of supervision in health settings throughout the UK. Supervision, when effective, remains a pivotal activity in delivering safe and efficient services, is central to workforce development across professional disciplines, and to the retention of skilled staff. In response to the Victoria Climbie Inquiry Report, for example, the Commission for Health Improvement included supervision and support as one of the

eleven core self-assessment areas for clinical teams. Similar requirements exist within the National Service Framework for Children, Young People and Maternity Service (Department of Health 2004), which states:

> *'High quality supervision is the cornerstone of effective safeguarding of Children and Young People and should be seen to operate effectively at all levels within the organisation'*

(NSF, p. 170)

7.4   In Northern Ireland, the report of the McCleery Inquiry (EHSSB, May 2006) highlighted concerns about the operational structure of the Trust concerned, in terms of clinical governance, line management and professional accountability. The report cited clinical supervision as an area where they considered confusion or ambiguity to have been in evidence. The inquiry panel recommended that all policies and procedures should provide for a robust system of monitoring and evaluation and demonstrate how this will relate to clinical governance arrangements. This included clear identification of responsibility for putting in place a written policy to introduce and maintain clinical supervision for nursing staff.

7.5   Other contextual drivers for more effective supervision include the increasing move towards integrated service delivery which sees closer working between, for example, nursing and social

care professionals when undertaking assessments for earlier discharge, and community care assessment that impacts on continuing care policy, in relation to, for example, free nursing care. Supervision is crucial in supporting and quality assuring such assessments, and when undertaken effectively, can enable staff to manage changes, negotiate extended roles and work with confidence in integrated settings.

7.6 Other drivers for supervision include a growing spotlight across disciplines on supervision, focus on workforce development, employer liability for duty of care to staff under stress and increased expectations from newly trained staff for good supervision. It has also become clear as a result of this review that while effective resource management is important as a means of ensuring staff have an opportunity for regular and effective supervision, the most important implementation factor relates to the need to change staff mindsets around the importance of supervision as integral to their day-to-day work and complementary to their ongoing personal and professional development. Supervision should therefore be something that every nurse requests and can access through a clearly defined organisational infrastructure for learning and development that offers a range of supervision models and contributes to individual appraisal. Finally, for supervision to be effective, it must be located within an overall performance management framework, and linked to competency and clinical governance systems.

Introduction to Guiding Principles and Action Plan

7.7   As a result of the extensive fieldwork, case study analysis and consultative feedback, the Review Group has agreed a modernised definition, set of Guiding Principles and an Action Plan in order to achieve effective Supervision systems across the HPSS.

7.8   The following modernised definition for Supervision (adapted from the NHS Management Executive definition, 1995) is offered by the Review Group, and should be used to underpin the implementation of future supervision activities across the HPSS:

> *'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 of care'.*

7.9   The following Guiding Principles and Action plan are presented, as a means of influencing effective supervision systems of the kind discussed above. They highlight four areas of responsibility and accountability – at a regional level,

organisational infrastructure level, Executive Director of Nursing and individual nurse level.

SUPERVISION GUIDING PRINCIPLES

1. A Regional Standard for Supervision should reflect a modernised definition, recognise diversity of approach and include key infrastructure components outlining documentation, monitoring and evaluation requirements.

2. Organisations should implement effective arrangements to meet Supervision, based on the Regional Standard in place, as part of their governance systems.

3. The Executive Director of Nursing should provide the professional leadership for Supervision within the organisation.

4. All registered nurses should recognise their responsibility and professional accountability for undertaking Supervision, as integral to their day-to-day practice.

SUPERVISION ACTION PLAN

(i)	A Regional Standard on Supervision will be developed to include a modernised definition and refer to a range of current and innovative approaches.	**Timescale April 2007 - Responsibility DHSSPS**
(ii)	A framework based on the Regional Standard for Supervision will be developed and implemented in every organisation and embedded with governance systems	**Timescale March 2008 - Responsibility Executive Director of Nursing**
(iii)	Responsibility for Supervision will be invested in the Executive Director of Nursing, who will report to Trust Board annually on Supervision monitoring and evaluation activity.	**Timescale March 2009 - Responsibility Trust Chief Executive**
(iv)	Supervision activity should complement appraisal and performance review processes for all registrant nurses.	**Timescale March 2008 - Responsibility Executive Director of Nursing**

(v) Service and education providers will review the quality of training and ongoing development for Supervision activity, based on the Regional Standard, and will modernise this accordingly.	**Timescale March 2008 - Responsibility DHSSPS**
(vi) Organisations must address capacity building to implement the Regional Supervision Standard.	**Timescale March 2008 - Responsibility DHSSPS, Trusts and Education Providers**
(vii) Documentation for Supervision activities must be developed and implemented for recording and evaluation purposes.	**Timescale October 2007 - Responsibility DHSSPS**
(viii) Robust monitoring and evaluation strategies must be developed and agreed, to demonstrate effectiveness of the Regional Supervision Standard and its impact on quality of care.	**Timescale October 2009 - Responsibility Executive Director of Nursing**

Summary conclusions from the Review Group

7.10 This review has provided a robust and systematic evaluation of a range of supervision models across nursing in the HPSS in 2006. A wide range of barriers to and enabling factors for effective supervision has been identified, as well as a concise and targeted action plan for future development work in this area. This report builds on the work undertaken by the DHSSPS in 2004 when offering recommendations for 'clinical supervision' in mental health and learning disability nursing.

7.11 The Review Group have offered a set of Guiding Principles and an Action Plan that we believe offers clear guidance for those planning a 'Supervision framework' in the re-structured HPSS. It is crucial to see supervision as integral to and embedded within an organisational learning culture that recognises the complementary nature of supervision, alongside learning and development, performance management and through influencing a care system governed by patient safety and continually improving practice.

7.12 It is clearly recognised that the term 'Supervision' within the professional context, in differing from the supervision of work activity, includes a wide range of activities and approaches that have a 'supervision' impact, such as action learning, individual and team supervision, reflective learning groups, critical

companionship, professional, managerial and peer supervision. Rather than being restrictive to the use of specific models, those planning supervision are challenged to recognise the diversity of approach required, so that individual nurses not only have a choice, but can identify with a strong and supportive organisational infrastructure that advocates a shared responsibility for this work, and builds confidence in individual processes. This also requires organisations to establish a robust system for monitoring supervision activity and evaluating its effectiveness in terms of patient safety and continuous improvement to nursing care across a range of levels.

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APPENDICES

Appendix 1: NMC Guiding Principles for Clinical Supervision (March 2006)

The NMC supports the principle of clinical supervision but believes that it is best developed at a local level in accordance with local needs. The following set of principles has been defined, which the NMC believes should underpin any system of clinical supervision that is used:

- Clinical supervision supports practice, enabling registrants to maintain and improve standards of care
- Clinical supervision is a practice-focused professional relationship, involving a practitioner reflecting on practice guided by a skilled supervisor
- Registrants and managers should develop the process of clinical supervision according to local circumstances. Ground rules should be agreed so that the supervisor and the registrant approach clinical supervision openly, confidently and are aware of what is involved
- Every registrant should have access to clinical supervision and each supervisor should supervise a realistic number of practitioners
- Preparation for supervisors should be flexible and sensitive to local circumstances. The principles and relevance of clinical supervision should be included in pre-registration and post-registration education programmes
- Evaluation of clinical supervision is needed to assess how it influences care and practice standards. Evaluation systems should be determined locally.

The NMC supports the establishment of clinical supervision as an important part of clinical governance and in the interests of maintaining and improving standards of patient/client care.

Appendix 2: Review Group Membership

Name	Position
Hazel Baird	Executive Director of Nursing, Homefirst HSST Project Chair
Phelim Quinn	Director of Nursing, Regional Quality Improvement Authority
Pat Patten	Council Lay Member, NIPEC
Phil Mahon	Director of Healthcare, Foyle Trust
Mary Burke	Senior Manager/Education Facilitator, Craigavon Area Hospital Group Trust
Brendan Mullen	Director of Mental Health and Learning Disability, Ulster & Community Hospitals Trust
Paula Forrest	Practice Development Facilitator, Royal Belfast Hospital for Sick Children
Maurice Devine	Nurse Consultant, Learning Disability, Down and Lisburn Trust
Kathy Fodey	Nursing Officer, DHSSPS
Sharon Barr	Community Nursing Manager, North and West Belfast Community Trust
Tracey Lupari	Child Protection Nurse Specialist, Homefirst HSST
Geraldine Connolly	Primary Care Facilitator, SHSSB
Anne Canning	Education Manager, Educare
Avril Redmond	Clinical Education Facilitator, Belfast City Hospital
Wendy Megarrell	Training & Operations Support Manager, Fourseasons Health Care
Janice Smyth	Deputy Director, RCN
Paddie Blaney	Chief Executive, NIPEC
Bob Brown	Senior Professional Officer, NIPEC
Lesley Barrowman	Senior Professional Officer, NIPEC

Appendix 3: Review methodology, project time-table and communication process

The methodology guiding the review process was informed by Appreciative Inquiry (Bushe, 1995). Three main fieldwork components were undertaken.

Stage One: The first stage involved undertaking structured one-to-one or focus group interviews with senior nurses to explore the experience of supervision across the HPSS, and through a focus on the following:

- What level of activity is in place?
- What is currently going well?
- What are the barriers to effective clinical supervision?
- What would help to ensure clinical supervision goes well every time?
- What evidence is there of training, policy guidance, and the effectiveness of different models of supervision?
- What evidence is there that clinical supervision improves nurses' competence and practice?

Stage Two: The second stage involved facilitating a case-study workshop to consider the effectiveness of a range of supervision models. The aims of the workshop were to appreciate the best of what is currently available in N.I on the subject of supervision (and related models of reflective practice that include support, challenge and learning)

The method used at the workshop involved:

1. A grounded observation of the 'best of what is'
2. Collaboratively articulating through exercises in vision and logic, 'what might be'
3. Developing consensus and obtaining consent of those in the system to 'what should be'
4. Collectively experimenting with 'what can be' (Bushe 1995, p. 15)

The following people attended the workshop and took part in group work according to the following areas of interest:

Area 1 – One to One models of Supervision

Sharon Dunn and Shirley Forsythe – Role Supervision – Royal Victoria Hospital
Bernadette Gribben – Critical companionship – Royal Group of Hospitals Trust
Mary Charlton and Mary McShane – Specialist Practice Clinical Supervision – Belfast City Hospital Trust
Damien Brannigan – Mental Health Supervision – Ulster and Community Hospitals Trust

Area 2 – Staff Nurse Induction and development programmes

Judy Houlahan and Margaret Murphy – Clinical supervision development programme – Foyle Community Trust
Suzanne O'Boyle – Staff Nurse Induction and development programme – Mater Hospitals Trust
Mary Burke – Rotational programme – Craigavon Area Hospital Group Trust
Anne-Marie Tunney and Jean Lennox – Staff Nurse Development programme – Causeway Hospitals Trust

Area 3 – Health Visiting and Child Protection models

Roisin Toner and Julie McConville – Craigavon & Banbridge Community Trust
Denise Kerr – Homefirst Trust
Angela Boyle and Frances Donovan – Down and Lisburn Trust
Caroline Goldthorpe and Debbie McCormack – Armagh and Dungannon Trust

Area 4 – Action Learning

Margaret Devlin – Cardiology Set – Royal Victoria Hospital

Carol McCorry – Ward Managers Set – Craigavon Area Hospital Group Trust

Annetta Quigley – Action learning in Coronary Care – Sperrin and Lakeland Trust

Rita Devlin – Problem-based Learning model – Ulster and Community Hospitals Trust

Vicky Toner and Teresa McCann – PD Action Learning Sets – Newry and Mourne Trust

Carolyn Kerr and Geraldine McKay – Action Learning Sets – United Hospitals Trust

The workshop was facilitated by the following people:

Bob Brown, Senior Professional Officer, NIPEC
Lesley Barrowman, Senior Professional Officer, NIPEC
Kathy Fodey, Nursing Officer, DHSSPS
Brenda Creaney, Directorate Manager - RBHSC
Wendy Megarrel, Training & Operations Support Manager, Fourseasons Healthcare

The process engaged in was as follows:

Cycle 1: Each of the groups discussed the following questions and fed back the work they had completed on flips charts

- What works about this example of a model of clinical supervision? i.e. what is effective

- For whom does it work? i.e. individuals, team, organisation

- Why does it work?

- In what circumstances? i.e. we were looking at context here, such as the enabling factors and barriers to implementation etc.

Cycle 2: As the group fed back their discussion on the above questions, an observer from each of the five groups noted key themes from the feedback session. The group of observers met over

lunch to thematically analyse their notes and reached consensus on the key themes that had emerged from the 1st analysis cycle.

Cycle 3: The five groups then reconvened to discuss the themes and produce a series of 'provocative propositions' (statements of intent).
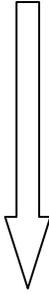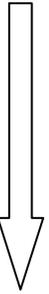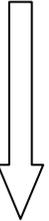
N.B Provocative propositions (Hammond, 1998) are challenging statements of goals developed in the Appreciative Inquiry process e.g. 'Everyone in the system will understand everyone else's role regarding clinical supervision'.

Once each group had reached consensus on their statements, the whole group met again to share feedback by reading out their statements. The observers then negotiated a consensus on which statements should be taken forward and these were then analysed by the Review Group and along with the interview analysis was used to inform the first draft of Guiding Principles and Recommended Actions.

Stage Three: This final stage involved facilitating a consultative workshop with senior nurses from across the HPSS, to enable a critical discussion to take place on the draft guiding principles and recommended actions that had emerged from the analysis of Phases One and Two. The following questions were addressed:

1. Do the guiding principles and recommended actions seem reasonable?

2. Having considered the guiding principles and recommended actions, does there appear to be any missing?

3. How easy would it be to implement the recommended actions?

Clinical Supervision Review Group Work Plan

23 June 2006	1st meeting of the Review Group Actions – Agree review methods and discuss fieldwork interview schedule/questioning content Continue e-mail correspondence with Review Group to agree interview questions and criteria for Case Studies Undertake fieldwork (Bob Brown)
25 July 2006	Present fieldwork analysis to-date and discuss Plan case study workshop (Selected participants – date to be agreed – August 06) Plan format for analysis workshop (Review Group – workshop likely to take place in September/October 06)
25 August 2006	• Present all interview analysis • Undertake case study workshop analysis • Agree all review findings • Plan consultative workshop format - all key stakeholders will meet to validate analysis and draft action plans
27 October 2006	Consultation workshop with key stakeholders to discuss the above analysis and recommended action plan/guiding principles for future HPSS supervision activity
9 November 2006	Review Group meet to agree the recommended actions and guiding principles and discuss the structure of the review report.

Communication Framework for the Clinical Supervision Review

1. Monthly meetings of the review group will take place at NIPEC between June and November 2006.

2. The Review Chair has written to each Director of Nursing, outlining the review and asking for their support.

3. A review group email has been set up to enable regular communication between NIPEC and group members. This will include the sending of agendas and minutes from meetings and consultation on the project methodology and timeframe.

4. The progress of the review will be reported on the NIPEC web-site and E-news.

5. As the review progresses, Directors of Nursing will be invited to take part in telephone or face-to-face interviews, offer case studies of good clinical supervision practice (according to set criteria) and have representation at stakeholder workshops. Communication regarding each of the above will be via email, letter and telephone.

6. The findings of the fieldwork undertaken during July and August will be consulted on with the review group and at a stakeholder workshop in September/October. In addition to face-to-face contact, the analysis of this information and eventual agreement on findings and an action plan will include e-mail correspondence.

7. The Review group will be invited to contribute to the final report, which will be available on the NIPEC web-site and forwarded to the DHSSPS in November 2006.

Appendix 4: Interview Questioning Framework

1. How does the organisation define clinical supervision and what activities come under the remit of 'supervision'

2. Is there an organisational framework for supervision activities?

3. Who has led the implementation of clinical supervision across the Trust?

4. Is there a supervision policy in the Trust – when was it implemented, how effective is it in guiding organisational implementation of clinical supervision and has its impact been evaluated? Does the policy state that nurses 'must' undertake clinical supervision, or do they have a choice?

5. Can the Trust provide evidence of the number of people undertaking supervision and the regularity of this; length of sessions etc? How many supervisors are there and how do supervisees choose a supervisor? Are supervisees and supervisors matched?

6. What is the level of enthusiasm for undertaking supervision across the organisation? How do you believe clinical supervision is viewed across your organisation by supervisees, supervisors and others i.e. practitioners and managers?

7. Is there protected time allocated for supervision? If yes, how has time for clinical supervision been facilitated? If not, how has the process been established?

8. Has the Trust evaluated supervision methods i.e. establishing supervision, effectiveness of processes and outcomes – how and what evidence is there of this i.e. on individuals and on improving the quality of practice?

9. How are supervisors/supervisees and managers with responsibility for supervision trained – has the impact of

training been evaluated? Is there any feedback on whether the training itself was appropriate?

10. What records are kept on supervision i.e. contracts and written accounts of sessions, action plans from sessions – can the Trust provide examples of how effective this is?

11. Has the Trust faced any barriers to 'establishing' supervision? If so, what are these?

12. Has the Trust faced any barriers to 'sustaining' supervision and enabling 'effective' supervision? If so, what are these?

13. What (if any) is currently going well as a method of supervision in the organisation? What are the factors that are enabling this to work well? Is there a particular group of staff that it has been easier to establish clinical supervision for?

Appendix 5:   Interview Analysis Overview

Analysis of principles and interviews/focus groups with Trust Directors of Nursing/Senior Nurses using the Questioning Framework (1-13 below) and undertaken during July and August 2006.

The following question format was used. For each question, an overview of the analysis follows

Q1. How does the organisation define clinical supervision and what activities come under the remit of 'supervision?'

Interview analysis indicates that Trust definitions for clinical supervision fall under three main areas:

No definition for clinical supervision is being used	25% of Trusts have not defined clinical supervision
A traditional definition for clinical supervision has been in place for some time	50% of Trusts have followed this approach
More modern approaches to supervision are reflected in definitions other than for clinical supervision e.g. action learning	25% of Trusts have moved beyond a definition for clinical supervision and focus on defining other approaches to learning and development e.g. critical inquiry, clinical support and learning

The range of activities that fall under a broad definition of clinical supervision are widespread and include:

- Formal clinical supervision (one to one and group)
- Informal clinical supervision
- Professional supervision
- Managerial supervision
- Peer supervision
- Clinical support supervision
- Professional group meetings
- Team meetings
- Action learning

- Mentorship
- Staff nurse induction and development programmes
- Problem-based learning
- Critical Companionship
- Reflective diaries

Q2. The level of robustness of organisational frameworks for supervision activities would appear to fall into one of three groups, as follows:

Organisational wide framework	Several Trusts (5%) have established a framework that ensures a range of supervision activities are in place.
Recently addressing the importance of implementing effective supervision frameworks	Around 65% of Trusts are working to develop an organisational framework for supervision activities that encompass a range of models
Appears to be somewhat behind in terms of an apparent lack of organisational impetus around supervision activity	Around 30% of Trusts would appear to fall into this category

N.B. An organisational framework for supervision activities could be defined as a 'clearly articulated and strategically focused organisation-wide approach to supervision, which is well established and has at least displayed emerging evidence of effectiveness'.

Q3. Who has led the implementation of clinical supervision across the Trust?

The level of leadership in each Trust to establish and sustain supervision activities falls into four categories, as follows:

No obvious leader for supervision activities	25% of Trusts
Being led by Director of Nursing	25% of Trusts
Being led by Senior Nurses and Practice Development/Clinical Education Facilitators	25% of Trusts
Being led by a specific team i.e. Trust Nursing and Midwifery Development Team	25% of Trusts

There is general consensus that the Director of Nursing has responsibility for leading clinical supervision, and this often involves promoting the concept of supervision at Trust Executive and Senior Management level, to gain support and feedback the impact of this work, increasingly from a governance context. While no Trust suggested that they were not interested in establishing clinical supervision, it is concerning that in approximately 25% of cases, there is no obvious leadership for this work.

Q4. Is there a supervision policy in the Trust?

The extent to which Trusts have an operational policy guiding clinical supervision fell into the following five categories:

No clinical supervision policy	Approximately 20% of Trusts
Old policy, which appears to be non-functional	10% of Trusts
Old policy that is/may be being followed in some areas of the organisation	30% of Trusts
Newly emerging clinical supervision policy directive	20% of Trusts
No clinical supervision policy	20% of Trusts

because guidance is focused on other areas e.g. nursing strategy	

It is clear from the above information that there is wide disparity regarding the development of policy for supervision activities. Evidently there is a need for a regional organisational review to ensure there is both a corporate and operational understanding of clinical supervision and related models of learning and development.

Q5. Can the Trust provide evidence of the number of people undertaking supervision and the regularity of this?

There was an immensely variable response to this question, ranging from Trusts that were unable to give any indication of the number of nursing staff availing of supervision, to the other extreme when numbers are carefully monitored. There were three categories to summarise this as follows:

No numbers available to suggest how many staff are undertaking supervision activities	Approximately 25% of Trusts
Vague or incomplete information on the number of staff undertaking supervision	50% of Trusts
Clarity on actual numbers undertaking supervision activities	25% of Trusts

The above evidence suggests there is an urgent need for a robust monitoring arrangement for supervision activity in each organisation. Similarly, only a few Trusts were able to offer clear information on how often staff undertake supervision and the length of these sessions. A vague estimate suggests that for the majority of Trusts 10-20% of staff regularly avail of one or more supervision activities. In one or two Trusts this figure may be closer to 40-50%.

Q6. What is the level of enthusiasm for undertaking supervision across the organisation?

It has become evident from the responses to the above question that while in some areas enthusiasm for clinical supervision is limited,

mixed or sporadic, the majority of Trusts suggest that there has been a renewed and growing interest in these activities in recent years. In some areas, enthusiasm is building to the extent that staff are requesting supervision, are placing a high degree of value on the importance of this and increasingly accepting that supervision is essential in any learning, development and governance culture. Two points of caution however relate to concerns around the term clinical supervision, to the extent that some Trusts are focusing their attention on developing an overarching framework for 'clinical support and development' or 'critical inquiry'. Secondly, while Trusts in general recognise the importance of clinical supervision as contributing to performance review and Knowledge & Skills Framework development, a number have indicated that staff are so focused on appraisal that supervision activities are not being given the emphasis they require. This is therefore an area requiring greater awareness and promotion in a way that helps nurses to recognise the importance of integrating the wide range of learning and development activities available to them.

Q7. Is there protected time allocated for supervision?

The issue of protected time has long been the focus of much contention among those responsible for establishing and undertaking clinical supervision. The literature highlights the fact that for some, clinical supervision is unsuccessful because it is not resourced financially and therefore isn't time protected. Others will argue that time isn't as important a factor as developing an ethos for and organisational understanding of clinical supervision that sees it as part of everyday practice and underpinned by processes of structured reflective practice.

Analysis from this question in the current review falls into the following three categories:

No protected time is given because there is no resource available for this	40% of Trusts
Protected time is offered to some groups	40% of Trusts
The focus is not on protected time, but on facilitating time, thus the focus is on valuing and enabling processes of supervision and embedding these in practice.	20% of Trusts

Q8. Has the Trust evaluated supervision methods i.e. establishing supervision, effectiveness of processes and outcomes – how and what evidence is there of this i.e. on individuals and on improving the quality of practice?

Evaluation of the impact of clinical supervision has also been the focus of a wide body of national literature in recent years. Rarely however is evaluation undertaken on whether supervision has a positive impact on the quality and safety of clinical practice, as usually the focus is on evaluating the process of supervision and on individual learning and development.

The current review analysis suggests that there are four categories that encompass the range of evaluation experience across Trusts in Northern Ireland:

No evaluation has been undertaken	30% of Trusts
Clinical supervision processes have been audited	20% of Trusts
Action learning has been process and outcome evaluated	20% of Trusts
Limited evaluation has been undertaken, lacking any robustness	20% of Trusts
Evaluation is embedded in monitoring the impact of a framework of supervision activities	10% of Trusts

While evaluation of supervision activities is generally weak across much of the HPSS, there is recognition of the importance of developing a robust evaluation framework that assesses the quality of supervision experience, impact on the individuals taking part, and on the quality of care. Several Trusts have placed careful emphasis on ensuring an evaluation component is built into their supervision work, and are actively pursuing evidence that displays impact on practice and performance. Despite this, it is doubtful whether any trust has evaluated the impact of supervision activity on improving quality and safety of care. Clear recommendations are therefore required to develop this area of interest.

Q9. How are supervisors/supervisees and managers with responsibility for supervision trained; is there any feedback on whether the training itself was appropriate?

The issue of training and preparation for clinical supervision was of great interest to senior nurses taking part in interviews, judging by the number of occasions that concerns about the quality of this was mentioned in discussions alluding to this and other questions.

It has become apparent that there are three categories representing the experience of training and preparing for supervision:

No training has been commissioned	20% of Trusts
In-service Education provision	60% of Trusts commission this
A range of training through in-house, facilitation programme, academic modules and practice development school	40% of Trusts commission this

While the majority of Trusts commission the traditional approach to training for clinical supervision through their in-service education contract, there are widely held concerns about the ability of this programme to prepare practitioners for supervisor or supervisee roles. Opinions vary from stating that surveys show staff in one Trust felt inadequately prepared despite accessing this training, to views that the training is narrow, lacking in depth and requires a creative and modernised approach to delivery.

Increasingly staff from Trusts throughout Northern Ireland are attending the RCN Practice Development school in addition to or separate from undertaking the Postgraduate Diploma in Facilitation, Learning and Development, which offers RCN Facilitator Accreditation. These opportunities are relatively new and while they are usually positively evaluated as learning experiences, it will be a few more years before the impact of these programmes on the quality of facilitating supervision activities will be recognised.

As noted earlier, evaluation of supervision activities across the HPSS must include monitoring the effectiveness of facilitation or supervisor roles and the quality/impact of training and preparations. It is also likely that a recommendation is required that calls for a review of current in-service provision in this area.

Q10. What records are kept on supervision i.e. contracts and written accounts of sessions, action plans from sessions?

The maintenance of records in line with various supervision models is possibly the weakest area across the HPSS. The following three categories indicate the level of recording apparent at Trust level:

No records are kept	30% approximately
The operational policy that has been in use for a number of years, offers guidance on records, but there is limited awareness of whether this is followed	30% approximately
Records are in place and regularly monitored for clinical supervision and other activities e.g. action learning	40% approximately

Given the lack of clarity around recording apparent during interviews and guidance sought by some Trusts on how best to record supervision activities, it is likely that a recommended action around a minimum record will be offered as a result of this review. The above figures are only approximates because often those being interviewed could not indicate how robust recording approaches are in their organisation, suggestive of a general lack of appreciation and detailed monitoring. In future is it likely that Trusts will have to maintain a clinical supervision record for every employee that sits within the governance framework of the organisation.

N.B An analysis of questions 11-13 has been presented in the main text of this report (pages 30-33).

Appendix 6: Criteria for Case-study Submissions

Criteria followed by Directors of Nursing when considering offering a case-study on 'effective' Supervision

1. Someone is 'leading' it locally, nurturing ownership of/enthusiasm for this model of supervision

2. The process can be described locally, particularly the success factors

3. The positive outcomes of this form of supervision can be offered as evidence supporting an effective model

4. The process of supervision has been documented and records are available to show this. There may be other records that show an evidence trail for how supervision impacts on personal and practice development i.e. action plans.

5. This form of supervision has been established for a reasonable enough time frame to enable others to identify the success factors, issues and challenges that have been overcome and impact of the process on individuals and practice

6. There is evidence of investment in the development of those involved i.e. supervisors/supervisees have been trained and are continuing to learn and develop in different ways

7. There should be at least some evidence to indicate that this form of supervision is working.

In selecting case studies we are aiming for exemplars of supervision that offer experience in a range of settings and using different models.

Appendix 7: Case-study examples

Role Supervision in the Royal Group of Hospitals

The development of reflective practice strategies falls under the remit of the Director of Nursing Research and Practice development and is operationalised by the Nursing and Midwifery Development team. The Developing Practice Manager has the role of monitoring and quality assuring these activities.

Sharon Dunn has led the development of role supervision in the Division of Medicine and Surgery in the Royal Victoria Hospital. Role supervision offers an opportunity for a ward manager to engage with their line manager is a process of critical inquiry into their role and development of that role.

Role supervision offers high levels of challenge and support to ward managers, encourages critical dialogue between the ward manager and the supervisor which enables the individual to develop their own learning, practice and personal development. The supervision relationship is also developmental for the supervisor. Each individual maintains their own record of the sessions which forms the basis for evidence of development which will be maintained in the individual's personal portfolio.

Role supervision has been established for 18 months within the Medicine and Surgery Division and has been seen to have a positive outcome for those involved. Ward managers feel more supported in their role and have displayed increased confidence in decision making. These individual managers have also developed their skills as facilitators through experiential learning with their line manager who is an experienced facilitator and who is also in clinical supervision examining her own practice. Some members have developed further through undertaking the in-house 'Facilitation in practice' module. Individuals evaluate the experience using the critical inquiry framework.

Supervision in the Ulster and Community Hospitals Trust Mental Health Directorate

Dawn Heather White, Assistant Director, Mental Health is leading the supervision model within mental health (Adults and Children & Adolescent Mental Health Services) and monitors implementation through meetings with the Senior Management Team and quarterly reporting from these managers.

Damien Brannigan, Senior Manager and Professional Lead for Mental Health Nursing within the Mental Health Directorate chairs the monthly Mental Health & Learning Disability Senior Nurse Managers meetings and the monthly Mental Health & Learning Disability Professional Issues Forum.

The process is directed by a local policy. All community staff have monthly supervision with their Line Manager. They also have access to peer supervision through the monthly Professional Nursing Issues forum. Supervision sessions are minuted, as are the forum meetings. The arrangements have been in place for ten years.

One of the positive outcomes of the monthly supervision is that staff no longer felt the need for separate quarterly professional supervision as their professional needs were being met through both their supervision with their Line Manager and attendance at the Professional Nursing Issues forum. However, staff can request professional supervision if they encounter a particular professional issue that they wish to discuss.

Other positive outcomes:
- Staff come prepared with an agenda
- Attendance is good
- Minutes are recorded
- Actions are agreed and implemented
- Development needs are identified and addressed both on an individual and team/group basis
- Trends re. development needs or emerging issues are identified.

All supervision sessions are minuted and both supervisor and supervisee keep a signed copy. The minutes include a summary of discussion and any agreed action, which is then followed up during subsequent supervision sessions. The Managers include a list of the dates staff have engaged in supervision in their quarterly reports to Dawn Heather White.

All community staff within Mental Health have engaged in monthly supervision with their Line Manager since the teams were restructured at the beginning of 1996. When a Trust merger took place in 1998, the policy was then implemented with staff in the Mental Health Day Hospital.

Training for supervision was commissioned by the Directorate from The Beeches for several consultation days. All G Grades and above are being facilitated in completing the Nurse Leadership Programme which has an emphasis on reflective practice and practice development.

Staff attend supervision routinely and are prepared to seek an alternative date should they be unable to attend the timetabled session. There are Supervision files for each member of community and day hospital staff. As action is agreed at each session the minutes would indicate that the actions are followed up and reviewed during subsequent sessions. The Directorate has just drafted a Supervision questionnaire to evaluate staff satisfaction with the supervision arrangements and monitor adherence to the local policy.

Group Clinical Supervision for newly qualified nurses on the Rotational Programme at Craigavon Area Hospital Group Trust

As part of the Trusts recruitment and retention strategy a rotational programme was developed for newly qualified nurses in October 2003. This programme was seen as a new and innovative way of recruiting and retaining staff and one that would support the newly qualified nurses' individual personal and professional development. This 12 month programme consisted of four 3 month placements covering general medicine, general surgery, care of the older person and a speciality of the individual's choice.

Group clinical supervision was the model adopted to support and facilitate the newly qualified nurse to develop as a safe, reflective confident and competent practitioner. Group clinical supervision can be described as a process, whereby nurses are brought together to reflect on aspects of practice/professional issues in a secure and confidential environment.

The newly qualified nurses on the rotational programme have a two-hour workshop at the beginning of their rotational programme to prepare them for group clinical supervision. They are given the option as to whether they wish to participate in group supervision and to date no-one has refused. Following agreement to participate a contract is agreed between the supervisor and supervisee. Group clinical supervision is guided by this contract which consists of ground rules, time, dates, duration of session etc and these are revisited and amended if necessary at the beginning of each supervision session. The group meets approximately every 4-6 weeks for a 3-hour period.

What happens in a set?

- Icebreaker
- Review the ground rules
- Feedback from actions undertaken from previous session
- Decide who presents
- Presentation of issues
- Clarifying, enabling and reflective questions to the presenter
- Identify actions

- Review the learning
- Evaluation of clinical supervision session

The positive outcomes of this form of supervision can be offered as evidence supporting an effective model:

- Nurses recognise the importance of reflecting on practice/professional issues
- Practitioners take actions away from group clinical supervision
- Share experience of practice issues learning from each other
- Promotes safe accountable practice
- Develops individual confidence to deal with emergencies e.g. cardiac arrest, anaphylaxis, infection control
- Develops knowledge
- Develops problem solving skills and leadership skills
- Improves communication skills
- Develops ability to question/challenge practice at ward level
- Develops ability to manage conflict
- Highlights additional training requirements
- Contributes to life long learning
- Values practice – identifying and building on what nurses do well
- Identifies and exposes what nurses do least well
- Supports personal growth and development
- Develops individual confidence and competence
- Enables nurses to meet PREP requirements
- Offers protected time for nurses to attend clinical supervision.
- Supported and approved by Director of Nursing & Quality, Assistant Director of Nursing & Quality and Directorate Managers
- Supported by a designated person to lead and facilitate group clinical supervision

Nurses keep records of ground rules, personal reflections issues they have presented and the actions they have identified and undertaken from their presentations. This is recorded in their personal professional portfolio

The supervisor/facilitator keeps brief records on the following:

- Ground Rules
- Attendance
- Ice breaker used
- Issues discussed/presented
- Actions identified
- Feed back on actions
- Additional training highlighted
- Evaluation of session
- Hopes, Fears, Expectations undertaken with nurses at the beginning of their rotational programme, these are revisited and reviewed at the end of the 12 months

Clinical Supervision commenced in October 2003 with 8 rotational nurses on the first programme. To date we have had 38 Nurses who have received group clinical supervision within the Trust through the rotational programme. Evaluations have been carried out at the end of each programme using semi-structured questionnaires. This is evidenced through the positive evaluation of the programme from the newly qualified nurses and the ward managers. The Trust has retained these staff and there is evidence to suggest that they have a wider range of knowledge and skills acquired from the range of clinical settings they experience. These nurses are demonstrating that they have been able to apply and transfer their knowledge and skills to other clinical settings and there have been requests from Clinical Service Managers/Ward Managers for placement of them in particular wards/departments, as they are deemed more competent and confident to work in speciality areas. Their individual confidence and ability to question practice issues has been noted.

Health Visiting Supervision in Craigavon and Banbridge Community Trust

The Director of Elderly and Primary Care takes a strategic lead and appropriately delegates through line managers the on-going development and review of models of supervision across its nursing disciplines.

The Trust health visiting team managers have developed this model of supervision in partnership with the health visiting policies and procedures group and in consultation with senior nurse managers. The philosophy and benefits of supervision are embedded within health visiting policies and procedures and through the induction process of new staff.

This model has further influenced the development of supervision models for other groups of staff in the Trust. The supervision process is described in detail within the relevant policies and procedures. All health visitors have a personal copy of the supervision policy and procedure and it is also available on the Trust Intranet.

The supervision procedures include specific standards on frequency and content of supervision meetings. The Trust provides supervision to health visitors using 4 methods:

- Individual clinical supervision
- Open door contact
- Peer group mentoring
- Audit of health visiting records.

Kolb's experiential learning cycle (1984) is utilised to explore complex issues during individual clinical supervision and peer group mentoring. This model is utilised to promote reflective practice, learning and to enable effective problem solving. Newly appointed health visitors must undertake supervision twice weekly for the first three months, and then monthly for three months, before continuing supervision on a 2-3 monthly basis after that. Each of the stages may be increased in length according to individual needs. Feedback from staff would indicate that they place a high value on the supervision provided.

This model of supervision effectively provides an opportunity:

- For team managers to develop rapport and support staff
- To encourage reflective practice and professional development
- To highlight good practice and give positive feedback
- To encourage staff to comply with Trust standards
- To identify training needs
- To identify emerging deficits in practice at an earlier date in order to agree a personal development plan with the staff member.

The supervision procedure contains a number of profomas, which reflect the different types of supervision offered and records of supervision activity are retained by supervisor and supervisee. The proformas are structured to include discussion and the actions/outcomes required following supervision.

Supervision for health visitors has been integral to practice for many years but the process was formalised in 2002 and updated in 2005. The health visiting team managers have an induction programme which includes training in supervision of staff.

Health visitors engage positively with this process and actively seek out opportunities for supervision. Team managers have identified faltering performance with individual practitioners and have been able to put strategies in place to address issues.

Evaluation of supervision activity includes findings from audit reports (2002, 2004) which indicate that health visitors felt that supervision was supportive, allowed work related issues to be addressed and positively impacted on their practice.

Action Learning as an example of group supervision in Causeway HSST

In May 2005, the Director of Acute Services identified that the process of support provided for newly qualified nurses within the acute sector required review and development. The Practice Development Nurse was asked to develop a preceptorship programme for newly qualified nurses coming to work in Causeway Hospital. One aspect of this programme is the provision of action learning as a form of supervision for newly qualified nurses. The Practice Development Nurse continues to lead the project locally, supported by Senior Managers within the Hospital.

Twenty-nine newly qualified nurses commenced a twelve month preceptorship programme in January 2006. As well as having a ward based preceptor, the Practice Development Nurse acts as Lead Preceptor coordinating the process and addressing identified training and development needs. This is carried out on a one to one basis between newly qualified nurses and their Lead Preceptor. In addition, bi-monthly, newly qualified nurses come together as a larger group to attend in-house training sessions facilitated by specialist nursing staff.

All newly qualified nurses were provided with a Personal Development Portfolio at the outset of the programme and an awareness session provided them with information on what to put into the portfolio and how to format this.

The main success factor in the preceptorship programme has been the establishment of action learning sets for the group. The larger group has been broken down into four smaller groups for the purpose of action learning. The Practice Development Nurse (who has completed a Postgraduate Certificate in Lifelong Learning (Facilitators Course) facilitates the action learning sets.

To date, a number of success factors and positive outcomes from action learning have been noted. These are evidenced in the following quotes from those undertaking action learning:

- *"I feel that the action learning set enables nurses to realise that everyone has similar problems to deal with in nursing. Having the ability to present these issues and attempts to resolve them is quite satisfying".*

- *"I really enjoy the action learning sets and learn a lot from each session. I find the learning sets a great way of talking through personal problems and helping other peers through their problems. Really look forward to the learning sets".*

- *"It is nice to discuss problems with other colleagues from different departments and know it was all confidential. It also helps to hear how others would cope in the same situation".*

- *"Allows us as nurses to share common problems in confidence. It makes me feel that I am not going through certain issues alone".*

- *"I was a bit nervous about presenting but the feedback was helpful. I like the idea of learning from one another and hearing/understanding other nurses experiences".*

- *"It was good to hear others also had concerns – useful to share your worries and get feedback".*

- *"An excellent opportunity to discuss/liaise with other newly qualified staff members and to share each others views and experiences of the working environment. I feel it has provided me with additional support and guidance as a newly qualified nurse".*

The Practice Development Nurse as facilitator of the sets keeps records pertaining to the action learning sets. These records contain information on who presented at each session and what they presented. These are kept confidential, as is all that is discussed within the sets. There is an individual section within the newly qualified nurses Personal Development Portfolio for written reflection

prior to them presenting their own issue and for written reflection on the experience of being a set member listening to others present.

Ward Managers have also commented on the success of the programme and a process has been established to ensure that the initiative continues for all newly qualified staff to the hospital. A formal evaluation day will take place in January 2007 (at the end of the twelve month period of preceptorship). This will be attended by Senior Managers, Ward Managers, preceptors and preceptees and will be facilitated by the Practice Development Nurse. This will give everyone the opportunity to evaluate the success of the initiative and to make recommendations for changes to current process. At the end of the twelve month period of preceptorship, clinical supervision will be provided on a one to one basis, organised at ward level.

Ward based preceptors have expressed an interest in action learning for themselves both as preceptors and for their own work environment. This demonstrates the positive impact that participation by newly qualified nurses in action learning has had on the rest of the work team.

Action learning among a group of coronary care staff nurses in Sperrin and Lakeland Trust

Action learning was adopted in Sperrin & Lakeland Trust, as a method of enabling critical reflection among a group of staff nurses in their new roles as lead coronary care nurses. Adopting an action research methodology, the seven nurses and the senior nurse for professional development became co-learners and co-researchers in agreeing the following objectives:

- To identify nurses' perceptions of the impact of action learning on their learning and development
- To establish individuals level of critical reflection
- To identify the actions that emerged from participation in action learning
- To identify any perceived barriers to individual's ability to undertake action
- To identify the level of autonomy achieved/experienced by the group

The action research methodology provided a systematic and rigorous means of evaluation that complemented the cyclical process of action learning. Moreover, reflective cycles of critical questioning, discovery and action are central to both processes. Also the nurses were already familiar with the techniques and the fundamental principles of collaboration, negotiation and critical questioning that was created through the unique researcher-participant relationship.

The process we engaged in involved 8 reflective sessions lasting 3 hours each, with the critical dialogue focusing on the impact of the components of action learning on individual experience. A range of evaluation evidence was collected, for example, through Values and Beliefs clarification, use of visual arts, set evaluations, reflective diaries and peer observation notes. In addition, the lead facilitator used audio taped narratives and field notes from open ended interviews written verbatim with co-researchers. As a result of an in-depth evaluation of this experience, the following learning outcomes became evident.

There was evidence of:

- Increased openness & honesty among individuals with the set;
- Increased support for each other and for those whom we worked with;
- Increased confidence as action learners and practitioners;
- Increased collaboration within and outside of nursing responsibilities;
- Increased levels of reflection within the workplace and individually;
- Increased skills in problem solving among the set;
- Increased focus on patient-centered care;
- Increased responsibility and accountability for decisions and actions;
- Increased critical dialogue with other colleagues and disciplines;
- Increased focus on involving patients in decision making about their care.

Whilst all participants reported that their confidence had increased significantly, this was interdependent upon how supported they felt within the group. In turn, the level of support was dependent upon disclosure from others, which only increased when others openly declared their apprehension and vulnerability. Sustaining an environment of mutual respect and collaborative working created significant trust among participants that had not been experienced before the meetings.

'Reflection' was accredited as having the most powerful impact on the nurse's learning and development. However, there were significant differences between the levels of reflection that each experienced. At its simplest, reflection caused all to think and to seek understanding and meaning. Some valued the structure of using a reflective cycle for solving problems on their own including its application in various situations in their wider lives.

Overall the findings reveal that action learning had a significant and mainly positive impact upon the participants learning and development. Challenges to the success of action learning include facilitating time for the process, encouraging commitment, and the potential for anxiety that can arise from in-depth and challenging critical dialogue, a factor that can be a feature of the emotional impact of the issues being discussed, and thus requires skilled facilitation. However the majority welcomed this self-determining and empowering form of learning, which supports the usefulness of adopting action learning in future staff development programmes and organisational initiatives.