Practice enquiry into supervision in a variety of adult care settings where there are health and social care practitioners working together

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Executive summary

Introduction

This practice enquiry was commissioned by the Social Care Institute for Excellence (SCIE) to form part of the knowledge base for a practice guide for *Supervision in adult services* where both health and social care personnel work. The practice enquiry explores the delivery of supervision in a range of joint and integrated team settings within adult care, uncovering the types of supervision in use and their perceived outcomes for stakeholders.

The purpose of the practice enquiry was to seek examples of supervision which stakeholders viewed as 'good practice', and in doing so, the research sought to explore the factors that made supervision practice effective for workers, people who use services, and organisations.

The aims in SCIE's commissioning brief were twofold:

1. Capture what is being practised in a minimum of three settings where there are both health and social care practitioners working: a community mental health team; a team supporting older people and a residential or nursing establishment for older people. This will allow a certain amount of coverage and spread. Precise groupings can be decided before commencement.

2. Ask about areas of practice in supervision that seem to deliver positive outcomes.'

Practice enquiry methods

The project aims for the practice enquiry were:

- To develop an understanding of how supervision is delivered in a range of joint and integrated adult team settings

- To develop an understanding of how identified types of supervision practice affect stakeholders

- To develop an understanding of the perceptions of supervision and its impact for people who use services

- To identify areas of good practice and of innovation in joint and integrated health and social care supervision

- To identify the costs perceived to be associated with supervision in different models of practice

The research team used a range of methods to collect data for the project. An online survey gathered qualitative and quantitative responses and was accessed at 28 sites across England and Northern Ireland (total replies = 136). The target number of respondents was 100. Four sites were chosen as study sites where supervision was perceived to be strong and/or innovative in its approach and/or outcomes, and 19 in

depth qualitative interviews were carried out across these sites with staff (managers, professionals, support workers, and other staff from health, social work and social care). These sites were:

- a local authority led integrated health team working with adults with learning disability in the community,

- a large social enterprise providing services for adults with learning disability, mental health difficulties, and other disabilities or frailty, within community led services or residential settings,

- a care home providing respite, assessment, and residential services for older people with mental health difficulties and dementia funded through two local authorities and a primary care trust,

- a community mental health team, part of an integrated service led by the NHS.

The views of people who use services were gathered in meetings with two established forums from the mental health and learning disability communities. Finally a 'key informant' interview with a service commissioner provided an overview of how supervision was considered when services were commissioned.

Findings

- Supervision was used to support workers to perform in their roles, but also to address a range of organisational and worker needs. While all respondents accessed formal (planned in advance) and informal (ad-hoc) supervision, the format of this supervision varied e.g., 1–1 supervision, and group or peer supervision. However the most commonly accessed and preferred form of formal supervision was '1–1'.

- Workers identified that supervision needed to respectful and supportive of the work they were doing. Within the findings from both the online survey and the case study sites it was clear that where supervision was perceived positively, a stronger 'working alliance' had been formed between supervisor and supervisee. Good relationships between supervisor and supervisee in formal supervision came across as an important factor in improving the perceived outcomes for practitioners and people who use services

- The type of supervision made available to staff was reflective of the needs of the organisation and the work staff were engaged in. For some, this meant engaging in a number of supervision meetings and working with multiple supervisors responsible for different work areas.

- There was some evidence from the research that supervision could be a dynamic process, which required leadership as well as effective management. Leadership practices were most evident in responses by supervisors who understood the role supervision within the wider organisation and its goals, as

opposed to supervision being treated as a discrete activity between supervisors and workers.

- Supervision supported innovative practices and service developments where teams worked collectively to deliver contracted services that were focused on delivering specific outcomes

- Respondents within the online survey were clear that 'good supervision' supported individual workers, which in turn, supported people who use services. This finding was followed up in the face to face interviews with more concrete examples of improved outcomes for people who use services that had arisen out of formal and informal supervision. This included, for instance, getting improved help for a person to attend an educational course as a result of formal supervision, or moving a person to a more suitable room in residential care.

- People who use services wanted supervision to be a place where their concerns would be heard, and where they could feed back examples of good as well as bad practices or events with those who work with them. They suggested that their experiences were that supervision did not seem to lead to the changes they would have liked to see happen. However, in case study D, a regular group meeting between a person using services and staff was being used to bring general issues from supervision to the former. The input of people who use services into supervision was largely at the discretion of workers for most respondents

- People who use services were concerned about decisions being made about them within supervision without their input. For many people, the purpose of supervision was not clear, and this raised questions about what people who use services should expect from supervision.

Introduction

This practice enquiry forms part of a knowledge base for good practice guidance for health and social care practitioners in adult services. It explores the delivery of supervision in a range of joint and integrated team settings within adult care, uncovering models of practice in use and their perceived outcomes for stakeholders. SCIE has commissioned a literature review separately which looks at the existing knowledge base around effective supervision in health and social care.

The context

The adult care system is being transformed in response to the increasing demand for health and social care services, as well as public and political demands for improvements to the quality of care being provided. The introduction of Personalisation (DH, 2007) has created new opportunities for users of services to purchase their own care, using self-assessment processes and personal budgets, which are supported by new resource allocation systems and direct payments. These changes are being communicated to users and carers to enable people to understand what they can expect, but also to help those working in care to deliver services in new ways, and to understand the new roles and responsibilities of the different organisations (DH, 2012c).

It has been argued that supervision in health and social care organisation needs to be 'adaptable to adjust to a diverse range of practice contexts' (Davys and Beddoe, 2010:18), however, Hughes and Pengelly (1997:77) highlight that 'Little work has been done on the effectiveness of staff supervision, and little thought given to how its outcomes can be defined and measured.' Supervision is associated with a range of benefits including improved patient safety (NMC, 2009), improved accountability (Hawkins and Shohet, 2006) improved worker satisfaction and retention (Mor Barak et al, 2009). However supervision studies are largely focused on defining what supervision is (CWDC 2010, Tsui, 2005), what supervisors do, (Kadushin 1992), and the supervisory functions (Hawkins and Shohet, 1989). These studies are often focused on the experiences of professionally qualified staff, and typically do not explore the impact of supervision interventions (including the costs and benefits), therefore it is difficult to know if one particular type of supervision intervention is more effective than another. It is within this context that the practice enquiry into best practice in supervision has been undertaken.

This research aimed:

- To develop an understanding of how supervision is delivered in a range of joint and integrated adult team settings
- To develop an understanding of how identified models of supervision practice affect stakeholders
- To develop an understanding of the perceptions of supervision and its impact for people who use services
- To identify areas of good practice and of innovation in joint and integrated health and social care supervision

- To identify the costs perceived to be associated with supervision in different models of practice

Project team

The practice enquiry has been carried out by a team from the University of Sussex, Department of Social Work and Social Care. It has been jointly led by Ms Sharon Lambley and Dr Tish Marrable, assisted by Dr Hilary Lawson, with supervision and advice from Professor Imogen Taylor and Dr Elaine Sharland. The team brings together expertise in management and supervision, inter-professional practice, and practice enquiry methodology.

We would like to thank all those who took the time to take part in this work, including groups for people who use services, individuals around the UK who told us how important supervision was to them, and the individuals within organisations who coordinated participation in the online survey and site visits. The project's 'virtual stakeholder consultancy group' provided guidance for this work as did the SCIE project advisory group. We would also like to thank SCIE for providing us with the opportunity to carry out this important work.

Practice enquiry methods

Overview of the practice enquiry

The methodology for this practice enquiry needed to reflect the variety of services in adult care that were shaped by contractual and professional relationships, whilst still focusing on sites where examples of good practice in supervision could be explored in more depth. The focus on 'good practice' reflects a working assumption that *supervision is key to achieving desired outcomes for service users, carers, professionals and organisations.* The research was designed to explore the lived experiences of workers and managers in four settings, (illustrated in the vignettes), which included:

- an integrated service for Adults with Learning Disabilities (Case study A)
- an Enhanced Partnership delivering integrated services in a community mental health team (Case study B)
- a provider services delivering residential and home-based services to adults with learning, physical, and sensory disabilities. (Case study C)
- a provider service providing assessment, respite, and other services for older people (Case study D).

The methodology adopted provided a process to explore the types of supervision within these settings. The practice enquiry looked for opportunities for people who use services and carer participation where supervision practice was working well, but did not seek to evaluate the effectiveness of supervision on people who use services and carers as this was not possible in the time available. However the research team did talk to people who use services separately to gain their views on supervision and how this practice might impact on their care. In addition the research team explored the role of commissioning in relation to supervision and the quality of services for users and carers. In doing so, the enquiry has adopted a systems view of supervision to go beyond the tasks and functions of supervision (Munro 2010; Fish, Munro & Bairstow 2008).

Activities for the practice enquiry

The research was planned in three phases: set-up and initial data collection through an online survey, study site, commissioner and service user fieldwork, and finally, analysis and report write up.

Phase 1

Initial project set up included gaining ethical approval, ADASS (Association of Directors of Adult Social Services) approval regarding governance in local authority adult services, and setting up advisory groups for the work. The University of Sussex Social Science Cluster Research Ethics Committee at the start of September 2011 gave ethical approval. ADASS approval was granted until December 2011. While SCIE convened an advisory group for the project, the research team set up small a 'virtual stakeholder consultancy group' to provide guidance and help to pilot the project tools such as the online survey. This consisted of Rachel Busby, a social work practitioner

and AMHP, Lorraine Ellames, a social work professional and trainer with a focus on supervision, and Angela Lane and Helen Zeida of Zeida Lane Associates, a training group who focus on learning disability practitioners. Angela is also a carer for her adult daughter.

The online survey

While set up took place, the research team used a *purposeful sampling method* to identify sites to take part in an online survey gathering rich, qualitative data as well as descriptive quantitative data. Online surveys have the advantage of being able to gather data from a wide range of sources under a limited budget, while being able to provide a safe, confidential and private forum for participants to provide their views on topics of interest. The methodology called for between 18 and 20 sites to take part in the survey, which would reach approximately 100 practitioners on these sites. Information from the surveys could be collated by site though not by individual, permitting an initial analysis to take place, and sites for the case studies to be identified. Invitations to take part were issued through the SCIE newsletter and through the online Choice Forum[1] run through the Foundation for People with Learning Disabilities, as well as through the extensive professional contacts and established networks provided from within the research team and in consultation with SCIE. Interested parties were sent further information about the project via an information sheet (Appendix 1). This sheet also provided an introduction and information about anonymity to all the online survey participants. A total of 28 sites took part in the survey. Replies from these sites varied in number from 1 to 47, and the total number who took part in this way was 136 respondents, exceeding the expected numbers by over a third.

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[1] http://www.choiceforum.org/

Type of Team/Organisation	N replies
Social enterprise – home based care for dementia, older people and disability – small residential homes for people with learning disability, people with autism, challenging behaviour including long term mental health difficulties	47
Health and social care trust – community mental health focus	20
Health and social care trust - disability	17
Third Sector - Residential college for 18+ learning disability	9
NHS/LA integrated team - CMHT, substance misuse	7
Charity - Palliative Care Hospice	5
LA Adult Social Services	4
LA integrated team - mostly learning disability	4
NHS integrated team - Community Learning Disability	3
LA – Adult & Community Services	2
LA Care home dementia and mental health difficulties	1
Independent domiciliary care services	1
NHS - learning disability integrated community team	1
Independent – learning disability residential	1
Independent - Care home – adult learning disability, autism, mental health	1
Direct Support - home based team for young adult with disabilities	1
Additional Individual replies - Come from a range of sites, including residential homes, day care centres, community mental health teams and community provision. Professionals from health and social care. Independent providers, charity provision, NHS, LA	12

Figure i: Online survey respondents

The online survey was designed using Survey Monkey and tagged for site identification, but allowed otherwise anonymous replies from both supervisors and supervisees. The survey was designed to provide a scope of the resources, processes, and perceptions of practice of supervision within these sites, and allowed respondents to highlight any outcomes from supervision that would benefit services users. It included only one mandatory question (related to whether respondents were also a supervisor as well as supervisee), and combined multiple choice questions, Likert scales, and open-ended questions to provide a flexible environment so that participants could choose which questions to answer (Appendix 2).

The survey links were sent out after ADASS approval was received. On each team a key contact was provided. The teams who responded are shown in Figure i. with the number of responses per site. One link allowed a range of individuals from teams who did not wish to be considered for the second phase to take part, and 12 sites were accessed in this way. Providers were from the private and not-for-profit sector, as well

as from public sector services. Respondents provided a range of job-related data within the survey. They demonstrated that sometimes it was difficult in integrated or joint services to differentiate between health and social care or social work; 11 per cent of respondents (n=15) had selected more than one option here.
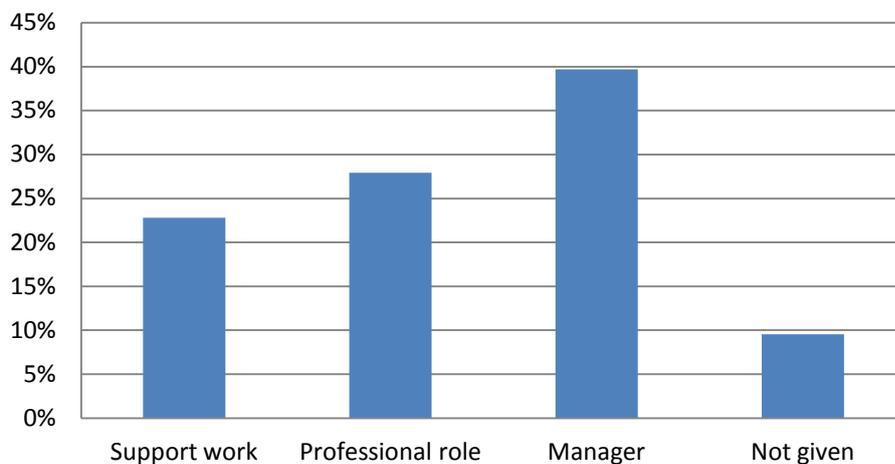
Areas of work
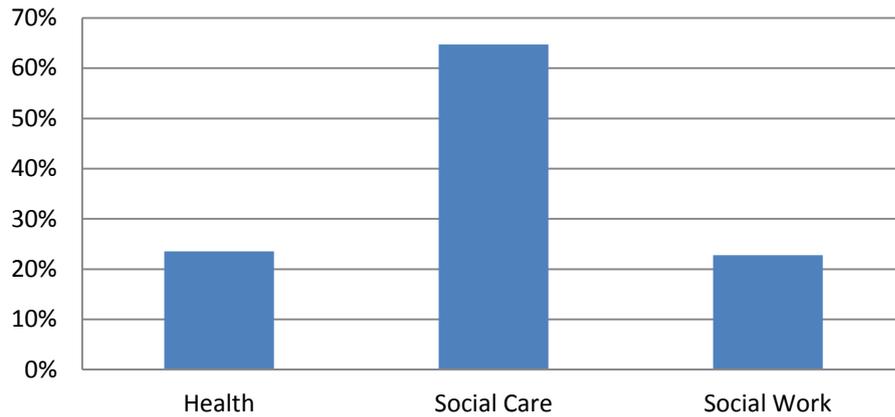
	Numbers of replies	
Health	32	24%
Social Care	88	65%
Social Work	31	23%

Figure ii: Areas of work from the online survey

Type of Role

Type of roles	Numbers of replies	
Support work	31	23%
Professional role	38	28%
Manager	54	40%
Not given	13	10%

Figure iii: Roles of survey respondents

The online survey asked respondents to identify their role. *Support workers* were grouped together on the basis that their role did not require that they were professionally qualified e.g., day care workers, support workers, administrative assistants, etc. *Professionally qualified* workers included social workers, occupational therapists, community nurse, psychologists, etc. *Managers* covered both professional services (e.g., social work managers, team leaders, community mental health service managers) as well as management roles that did not require professional qualifications (e.g., day services manager, registered manager, deputy manager). 51 per cent of respondents (n=69) were also providing supervision for others, although all of these also commented on supervision they were receiving themselves.

The online survey was used in part to differentiate sites where supervision practice was seen as particularly good in order to identify 4 sites for case study visits. However, before a decision was made as to which sites would be chosen, a further step was taken. All key contacts were asked for additional information regarding the involvement of people who use services in supervision. This step was taken after the first of the focus groups took place to explore some of the issues that had arisen there. Five contacts replied. Although only one of these was able to give a direct example of the way that the voice of people who use services was brought into supervision practice, all expressed interest in how this could be done, and about whether it was being done elsewhere.

Following the presentation of the interim report to SCIE and the advisory groups, it was determined in discussions with advisors that four sites would be approached out of those reporting good practice to take part in the face to face interviews within case studies. The four sites were selected to allow for the best spread across service provision focus, funding, enterprise size, and management arrangements. These study sites provided settings of residential care homes, a community mental health team, and two different examples of adult services provided in the community.

Phase 2

The second phase was planned to explore the perspectives of people who use services, the case study sites, and commissioner perspectives.

Perspectives of people who use services

The perspectives of people who use services on supervision were gathered through meetings that were set up with two existing forums; one provided by people with learning disabilities, and one from people who use mental health services. These were facilitated using a short range of questions provided in advance to the groups, and including visual cues for providing a focus of discussion (see Appendix 6). A written synopsis of the conversation was sent to the forums for verification before use in this report.

Case study sites

Face to face interviews were conducted on the four sites selected for in-depth case study, accessing where possible service providers from management to front line worker levels, and from the range of relevant professional backgrounds. A total of 19 face-to-face interviews took place across the sites, each lasting between 45 minutes and 1.5 hours. All participants were provided with a 'phase 2' information sheet (Appendix 3) and the schedule of questions for the interview (Appendix 5) in advance of the interview, and before being asked whether they gave consent to take part in the research (consent form at Appendix 4). Any questions about the research, confidentiality, or the outcomes of the interview were answered in advance of the interview.

The questions used on the interview schedule reflected a systems approach, asking about areas of the context, process, and outcomes from supervision (Appendix 5).

Commissioner interview

An interview took place with one commissioner, acting as a 'key informant' for the research to provide a context from outside of the services. This was to assess whether supervision was considered when commissioning services, and in assessing or monitoring the effectiveness of services.

Phase 3

The final phase focused on analysis and presentation. Draft findings were presented to SCIE's advisory group, for comment and development of the recommendations prior to drafting this final report for presentation to SCIE.

Services are provided from publically funded bodies such as local authorities and the NHS, from not-for-profit organisations, and from independent (private or for profit) groups. Participants included the range of key roles across health and social care organisations.

Findings

The findings address the questions embedded within the research aims:

- How is supervision perceived and delivered in adult settings, and what *effect* does supervision have on stakeholders
- What *impact* does supervision have on people who use services
- What are the areas of good practice and innovation in joint and integrated health and social care supervision
- What are the costs of delivering supervision from the different models of supervision that emerged from the research

The findings are presented following the format illustrated here:
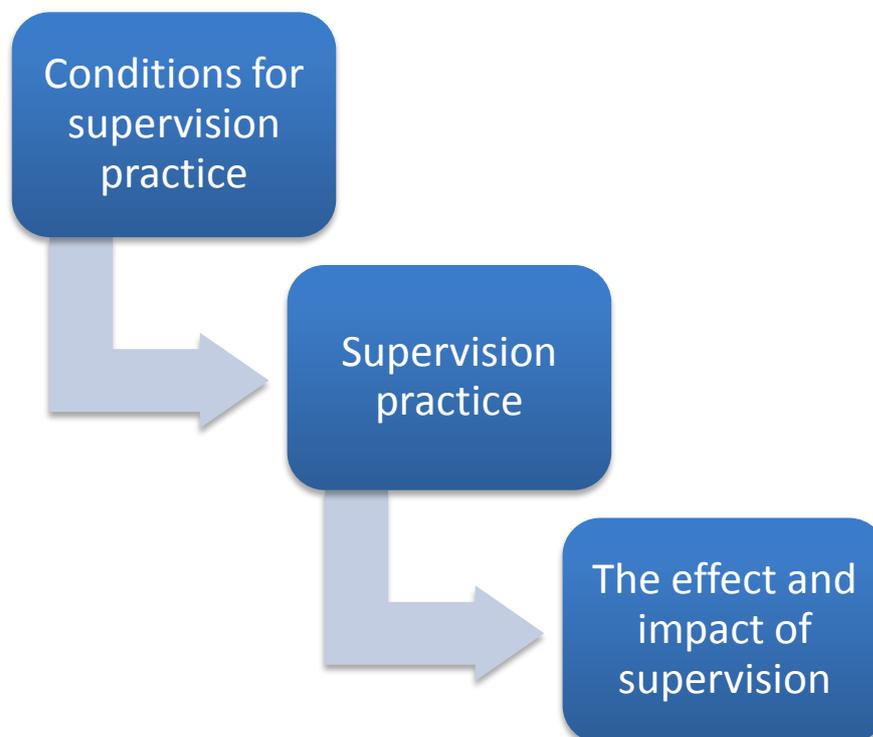
For the sake of this analysis, these areas will be unpicked separately. However they do not sit in isolation but are interconnected. As one respondent put it, supervision reflects:

> '[the] fact that (an) organisation has [an] embedded frame of mind in their structures, policies, procedures, etc. That it directly impacts on the people we support. Encouraging [us] to be reflective and to work on own good performance.' (house manager, social enterprise)

## The conditions for supervision practice

According to the online survey supervision policies and procedures were largely in place to guide supervision practice. This was a situation confirmed in the four site interviews.

One worker (Case study B) said that supervision policies and procedures dovetailed with human resource policies, and supervisors and managers were expected to be aware of these policies when they were supervising staff.

A small number of the online survey respondents however, said that they were not aware of the supervision policies in their organisation. Two respondents stated that the organisation did not have any policies, although other respondents from their organisations had all replied that they were aware of such policies. A total of 9 respondents either left this question blank or replied 'not sure'. The majority of those who were aware of these policies and procedures (91 per cent, n=112) were familiar or very familiar with them.

The supervision policies provided the framework for supervision. None of the paperwork provided to the research team required direct feedback from people who use services for use in supervision.

Figure iv: Options within online survey data

Online Survey data. Do respondents:
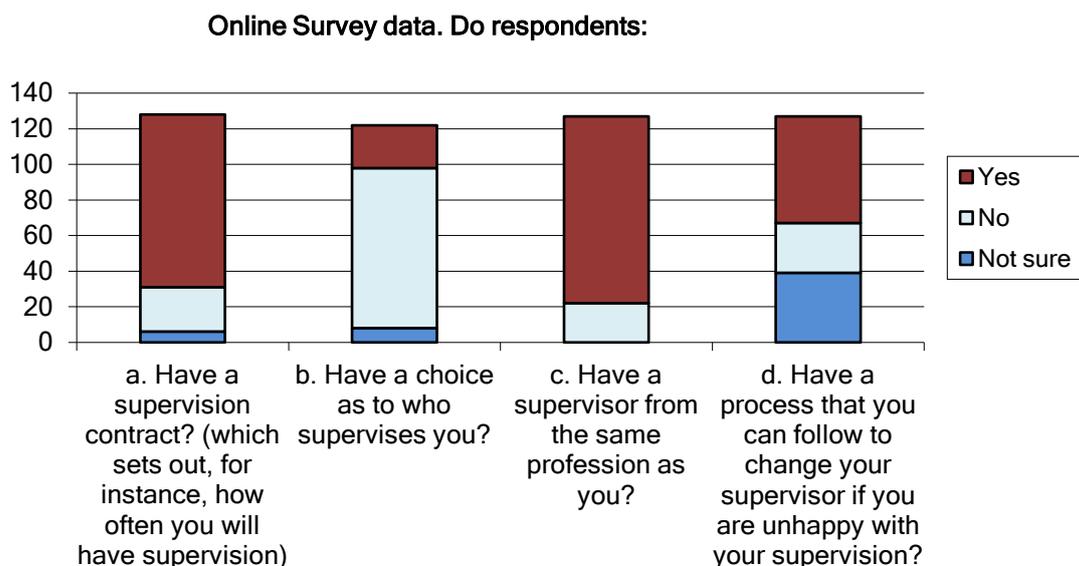
Online respondents and case studies sites reported that supervision contracts were commonly used. The online survey found that whilst most staff were unlikely to be able to choose their supervisor, some were be able to ask for a change of supervisor (Figure iv). Although respondents did not normally get to choose their supervisor, one organisation (case study C) used staff profiles to try and match people to a preferred supervisor, *and* it was also possible to request a change of supervisor.

The online survey also revealed that most workers were likely to be supervised by someone from their own professional background, but this wasn't always the case.

Having established that most employers and employees were aware of and had in place policies and procedures for supervision, the research team sought to understand the cultural practices within organisations in relation to supervision.

The research team wanted to understand how much time was being given to supervision sessions, and how frequently it was bring provided. According to respondents in the online survey, the most common reply to the amount of time given to each supervision session was one hour, although this varied from 30 minutes to three hours, along with the frequency. Whilst formal supervision took place in intervals from weekly (n=7) to six monthly (n=2), the majority of respondents (n=87) reported having supervision monthly. Most respondents from the 4 case study sites said that supervision lasted for about 1hr30 minutes, but it was commonly reported that supervision could be shorter or longer than this if it was required. Normal frequency across the four case study sites was monthly.

Asked whether they received the right amount of supervision, 91 per cent of online respondents replied 'yes' (n=108), 8 per cent (n=10) that they would like more, and 1 per cent (n=1) that they received too much. In the four case studies formal supervision was planned, and access to informal supervision was available if more time was needed.

In two case study organisations (C and D), supervisors reported that they were allocated time to deliver supervision and were then closely monitored to ensure that they were delivering it, as supervision was a management performance target that had to be delivered. In the remaining two organisations (A and B) there was a commitment to supervision (cultural expectations that supervision was taking place) but respondents reported that it could become less of a priority when workloads were high. The question as to whether supervision time was protected or not, was not easy to evaluate, according to respondents from online survey, although 71 per cent (n=47) said it was protected. This may reflect that it was not protected within some specific roles, with 18 per cent (n=12) replying that it was protected 'in some cases', while 11 per cent (n=7) said it was not given protected time.

Monitoring was seen by most respondents to the online survey as 'taking place' and important,

> 'it is logged on a very efficient NHS trust website which covers training , yearly appraisals and supervision. It is monitored with hawk- like eyes!' (Occupational therapist)

However, there was a small amount of uncertainty, with 13 per cent (n=8) of respondents being 'unsure' if monitoring really was taking place. It is possible that without a strong performance feedback loop in place, a small number of respondents may have been unsure if monitoring was taking place.

The research team was interested to find out how the organisation supported the delivery of good supervision practice in the workplace and asked respondents about the training they had had. Supervisors reported that they did have access to specialist training in supervision, where and supervision techniques was common, with 90 per cent having taken part and a small number (3 per cent, n=2) not sure. While most felt that their training was to a satisfactory level, 18 per cent (n=12) said they would like

more. The type of training varied and included training on poor performance; coaching, supervision skills, non-verbal behaviour and communication skills, case and clinical supervision and appraisal training as well as some knowledge acquired through national vocational occupational training and accredited management training. One senior support worker said 'I was on training here about supervision and how to give it, what kind of things you can discuss and how to approach staff'. Only one respondent said that they had had a two-day supervision-training course on psychodynamic counselling.

The research team was unable to assess whether the supervision training that individuals received reflected the needs of the organisation as well as the individual job roles that supervisors had. It was clear that most were satisfied with the training they had received but supervisors from the online survey said that they would like more training on:

- supervision and performance management (particularly in relation to under-performing staff)
- conflict management and supervision
- annual updates on service modernisation to help inform supervision
- theory and practice in using models of clinical supervision in supervision
- coach training, group work, action learning.

This suggests that staff wanted very focused forms of training. In recognition of the very specialist nature of the supervision task, one respondent said that they would like a Diploma in Supervision and/or Diploma in Coaching.

In carrying out the supervisor role, respondents from the online survey and the case studies identified the need for supervisory behaviour, which demonstrated 'leadership'. In the case of supervising professionals good leaders needed to keep up to date with theory and methods of practice to be able to engage with and support professional practice, which meant that supervisors and supervisees were continually engaged in learning. This was a challenge according to one respondent who said that it wasn't always easy to get access to good training (case study B).

The leadership approach used by the supervisor was also important. One case study respondent described good leaders as firm but fair. 'A good boss can say no, but tells you why and is fair. She never asked me to do anything she wasn't prepared to do and that meant that people will do anything for her because they know she is the same' (Community nurse). Good supervisors needed were said to challenge as well as support staff in supervision (Community nurse).

In addition to these conditions for supervision practice the research team was keen to understand what types of supervision was being delivered within health and social care organisations and began by asking respondents in the online survey to describe their organisation.

A significant proportion of the respondents (41 per cent, n=55) said that they were employed within an integrated setting, or in a partnership, whilst others said that they worked in 'single' services, which they described as 'other' i.e., residential, educational, housing, charity, voluntary or care home provider.

Figure v: Description of working relationship between health and social work/care

How would you describe your organisation?
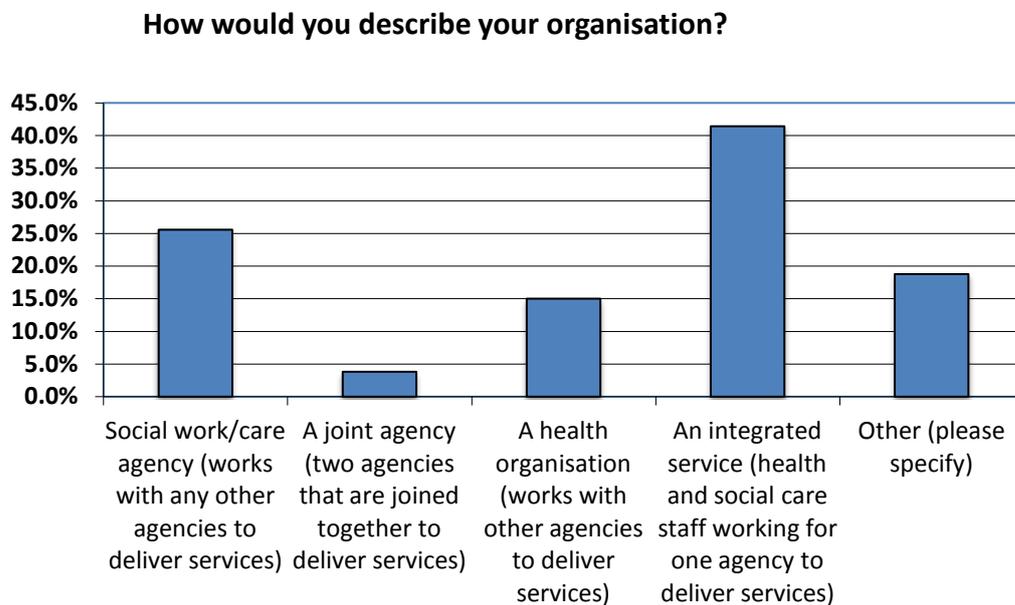
In the interviews in the case study sites respondents described their organisations as *an integrated service*, an *enhanced partnership (which delivered integrated services)*, and two *provider services that delivered contracted services for health and social care commissioners*. The types of supervision were identified and explored in each of these settings which are now considered. .

Case study A: Integrated services

Professionally qualified staff and their assistants who were non-professionally qualified staff, were employed within an integrated service for Adults with Learning Disabilities. The interviews were conducted with two community nurses and one health facilitator. All three staff worked with other professionals e.g., psychologists, speech and language therapists, general practitioners etc. The supervisor was a nurse manager.

When asked what kind of supervision workers accessed, staff identified a formal and informal supervision that was delivered in a range of ways;

The main type of supervision was '**1-1 management**' *with* **clinical supervision**. Historically management and clinical supervision were delivered separately but this required considerable staff time. As workers still needed 1–1 management supervision for decision-making, the two forms of supervision were integrated into a 1-1 supervision, which combined both agendas (management and clinical). One community nurse said that she accessed ad-hoc clinical supervision in addition to 1–1 supervision if she needed it.

Case study A: Types of supervision
1−1 **Management** with **Clinical** supervision
Peer supervision (informal)
Ad-hoc informal supervision
Direction and support on a daily basis

Clinical supervision was described by one community nurse 'as discussions that are focused on clients and work with clients', whilst management supervision was described as 'anything to do with HR, training, problems and management feedback'. Clinical supervision was associated with clinical practice but respondents also linked it to personal and professional support. Whilst respondents talked about management and clinical aspects of supervision as separate, in practice their accounts of supervision brought together management and clinical considerations. 'So we go through discussing and talking through things and the supervisor usually prompts you with questions, or sometimes if you say certain things then maybe you're prompted to say a particular deadlines, so it focuses you a bit' (health facilitator).

Informal support was also available. A nurse meeting for example, was held every two weeks where staff got together to discuss changes and updates, and some of this was 'like peer supervision' (getting advice and input into work challenges).

Informal supervision also included **ad-hoc case discussions**, which took place with colleagues in the office, or with other professionals in a variety of ways and settings (in group settings, on the phone, email or face to face). This support was embedded into everyday practice as illustrated by one worker who said:

> *'I have a lot of professionals that I can access to help with my concerns with patients, e.g., psychologists, OT and speech therapists, doctor, whatever.' (Community nurse)*

Community nurses were responsible for supervising non-professionally qualified health facilitators. The health facilitator described 'direction and support' on a daily basis as supervision, along with 1−1 management supervision from the nurse manager.

The different forms of supervision within this organisation supported the worker and organisational needs. Feedback from people who use services into supervision was indirect (via case discussion).

Case Study B: Integrated service (enhanced partnership)

This enhanced partnership aimed to deliver 'integrated' community mental health services. The Local Authority employed some staff, whilst the NHS employed others, although the NHS had the overall responsibility for governance. All respondents in this case study site were professionally qualified and had access to a range of supervisors.

The respondents identified 3 types of formal and informal supervision:

Case study B: Types of supervision
Management supervision
Professional supervision
Clinical supervision
Informal ad-hoc supervision
Informal team supervision
Informal networking

Three types of formal supervision was available; *management*, *professional* and *clinical* supervision, although the staff who were interviewed normally accessed management and professional supervision to reflect the professional, rather than clinical focus of their role.

Management supervision was described as *task orientated* to deliver specific organisational outcomes whilst professional supervision was focused on the work being carried out with people who use services and was described as 'structured with clear protocols and competencies that have to be met' (senior approved mental health worker). Clinical supervision was offered by psychologists to enable workers to talk about the effect disordered personalities can have on both workers and the patterns of behaviour workers can be drawn into. This forum was considered important because of the specific risks of working with the group of people who use services.

Workers accessed supervision that they needed to support their role. One worker reflected that supervision would probably be best if it was a 'one stop shop' but this wasn't possible, so professionals had to 'think about how they could use what was available to them to meet their needs'.

In addition to formal supervision, three forms of informal supervision were identified. *Ad-hoc supervision*, which was accessed for short pieces of work and the outcomes, was then brought to the appropriate formal supervision and discussed. This was needed because 'sometimes you can't wait for supervision'. In addition informal supervision was accessed from colleagues, safeguarding leads, and people from other agencies.

One respondent said that informal supervision was also available in the team meeting where time was used to discuss individual cases, case law and why individual practitioners were acting as they were. They described this form of supervision as *informal team supervision*

> *'I love being in there because its so supportive and we do have such good discussions… (Approved mental health professional)*

Informal networking was also used to 'bounce ideas of colleagues and check out what you are doing, as well as talk things through and support each other'. It was suggested that these networking relationships de-stress staff and enables professionals to challenge each other, *'so it's very important and massively underrated'*

Case study C: Social enterprise – contracted services

Model C was a complex not-for-profit multi-site service, for adults with mental health, physical and sensory disability and/or learning disabilities, as well as residential care for older people. All staff were supervised i.e., administration and support workers, senior support workers, team leaders and operational managers. The service did not employ professionally qualified staff, but workers accessed professional 'expertise' from the community e.g., occupational therapists, psychiatric teams, or behavioural specialists, through partnership agreements.

Types of supervision in this context
1-1 **Management**
Informal supervision
Team meetings
Group supervision

1–1 management supervision was *the* main type of supervision that was used in this organisation. Supervisors used a proforma which included; a supervisor's update, a review of the last supervision, current workload, staff and team issues, budgets, general office issues, learning and development activities and personal issues (annual leave, flexi-time, sickness etc). Despite the obvious focus on the management agenda, the supervisors used the proforma flexibly and did allow time to focus on people who use services. One senior support worker said that it was in supervision that they were able to talk about concerns that they had about a person using services with poor communication skills who had become visibly unhappy. Through supervision they were able to identify the issues, and began to implement a plan to address these issues. The involvement of people who use services in defining the issues was limited and therefore the key worker role was important in advocating on behalf of the person using services.

Staff could also access **informal supervision,** which was useful 'if you can't wait for your next formal supervision'. It was suggested that;

> *'formal supervision is once a month where I raise concerns or issues (or ideas) and we discuss and document them. Informal supervision compliments formal supervision, as you don't have to wait. It stops you from running wild with an idea and causing chaos'. (Support worker)*

Informal supervision allowed for decisions to be taken outside formal supervision, as these meetings were supervised by a manager, and these decisions were then shared in **team meetings** (to communicate to the team that work with individuals had been changed). The emphasis upon the delivery of a service from a collective group of workers was a condition for supervision practice in this setting that was different to case study A and B. The recording from informal supervision therefore had to be completed in a variety of places e.g., memos, key worker and best interest meetings as well as the

communication book (used for staff handover notes for oncoming shift workers) to ensure that the agreed decision was known and enacted by all the workers. All discussions (and decisions) were then formally brought into supervision and captured in the recordings as these notes were used in discussions with care managers who were responsible for placing the person in the service.

Senior workers also accessed **group supervision** (called a seniors' meeting). This meeting involved all the service managers but could also involve other people such as GPs or nurses if their input was needed, and case discussions and decision making relating to people who use services could be taken at this meeting. Any outcomes would then be fed into the communication mechanisms already outlined, and formal supervision.

Case Study D: Care home provider

A local authority specialist residential care home providing assessment and respite services employed mostly non-professionally qualified staff, but a mental health nurse was also attached to the team, and received clinical supervision from a community psychiatric nurse. Interviews were held with non-professionally qualified staff. These staff included care workers, care officers, a supervisor, and a registered manager.

Types of supervision in this context
1-1 **Management**
Informal supervision
Team meetings
Open door
Group meetings
Clinical supervision – for the attached worker

1–1 **management** supervision involved using a proforma, which was specific to the worker role, and unless the worker was carrying out management responsibilities the focus of supervision was on the person using the services and the worker. Supervision was a negotiated process (supported by a supervision agreement), which included the amount of informal supervision that the worker could have access to. **Informal supervision** was a 'short version' of formal supervision and could be requested at any time.

Team meetings were used by key workers (staff responsible for a named person) to access supervision support. In addition the manager had an **open door policy** so that any issue could be discussed at any time (ad-hoc supervision). This was perceived as important because issues couldn't always wait for supervision or be agreed in a group setting.

The care workers held **weekly group meetings** with people who use services, to discuss any changes to the service, and to be updated by them on any issues they might have. In this way discussions from supervision could be brought to group

meetings with staff and people who use services for consultation, and this often led to service innovation.

As in the previous three case studies, respondents said that confidentiality and proper recording was paramount

Online survey results

In all four case studies and in the online survey, a 1-1 supervision model was the most commonly used form of 'supervision', but the type of supervision that respondents experienced (management, professional, clinical) varied . Most respondents in the online survey reported that they received 1–1 supervision (96 per cent, n=122) and of those who expressed a preference (n=63), most liked 1–1 supervision (n=58). A typical comment was 'one to one. Confidential, able to speak openly, feel it is my "protected" time'.

Figure vi: Formats of supervision for online survey respondents

What are the formats of the supervision(s) you currently receive?
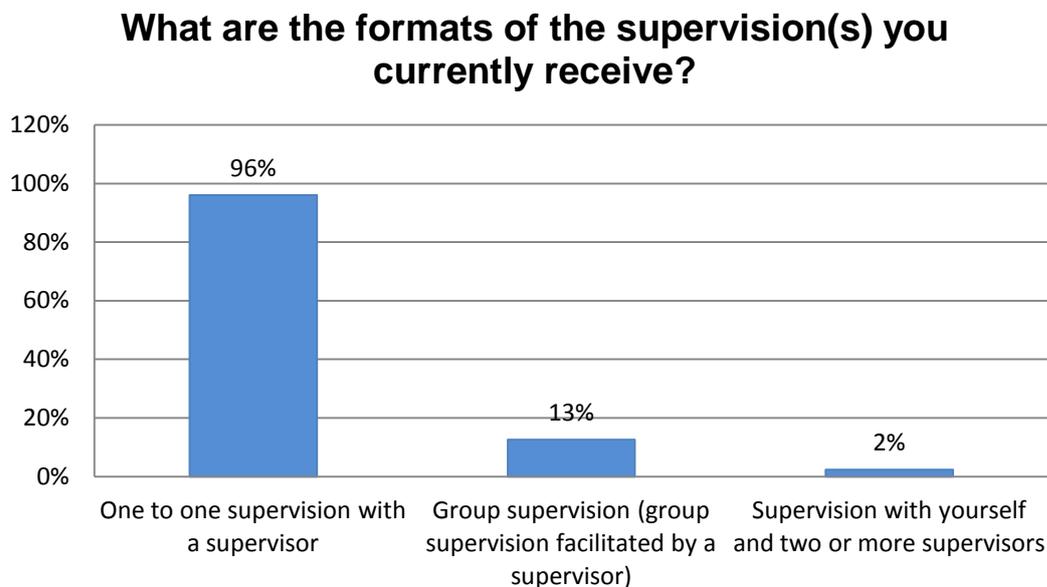
One online survey respondent made this comment about the variety of supervision;

> 'I think they are all important, so have no preference, although I do not think group supervision or social work forums should take precedence as I believe strongly that individual supervision is crucial and it should be held every 4 weeks irrespective of other forms of supervision.'(Senior support worker)

The online survey showed that clinical supervision featured least often although nearly half of those who replied to these questions (48 per cent, n=59) were aware that they received it. Clinical supervision is largely provided by the health services, and this was the smaller proportion in the survey (24 per cent) compared to social care. It could be that clinical supervision was being accessed 'outside formal one-to one supervision'.

Aspect of supervision provided	%	n
Supervision for performance	83%	103
Supervision for personal and professional support	87%	108
Supervision for development	80%	99
Supervision for clinical practice	48%	59
Number of respondents who replied		124

The online survey asked respondents to say if the different aspects of supervision were received at one time (simultaneously) or delivered separately. 91 per cent (n=71) of respondents said that the supervision sessions were simultaneous, and when asked who provided these sessions, 80 per cent (n=62) of respondents said 'their line manager', rather than a clinical supervisor (6.5 per cent n=5). This may be the result of time pressures, but could also reflect the availability and easy access to other forms of supervision to compliment 1–1 supervision.

Within the survey 77 per cent (n=105) of those who were professionally qualified said that they had a supervisor from the same profession. The benefit of this was expressed as a deeper understanding of the role, for instance one survey respondent said:

> *'My supervisor has previously done the job I am doing and knows many of the service users and this is a great help as I feel she understands what I am dealing with. She also has specialist training in working with D/deaf people and this is very important.'*

In the cases studies the value placed on having a supervisor who understood the workers role was evident across all four sites. In addition, some respondents viewed progression into supervision roles as a positive development, which they attributed to the support they had received.

In total 9 respondents (7 per cent) from the on line survey left no response to being supervised by someone from their own profession, and the 16 per cent who did not receive same-profession supervision (n=22) gave more mixed responses. Availability and access to same professional supervision may be less of an issue where other support was in place e.g., several respondents reported using professional forums to provide this element in their support, particularly in social work.

What happens in supervision?

It was clear from some of the respondents that the structures and conditions for supervision practice were important for preparing the ground for good supervision to take place. As part of this, having a structured plan for the session (with some flexibility built in) was seen as a help:

> *'I am happy with the way supervision is conducted at my current workplace. There is a structure in place for specific items to be covered as well as case discussions and there is also flexibility to include additional areas of discussion which the supervisor or supervisee feels that they would like to cover.' (Social worker)*

In terms of what happened in supervision, all respondents described following a format, outlined in a supervision proforma. The supervisors used this format to guide the supervision meeting but most adapted the delivery of the questions, and the order in which these questions were asked, to the individual worker. Supervisors and supervisees talked about the structured nature of supervision. One worker said:

> *'We meet in a quiet room and the session is confidential. It starts with a cup of tea. I have all my files, my diary and notes so that I am prepared and we work through the list. I do like structure' (Care worker)*

One-one supervision was a formal process, as illustrated in this example from a worker.

> *'A good supervision session has a clear agenda and is time limited so that I know what issues are to be raised and how much time I have to cover that issue. It helps me to bring my agenda and any evidence and is a clear plan of what's going to happen. It provides me with space to debrief and to identify my needs and any training. So a structured session, with clear parameters, and clear outcomes. I don't value having a chat' (Senior Approved Mental Health worker)*

For one registered manager the focus on the management task in supervision was important

> *'So part of the manager's job is to check that stuff is being done. So our files are up to date and they've got the right amount of bits of paper in them.' (Registered manager)*

In case study C, respondents told interviewers that they adapted the script to suit the needs of the supervision session, and would spend more time on one item than perhaps another to fit the workers and their own needs. However, they had to use the proforma as supervision records were monitored against the list outlined on the proforma. Supervisors were interested in the progress of people who use services against the delivery of care plans, which were reviewed at agreed intervals, and supervision provided the means for collecting evidence of progress. Supervisors were also required to undertake a quarterly review of behaviours, objectives, key accountabilities and responsibilities, and personal development planning for each supervisee in case study C. All of this information was recorded on a form, which was signed by the employee and supervisor.

The online survey covered some of the areas workers and supervisors discussed in supervision:

Figure vii: Tasks during supervision

What do you and your supervisor do during your formal supervision sessions?

number of replies - grouped
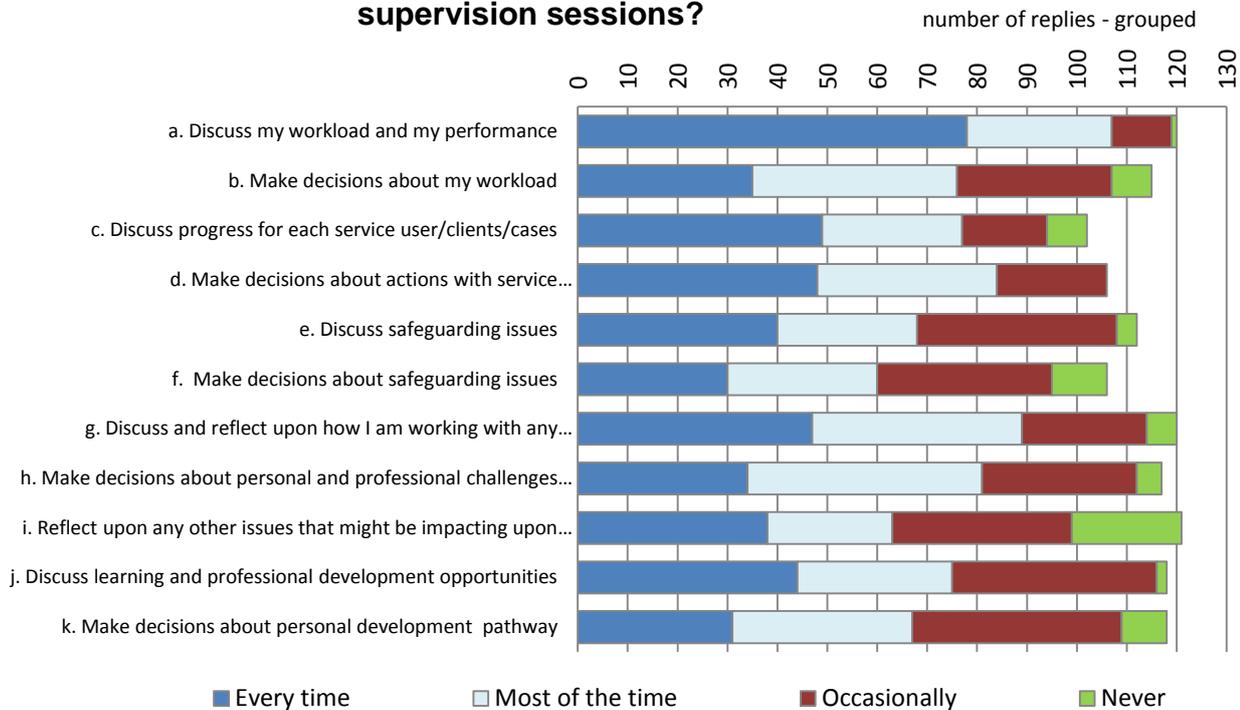
Supervision involves planning, evaluating progress and achievements, reflecting on issues and challenges, making decisions and identifying development opportunities. When asked how helpful these supervision activities were for staff, most respondents replied that they were either very helpful or quite helpful.

Performance issues are raised and often dealt with in supervision. For example, one supervisor told the interviewer about a staff member who was not working satisfactorily, and was challenged in supervision. The staff member was given a plan to improve, which was monitored. All of this was recorded and the supervisor was able to address this issue quickly. The supervisor said that if the unacceptable behaviour didn't improve they would start monitoring the performance closely – setting goals etc, and would invoke capability procedures if necessary. Because these conversations can take place in supervision it is possible to systematically collect evidence on performance. It was recognised that the context for good supervision was openness and honesty and this could be challenging given the link to capability procedures. Supervision records was also used to provide information for re-registration purposes, and they were also used in key worker meetings where workers record progress of the people in their care, against care plans (monthly, six monthly and then annually) was reviewed. One respondent said that they '*get the year's worth together, get the care manager in, sit and discuss what's happened over the year*' (Care worker)

The link between supervision and internal and external accountability systems was important for workers, particularly in complex working environments. For some supervisors, time was allocated to them (1hr 30 minutes per worker) to undertake supervision work, but not all supervisors' felt that they were given adequate time to supervise staff.

For staff, what made supervision work for them, was how supervisors engaged with them in the time that they had. One worker said that supervision was not just a job and that supervisors needed to use the same skills that workers used with people who use services to make staff feel comfortable, respected and supportive of what the staff member was working on.

It was suggested that sometimes managers focused on lists and issues that were important to them, whereas good supervisors were described by supervisees as using supervision as 'your time' and would only add their issues at the end if there was time. Good supervisors, it was suggested help people to work better and they support people to be committed and take ownership of what is being discussed, they support workers who have ideas, which they bring in to supervision, and advocate and support staff in what they do.

 Across a range of organisations represented in this study, the importance of supervisors behaving 'as leaders' who would act on information they were given was evident. Whilst 50 per cent (n=39) of supervisees said that when they raised concerns in supervision these concerns were always addressed, 41% (n=32) said they were mostly addressed, whilst 9 per cent (n=7) said that concerns were sometimes never addressed. In the case studies supervisors were identified that would support and empower workers to address and break down barriers, as well as take concerns outside of supervision and have these concerns addressed.

Within the online survey, a modified[2] version of the 'Supervisory Working Alliance Inventory' (SWAI: Efstation et al 1990) was used to test the relationship between the supervisor and supervisee in the survey, from the supervisee's perspective. It focuses on 'rapport' and a 'service user focus score'. Respondents score questions from 7 – almost always, to 1 – almost never. Although there were a few low scores in each of these categories, the median score for 'rapport' was 6.25, with 92 per cent of replies being 3.5 or over, and for 'service user focus' the median was 5.86, with 87 per cent scoring 3.5 or over. This demonstrates the high level of strong working relationships within the respondent group.

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[2] This was modified only in relation to some wording to reflect the health/social care audience and the adult services setting. The SWAI was devised for trainee counsellors in supervision.

Figure viii: Supervisory Working Alliance Inventory: online survey results

Supervisory Working Alliance Inventory
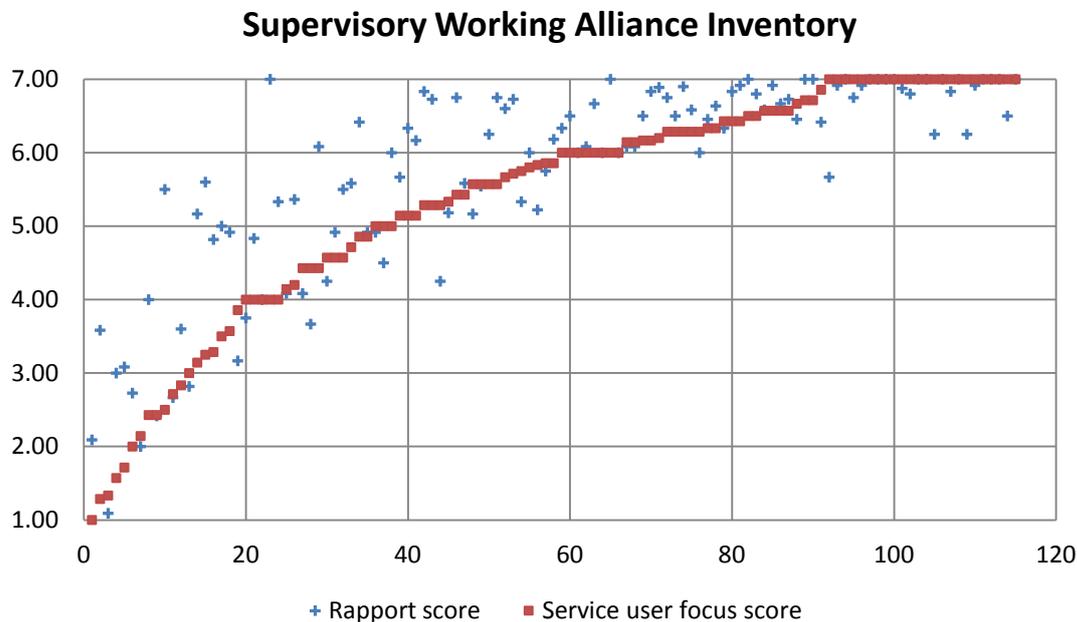
Not only was a shared understanding of the purpose of supervision important, the processes that underpinned the 'work' in supervision needed to be fully understood. For non-qualified professionals, good supervision provided some relief as 'it's just discussing and offloading oneself in any worries I might have – You can ask for advice and I have learnt a lot' (case study C). For professionally qualified staff on the other hand, the feelings that emerged from working with people who use services was 'material' that underpinned the work with clients/people who use services. This work required workers to use the self and this acknowledgement was an important feature of the supervision discussions, rather than merely a matter of unloading feelings. Clinical supervision also addressed the feelings that emerged from working with people who use services and helped staff to untangle any of their own issues, from recipient of care.

Accessing training and development was considered important for all workers to support good practice. The link between supervision, training and the development of workers was evident from the interviews. In one organisation for example, every member of staff had a personal development plan, which was routinely reviewed in supervision, where learning and development opportunities were identified. Group or clinical supervision also provide opportunities to access expertise and development opportunities. Sometimes the support that staff needed was personal, and might include counselling services or other forms of support, which could be made available through supervision.

Formal supervision is a process therefore that most respondents said followed a 'script' but what happened in supervision was largely determined by the role and expectations of supervisors and workers, the availability of additional support, and the relationship approach adopted by the supervisor and supervisee.

The effect of supervision on staff

The types of supervision received, its appropriateness to meet the needs of the worker/the organisation, the way in which supervision is delivered and its impact isn't easy to link as a direct 'cause and effect' relationship. One manager from a private social care agency, when asked what they thought was the outcome from supervision on staff and people who use services said that supervision:

1. Makes care workers aware of their performance, good or bad.
2. Makes care workers want to attend more training to enhance their skills and knowledge for their job roles.
3. People who use services will receive care from competent and skilled staff.
4. Quality care will be given all round to all people who use services.
5. There will be a reduction in complaints from people who use services.
6. Care workers are more motivated and there is good staff turnover.'

However, this amounts to what the manager believes to be 'cause and effect links', but it was not possible to test this assertion in this research. When the researchers asked respondents to give examples of supervision sessions that had a positive impact on them, the people who use services and/or the service, some struggled to think of ones that they could easily evidence.

One supervisor of professional staff said:

> *'It's really hard for me to say actually a particular session where I think actually I've really seen a positive outcome for me, because it's more about… I don't know, having back up for some of the decisions I make really.'*

One approved mental health worker however said that supervision had had quite an effect on her:

> *'I have gained confidence in my working with challenging clients, including being able to set my own boundaries around what is safe. I have also begun to think about preparing work for publication. I have also used the session time to debrief and so feel contained with un-contained and emotionally needy clients.'*

Most respondents, when pressed, were able to provide some examples of the effects supervision had on them, and what they believed to be positive impacts for people who use services, but they found it difficult to uncouple the worker and the person using the service. One worker said that:

'After supervision I tend to deal with the service user with more confidence feeling like I've got an action plan in place to help them and get them the services they need. Supervision certainly has a positive effect on how I deal with people and what kind of services they receive.' (Assistant manager, older people's service, local authority)

There were of course, many positive effects identified by workers, supervisors and managers. 52 respondents on the online survey generated a long list of words that they used to describe how supervision made them feel; some of which are included here:

'Keen, happy, secure., settled, confident, safe, supported, motivated, relaxed, positive, professional , reflective, very appreciative, looking forward, focused, hopeful, clear, valued, reassured, stimulated, beneficial, understood.'

Supervision could however also leave workers feeling less supported, and some online respondents described their feelings as 'Frustrated, anxious, boring, stagnant, useless, apprehensive, indifferent, pressurized, criticised, angry, disappointed, de- motivated, insulted'

Understanding how people felt about supervision was important because good supervision was associated with generating positive feelings for individuals. This is particularly true when the work is very challenging. One respondent working in mental health services said, 'Supervision helps me to deal with difficult situations and with more confidence and helps me to bring new solutions to the problems that I experience'.

Some of the more positive feedback from respondents suggested that a dynamic process was taking place in supervision. For example, supervision made one non-qualified supervisor feel good because they received positive feedback on their work:

'…I get feedback to say that staff have noticed good things about the way I'm working and it's like, it's nice to know because you feel that sometimes you're not doing a very good job (Laughter). So that's quite nice.'

The link between supervision and positive action is something that was identified at the individual and at the system level:

At an individual level:

'I feel listened to, I actually really do and I feel he actually trusts my opinions and things like that you know….. he actually listens to them and some things get looked at and go ahead and it feels like it's not a problem, you know, it's so much better. It makes you feel different about yourself, in work and outside' (Administrator)

At a system level:

One manager (Case study D) described how people using the service needed support to be prevented from losing valuable housekeeping skills whilst being assessed for services or in respite. The manager decided to involve the housekeeping team in working with residents as part of a 're-enablement programme' to encourage people who use services to maintain their housekeeping skills. This development generated a

lot of work for the manager who had to plan how to make this happen, and he did this in his supervision meetings, He also had to support the housekeeping staff whom he supervised, to work in different ways. Supervision was seen as the key to supporting this service innovation and change.

One senior worker said that good supervision supports workers at a strategic level:

> *'I don't work directly with service users but supervision is part of a whole system. I meet with my manager and other professionals e.g., safeguarding leads and we discuss what we are trying to do and how we will work together and I get involved in strategy work too. Supervision supports me to go off and do this work.'*

One respondent said that supervision could:

> *'keep me motivated, keep me focused, explore alternative ways of understanding behaviours, explore different ways of working with service users, prevent burn out.'*

Good supervision was linked to staff retention and career progression, with respondents across the case study sites citing access to development opportunities that improved their work practices and in some cases led to career advancement.

Whilst most respondents said that they valued supervision, some staff in the survey and in the site visits said that they did not like supervision and had to be encouraged to attend. In these cases respondents suggested that supervisors did not listen, the worker didn't feel contained or supported, and the supervisor was described as uninterested. However supervision was valued where the supervisor was honest, challenging, supportive, informed and helpful.

The impact on people who use services

Within the online survey data participants replied to a question about the impact of the supervision received on the outcomes of people who use services. For the majority of those who replied to this (92 per cent, n=79), this related directly to improvements in their own performance. This also related to safeguarding practices. As one respondent wrote, a supervisor who models good practice and strength provides an environment where supervisees feel confident about reporting concerns:

It is important to invest time and care into the staff so that we all feel valued, and that what we do has worth and meaning. This caring attitude should then cascade down to the service users. The supervisor and management team should be modelling best practice. This enables them to take a strong position, so that staff are open and honest, and do not fear reporting any issues of concern. Staff should have confidence in management to act on these issues and also feel supported. It is about respect and confidentiality.

Reducing burn out was also mentioned by some respondents, linking their own wellbeing with the wellbeing of those they work with.

To follow this up and see if there were more concrete examples of the outcomes of people who use services linked to supervision, the research team asked staff within the

study sites to identify direct impacts they thought supervision had on people who use services.

Researchers then asked people who use services in two focus groups what impact supervision had on them. It is important to bear in mind that the service providers who took part and the focus groups for people who use services were not connected through a working relationship. The focus groups are reported in section 3.6.

Staff gave the following examples:

A supervisor and member of staff discussed the possibility of changing a resident's room when a room was being redecorated. The worker consulted other staff including the key worker who talked to the people who use services, who was happy to move to the bigger room. The member of staff said that '*all conversations we have, whether they're in supervision direct or not, we have an outcome for people.' (Care worker)*

An administrator noticed that a lady used to ring the office regularly and would cry, so the administrator brought this up in an ad-hoc supervision and asked for something to be done. The administrator felt that supervision had benefitted the lady as her behaviour had been brought to the attention of the staff team who could act on this information.

Having experienced frequent migraine attacks, a professionally qualified staff member learnt through feedback from a person using services that they wanted continuity of service, and therefore she might need to see the people using services less often, but should commit to attend arranged appointments. Supervision helped the staff member to slow down and manage her health problems so that she could be reliable and available to the people using services when they needed her

In one home, the staff used regular residents' meetings to seek residents' views of what they needed/wanted. In response to such discussions, staff implemented changes and this often produced service innovation.

A key worker wanted to support a person to access a new gardening opportunity called 'Time out'. The key worker brought this to supervision and came up with a plan with their supervisors. As a result of implementing the plan with the person, they were accepted onto the gardening course

One of the people who use services went to a chiropodist but became stressed at going to visit them in their workplace, and needed further treatments to sort out the skin around their toenails. The worker discussed this situation in supervision and then talked with the person who readily agreed to having a chiropodist coming to their home instead, as it would be less stressful for them.

One supervisor was able to challenge and support a supervisee, which enabled the worker to get a service that her client was struggling to access. This was done by helping the worker to work through the barriers and providing the support needed to move the case forward.

One community nurse said that she used supervision to bring up a concern that she had about a person, which was taken up to be discussed by the senior management team as there were funding issues and something needed to happen at a more senior level.

One professional worker said

> *'But the whole thing interweaves the whole time, so from the supervisions I'm discussing my needs; I'm also discussing the needs of the service user and what I need to support him and how you can support me and how I can support you and the whole thing works that way.' (Senior support worker)*

Experiences of people who use services

In order to obtain the views of people who use services about supervision, while maintaining confidentiality and anonymity for the service provider respondents, the research team spoke with two separate focus groups for people who use services who were unconnected to the case study sites.

A focus group was held with five adults with learning disabilities, supported by a group facilitator. The group accessed people who use services and carers to get feedback about the services they received, and the changes they wanted to services. They helped a local strategic partnership board to develop and deliver policies, as well as develop guidance and training to support service changes. Members of the group had direct experience of social workers, general practitioners, nurses, psychiatrists, as well as support workers, care workers, key workers, senior care workers, deputy and care managers.

The group had been involved in developing guidance for service providers on how to involve people who use services in staff appointments, inductions, appraisals, the evaluation of staff performance for probationary reviews and exit interviews, but they had not been previously undertaken any work specifically in relation to the supervision of staff.

Group members said:

- They were unaware that health and social care staff were supervised
- They had no personal experience of being involved in, or providing feedback, for supervision.

They identified how people who use services and carers provided feedback:

- Satisfaction questionnaires
- Complaint post cards (this was being piloted by one local authority customer services)
- Telling 'trusted staff' what they felt about a service they had received or a problem they were experiencing.

The group expected to be treated as 'customer(s) with a right to a good service'. However they provided positive and poor examples of their experiences of the services, and suggested that they would like to be able to feed these experiences into supervision because they were not always convinced that the feedback methods currently used by service provider's led to any real change

An organisation led by people who use services that provided support to people in the community who have, or who are using mental health services agreed to be a second focus group for the research. The 11 members of the focus group had experiences of services provided by health and social care professionals, management and care staff, as well as services provided by housing and voluntary organisations.

Some group members said that they knew staff were supervised, and that supervision was 'not just about what the worker brings up, but it is an open process where anything might be discussed.' They said that supervisors had to work within guidelines given to them, and supervisors tested out what workers were doing in their practice. The group said that they knew that not all workers got supervision (e.g., personal assistants didn't get supervision) and that some workers had too many people who use services on their caseloads, and they questioned whether it was possible to supervise workers properly with a high caseload.

The group said that they were confused about different worker roles (e.g., what's the difference between a social worker and a care manager?), and were unclear why a person using services couldn't be a supervisor. They were unclear about what actually happens in supervision, and in particular how a worker might make sure that the thoughts, feelings or wants of people using services were conveyed in supervision. They wondered why supervisors didn't know about poor services, and why they didn't improve services, when they did know. One person said that when he complained about how he was being treated by housing support staff (who were getting paid to care from him), he didn't feel supported, and that 'staff didn't like it' when he complained.

The group said that they understood that workers needed time to talk to supervisors about how they might be feeling because they deal with difficult feelings that people using services have, but they felt that supervision should really be about the person using services because they were having the difficult feelings in the first place. They thought that supervision could have good outcomes for people who use services and one service provided the group with an example. The person using services was able to express to their key worker what service they thought would help them and the key worker took this request into supervision, where a decision was made to support this request (but in the end the service wasn't available). However, another person using services said that they did not feel that supervision always had a good outcome for people who use services as he had experience of being denied a service for 18 months by a supervisor, even though it had been agreed that he needed this service, and he was unable to access any other support during this time

Costing supervision

The four sites were all asked how supervision costs were calculated. They were provided with examples from the research of Soper, Munro and Holmes (2010) where amounts of time spent on supervision were multiplied against the salaries of supervisor and supervisee, administrative and management overheads and 'other expenditure'. Three sites all replied that supervision was not separately calculated, in this way, since it was seen as an integral part of working roles. Where a calculation of the cost of

supervision was made, a simple sum of the supervisor and supervisee's hourly rate was used, multiplied by the time taken for supervision.

This calculation, putting a simple cost on supervision, was not considered to take in all the benefits of supervision, for instance, increases to output, improved outcomes for staff and people who use services, retention of staff, and improvements to efficiency at work. As one manager put it:

> *'We do not cost supervision as it is part of what we do. If we wanted to we may just do that simple calculation of the two people's hourly rate multiplied. However it might not be very sophisticated as you may be taking people away from direct support but productivity should increase.'*

The final site also used a salary based calculation (including additionally National Insurance and pension costs), without any extra organisational, management or central charges, which the organisation budget for separately. They provided a costing per hour for Team Leaders, Support Workers, and Senior Support Workers, based on a recent salary rate:

- Team Leaders: £15.35 per hour
- Senior Support Workers: £9.28 per hour
- Support Workers: £8.13 per hour

This organisation uses separate costing systems for their residential services and community support services. Within residential services supervisions are not costed separately. This is because staff and managers are based in the same building and time can be found to supervise staff when the service is quiet.

Within the community support services, supervision is costed as part of 'downtime', which is a time allowance for training, supervisions, team meetings, travel time, sickness, bank holidays, and annual leave. All support workers, senior support workers and Team Leaders have a downtime allocation which is calculated/budgeted for annually in days. This 'downtime percentage' is then costed into the hourly rates.

Using these calculations, the organisation writes the following into their budget:

- Supervisions for Team Leaders are budgeted as four days per annum, a total of 7 per cent downtime, which costs the community support services subsidiary £478.98 per person annually.
- Supervisions for Senior Support Workers are budgeted as three days per annum, a total of 6 per cent downtime, which costs the community support services subsidiary £217.18 per person annually.
- Supervisions for Support Workers are budgeted as three days per annum, a total of 6 per cent downtime, which costs the community support services subsidiary £190.23 per person annually.

While these calculations are useful and necessary for organisational planning, they do not take into account the benefits of supervision to workers or to people who use services. Francis and Byford (2011) specify that 'economic evaluation in social care

should measure outcomes that are defined from the perspective of people who use services and their carers' (Francis et al, 2011: v); to do this a much broader analysis of the costs and benefits of supervision needs to take place.

Commissioning

In an interview with a commissioner of services it became clear that the commissioning process for Adult services is in transition from 'block contracts' to an 'outcomes' based approach. The introduction of a commissioning 'prospectus' seeks to ensure that commissioned services reflect 'what service users want' and then it is up to providers to deliver what they promise'. The local authority has started the new commissioning process with the voluntary and community sector and is in the process of moving onto the independent for profit sector. Providers are required to provide a range of specified operational information if they wish to become approved to provide services. The Local Authority documentation allows commissioners to check information e.g., light-touch financial checks etc. Providers have to meet standard checks e.g., the must be registered with the CQC. Awards are evaluated on cost, quality and social capital (a third of scoring to each). There is a monitoring team who are responsible for any quality issues.

The contracts that are awarded determine what will be provided and how the delivery of the contract is measured, and there is a monitoring team who monitor the provider using a range of measures e.g., they use matrix which includes CQC reports, 'soft information (questionnaires and any other feedback e.g., link) as well as any performance data. If there are any concerns these are identified and a plan is produced to correct the problems. The social worker responsible for placing an individual in a service will review the placement at intervals. If there are any issues they will talk to the provider and the monitoring team. For example, if safeguarding issues are identified, the monitoring team may ask a nurse to undertake a clinical review, which will inform a plan to improve safeguarding standards. However, it would not be usual for supervision to be identified in a contract: inputs are not the focus of attention. As long as the person using the service is getting the service that has been commissioned, and this meets their needs then the commissioner (and even monitoring team) wouldn't become involved in details such as supervision. The service is evaluated in a range of ways, including the Care Quality Commission reports, and Link (a group of people who use services who ask other people who use services for their views on the service they are receiving, questionnaires, etc.) The methods used have to be proportionate, but the key tool is a quality matrix. One provider manager used this feedback in supervision to improve performance, but he also said that his own performance was measured against feedback, and whether or not he had provided feedback from adults using the services he managed.

Discussion

According to Davys and Beddoe (2010:11), 'the difficulty of evaluating the effectiveness of supervision is compounded by the variety of definitions, the complexity of the activity, the multiple relationships and the variability of the context. Such complexity can be overwhelming not only for researchers but also for participants'.

In an attempt to understand this complexity, the research team asked respondents to identify the conditions that supported good supervision practice, what happened in supervision and to identify the impact and outcomes from supervision, as illustrated in this diagram here:

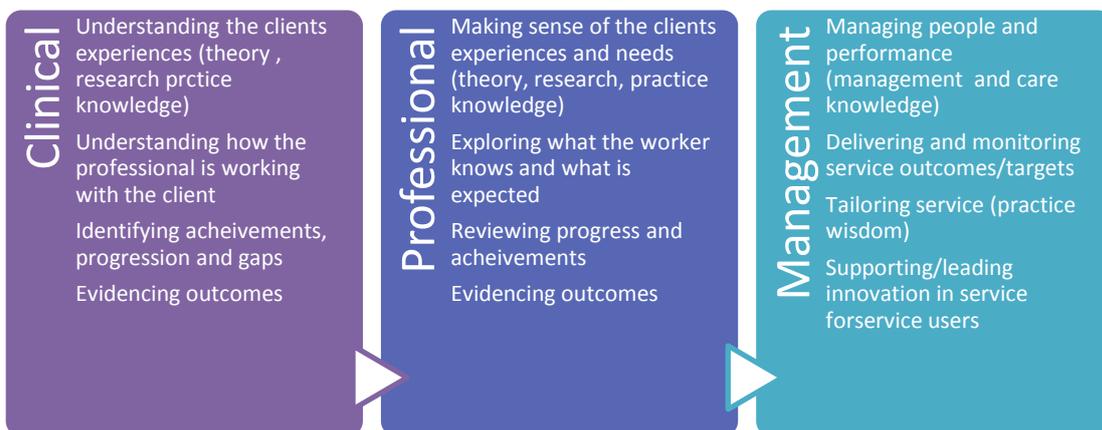**Figure ix: The supervision system**
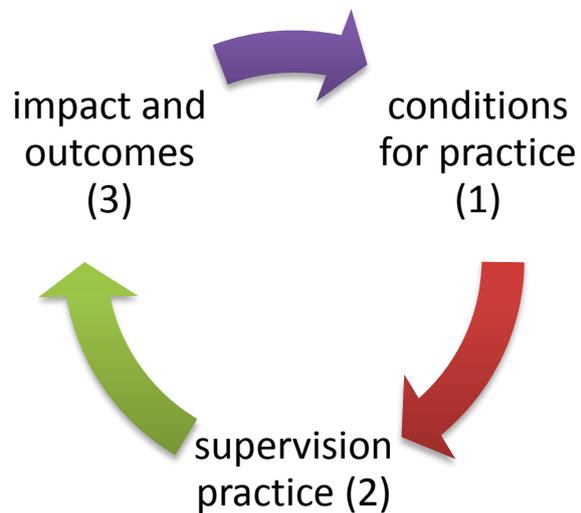
The findings are now discussed with respect to the project aims.

Project aim 1: To develop an understanding of *how* supervision is delivered in a range of joint and integrated adult team settings

Supervision was being delivered in a range of settings and was provided *informally* and *formally*. Informal supervision included ad-hoc meetings, discussions with colleagues, peer supervision, informal networking, team and 'group supervision.' This form of supervision was a way for workers to access temporary support to be responsive to people who use services.

Formal supervision was planned in advance, structured, and was underpinned by a relationship between worker and supervisor. The research identified three types of formal supervision: clinical, professional and management supervision:

Figure x: Frameworks for supervision

Clinical
- Understanding the clients experiences (theory , research prctice knowledge)
- Understanding how the professional is working with the client
- Identifying acheivements, progression and gaps
- Evidencing outcomes

Professional
- Making sense of the clients experiences and needs (theory, research, practice knowledge)
- Exploring what the worker knows and what is expected
- Reviewing progress and acheivements
- Evidencing outcomes

Management
- Managing people and performance (management and care knowledge)
- Delivering and monitoring service outcomes/targets
- Tailoring service (practice wisdom)
- Supporting/leading innovation in service forservice users

Clinical and professional supervision shared similar characteristics as highlighted above, and both were associated with supervisors providing 'support as well as challenge', to professionally qualified workers. Respondents highlighted what is already detailed in other research that both these forms of supervision, which were seen as 'a process of in-depth reflection by practitioners on their work in order that they continue to learn and develop from their experiences' (Davys and Beddoe, 2010:21) The use of research and up to date knowledge was said to be important in this process.

Management supervision had a dual purpose according to a registered manager who said that 'there is obviously a business bit but don't forget the person within that when you are running a service for people who are looking after people – you need to make sure that they are well really' (Registered Manager)

From the research it was apparent that non-professionally qualified staff largely accessed management supervision, whilst professionally qualified workers were able to access management and either clinical and/or professional supervision.

The form of formal and informal supervision in each of the case study sites reflected the primarily needs of the organisation, and staff, although the expectation was that

supervision benefitted people who use services. The most common way of delivering formal supervision was via 1 – 1 meetings. Trust, openness and respect for the workers role was said to be important to the way in which all types of supervision was delivered. Supervision needed to support decision-making and the recording of these decisions was important. For professionally qualified workers the supervisor was often the manager, who was a senior professional, but not always.

The delivery of supervision was personalised by the use of discretion, which respondents said was important. In professional and clinical supervision feelings were explored and used in understanding what was happening between workers and people who use services, as they worked together. Good supervisors were said to be respectful of this work and supportive.

Project aim 2: To develop an understanding of how identified models of supervision practice affect stakeholders

What the research showed is that despite often blurring of boundaries between the different types of formal supervision, workers understood the differences although they sometimes found it difficult to articulate these differences. Respondents linked clinical and professional supervision to clinical/professional standards and a focus on the needs of the patient or person using the service, whereas management was focused on the organisational needs. Grey areas were identified e.g., 'staff development' was a concern from a professional/clinical perspective (workers need to be up to date in their practice) as well as from the organisation's perspective (human resource strategies and policies required workers to be capable and able to do the job they were employed to do).

The link between capability and performance management within supervision was reported across all types of supervision. In case study B for example, a worker became aware, through formal supervision, that they were not performing well and that her poor performance was affecting people who use services. The worker learned how to manage their sickness levels, which had been impacting negatively on the people using services. The worker described this process as really helpful and supportive.

The on line survey generated lots of negative and positive impacts on workers from supervision, across a range of organisations, which seems to suggest that the type of supervision may have been less important than the quality of the relationship between the supervisor and supervisee. One supervisor who delivered 1-1 management supervision (case study D) said that good supervision was really all about good communication, but also 'you have to have an understanding with the person that you are supervising that you are with. You have to have a good working relationship.'

Project aim 3: To develop an understanding of the perceptions of supervision and its impact on people who use services

The link between good supervision, and its impact and outcomes for people who use services wasn't easy to capture. Respondents made links but these were difficult to evidence other than as causal links. For example:

> *'When I feel good and know I am doing my job right then I know that the clients are happy as they are getting what they need and it's working'* (health facilitator)

> *'All conversations we have, whether they're in supervision direct or not, will have an outcome for people'* (registered manager)

Supervision was reported, as a *time for workers* and not just about the job.

> *'Supervision is really about me, and my work'* (health facilitator)

One supervisor described how supervision makes the link between the individual worker, the work, and the people using services. They suggested that 50 per cent of supervision was about disentangling cases and thinking about the impact of the case on the worker, as well as considering operational issues and barriers which can cause stress to workers. In this way, the process of supervision supported effective interventions to help people who use services, and a focus on the worker was an important part of delivering this outcome.

People who use services, who were aware of supervision and supportive of it to help workers deal with the difficulties in supporting them, would have liked stronger links to be made between supervision and improved practice and outcomes for them.

Project aim 4: To identify areas of good practice and of innovation in joint and integrated health and social care supervision

Respondents identified many areas of good practice in supervision, and highlighted how supervision supported this, by way of discussions, (which generated ideas), research and practice evidence (available through the expertise of the supervisor), or through access to training.

Innovation in practice and service development was particular evident in one organisation: case study C. A senior support worker said that the organisation gave workers commendations if they were able to generate ideas that improved the service or experience for people who use services In addition service innovations arose from discussions in supervision and then with people who use services. This link between supervision and people who use services was an exciting discovery.

Project aim 5: To identify the costs perceived to be associated with supervision in different models of practice

Supervision has long been associated with the provision of support to workers , rather than being viewed as an activity with associated business costs. The different models of supervision practice and the costs of providing supervision has not been an area for challenge or scrutiny by accountants or senior managers. Any costs associated with supervision are therefore absorbed within the normal running costs for the business (time spent in supervision meetings, staffing etc). The research team was unable to do any more than report on how organisations identify costs for supervision as the methodology for this activity is under-developed. As such it is difficult to identify the costs, nor indeed the benefits from the types of supervision found.

Limitations to the practice enquiry

- 'Joint and integrated working' is a large field with many different combinations of structural and working models. The limited resources available for the practice enquiry meant that it was impossible to scope all models of supervision in this field.

- Neither the survey respondents or the four case study sites are representative of organisations in social care, and selection of the case study sites *purposively* identified organisations where supervisory practice appeared to be positively regarded by respondents.

- The 'cost and benefits' of supervision was an area that had not been calculated within any of the study sites in a sophisticated way. This provides food for thought with regards to the complexity of the working relationships, and outcomes, within this field.

- Language was sometimes an issue in the survey, where our more academic understanding of the aspects which make up different models of supervision sometimes meant that respondents described as an 'other' category one of these aspects, picking out a component that was important to them.

- The scope of the practice enquiry did not allow for any in depth work looking at the supervision of personal assistants and home-based care provided through direct payments. This is an area which requires further study.

- A separate study is called for looking to identify any causal links between good supervision practices, which include the voices of people who use services on staff retention and turnover. While the practice enquiry was able to provide some limited associations in this area, it would benefit from a closer and more specific focus.

Conclusion and recommendations

The research findings suggest that 'good' supervision in joint and integrated working has the following elements:

- Clear articulation of the purpose and practice of supervision, which is embedded within communication and performance management systems. Where the working context is complex, professional leadership was said to be important to ensure that workers were challenged and supported.

- Policies, procedures and professional standards that support the practice of supervision, and are linked to other organisational policies e.g., sickness and absence, flexible working, health and well-being, whistleblowing, grievance, capability, etc, are necessary to promote and sustain good supervisory practice.

- The role of supervision should be understood and valued within the culture of an organisation because it has a clear role in delivering good services and outcomes for people who use services. Workers therefore need allowance of preparation and supervision time as part of their workload, to provide access to appropriate support.

- Cultural expectations and values are clearly understood and articulated as to the purpose and practice of supervision, the role of the worker, and supervision practice is monitored

- Mandatory training and a wide range of support and development opportunities are accessible to support supervisors and supervisees to engage positively in supervision. This is particularly important in complex systems where the type of supervision available needs to inform the training and development needs of staff

- Availability of 'informal supervision' – accessibility when in need, not waiting for formal session – which is recorded in the same way as is formal supervision. Availability of different forms of supervision and methods (phone, email as well as face to face in planned and unplanned meetings) supports decision making in real time, and short term interventions that cannot wait until formal supervision meetings.

- Availability of a supervisor from own profession for supervision, even if only as part of a model of practice. The responsibilities of qualified professionals within complex organisational systems, and accountability requirements, means the type of supervision provided need to be appropriate for workers, which may require adaptations or changes in the way in which supervision is organised and delivered.

The research findings suggest that supervisors and supervisees need:

- Clear frameworks for supervision sessions – internally devised or national i.e., NHS Knowledge and Skills Framework, National Occupational Standards for Social Work, etc., that are linked to worker roles and improved outcomes for people who use services.

- Relational Working and Respect. Whatever policies, procedures and pro-forma's are created, in the end a supervision service will only be effective if the people delivering and using a supervision service can work well together. Good supervisors were able to create the conditions for this to happen which was valued across all four sites

- Promotion of reflection as a means of increasing worker understanding to improve and support practice development. The way in which workers reflected, and the degree to which they used 'the self' in their practice differed, but supervision provided a space for reflection and good supervisors were skilled to support this.

- Quiet, safe and comfortable space and sufficient time. Good supervisors also asked open questions and provided refreshments, which made workers feel valued.

- 'Actions' that allow the supervisee and supervisor to work together to review what they are achieving from session to session, what is working – achievement. Good supervision was developmental i.e., there was a sense of progression and this was developed through building on previous supervision sessions.

- Sensitivity to what is said, and clarity about where information goes – the limits of confidentiality. Good supervisors built relationships with workers, working openly and honestly with them. Even when there were difficulties or problems they approached their work with supervisees in a respectful and sensitive way to respect the feelings of the worker.

- Difficult issues are addressed in an open and honest way. Poor supervision experiences had emphasised a focus on blame and criticism. Good supervision was underpinned by values that were explicit in the supervision contract.

What outcomes are generated from good supervision support and practice for people who use services?

- Seeing clear outcomes as important to practitioners, for themselves and also for those they work with. Good supervisors were able to link practice to a rang e of outcomes and this was explicit

- Supports innovative working, gives practitioners the opportunity to bring new ideas into their work, and service development. Good supervisors were open to discussing possible service developments, to changes to working practices, or

ways of thinking in supervision, including those brought to them by supervisees from their own contact with people who use services.

- Supportive nature for practitioners promotes better working relationships and well being – almost all preferred to have at least some one-to-one supervision. Staff valued the one to one supervisory relationship as it enabled them to have a safe space to explore practice weaknesses without feeling defensive. Other forms of support did not always provide this opportunity.

- Continuing professional development a key outcome for many participants. Many staff said that they found supervision to be motivating as they engaged in learning, but for some supervision became a place where they were able to develop the confidence to take on new responsibilities and access to accredited learning, which they would not have done without this support.

- Informal supervision seen as key to providing good services – when need arises, not waiting for planned supervision meetings. Whilst planned formal supervision allowed for reflective scrutiny through detailed discussions, there was a need for ad-hoc supervision, which provided an intensive discussion in order to support 'fast developing' work with people who use services.

Recommendations

The research findings identified good practice as experienced by supervisors and supervisees, but did not go beyond identifying associations rather than causal links between the types of supervision that was available to workers, what happens in supervision and the impact and outcomes for people who use services. It was not possible to clearly identify the cost/benefits of the types of supervision that emerged from the research.

Further research is needed to:

- Develop, pilot and evaluate methods for collecting data on the impact and outcomes from supervision

- Engage people who use services in developing our understanding of how supervision practice can further support practice and service improvements

- Identify any causal links between good supervision practices, which include the voices of people who use services on staff retention and turnover. While the practice enquiry was able to provide some limited associations in this area, it would benefit from a closer and more specific focus

- Develop a costings methodology to help employers to understand the cost/benefits of use of different types of supervision models.

References

Barak Mor, M.E.,, Travis, D.J., Pyun, H and Xie, B (2009) *The impact of supervision on worker outcomes in child welfare, social work and mental health settings: a meta-analysis and state of the art review*, Social Service Review, 83 (1), pp 3 - 32

Bewis, J., (2007) *Culture*, in Knight, D and Willmott, H (eds) Introducing Organisational Behaviour and Management, London: Thompson

Coulshed, V., & Mullender, A with Jones, D. N., & Thompson, N (2006) (3rd edn) *Management in Social Work*: Basingstoke: Palgrave MacMillan

CWDC/Skills for Care, *Providing effective supervision* (2007).

Daveys, A, and Beddoe, L (2010) Bets Practice in Professional Supervision A guide for helping Professions, London: Jessica Kingsley Publishers

Department of Health. (2010c) Responsibility and Accountability: Moving on for New Ways of Working to a Creative, Capable Workforce. Department of Health,

Department of Health (2012a) *Caring for our future: progress report on funding reform.* London: Stationery Office

Department of Health (2012b) Bringing Clarity to Quality in Care and Support,

http://caringforourfuture.dh.gov.uk/better-care/quality-of-care-and-support/

Efstation, J. F., Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology, 37,* 322–329.

Evans, T (20010) *Professional Discretion in Welfare Services beyond Street-level bureaucracy*, London: Ashgate

Fish, S., Munro, E. and Bairstow, S. (2008) *Learning together to safeguard children: developing an inter-agency systems approach for case reviews*, London: SCIE.

Francis, J. & Byford, S. (2011) *SCIE's approach to economic evaluation in social care.* SCIE, London.

GSCC (2005) Specialist standards and requirements for post-qualifying social work education and training, Leadership and management,

Hawkins, P. and Shohet, R. (1989) *Supervision in the Helping Professions,* Milton

Keynes, Open University Press.

HM Government (2007) *Putting people first: A shared vision and commitment to the transformation of adult social care*, London: HM Government

Holmes, L., Munro, E. R. and Soper, J. (2010) **Calculating the cost and capacity implications for local authorities implementing the Laming (2009) recommendations.**

Kadushin, A (1992) (3rd end) *Supervision in Social Work*, New York: Columbia University Press

Mead, S, (2004) Overview of Joint Reviews Audit Commission

Morrison, T. and Wonnacott, J. (2010) *Supervision: now or never – reclaiming reflective supervision in social work,* **http://www.in-trac.co.uk/reclaiming-reflective-supervision.php** accessed July 2012

Munro, E., (2010), *Part One: A System's Analysis,* London, Department for Education (available online at **http://www.education.gov.uk/munroreview/**).

NHS Confederation/Association of Directors of Adult Social Services (2010) Where next for health and social care integration? London: NHS Confederation/ADASS

NMC (2009) **http://www.nmc-uk.org/Documents/Midwifery-LSA-reviews-reports-to-Council/Analysis-of-the-LSA-reports-to-the-NMC-2008-2009.pdf**

Report to the Local Government Association. Loughborough: Centre for Child and Family Research, Loughborough University

Tsui, M., (2005) *Social Work Supervision, Context and Concepts*, London: Sage

Practice enquiry into supervision in a variety of adult care settings where there are health and social care practitioners working together

This practice enquiry was commissioned by the Social Care Institute for Excellence (SCIE) to form part of the knowledge base for a practice guide for *Supervision in adult services* where both health and social care personnel work. The practice enquiry explores the delivery of supervision in a range of joint and integrated team settings within adult care, uncovering the types of supervision in use and their perceived outcomes for stakeholders.

The purpose of the practice enquiry was to seek examples of supervision which stakeholders viewed as 'good practice', and in doing so, the research sought to explore the factors that made supervision practice effective for workers, people who use services, and organisations.