Clinical supervision using the 4S model 3: how to support supervisors and sustain schemes

After training, supervisors need ongoing support to enable them to deliver effective supervision. It is vital to plan how to sustain supervision schemes.

INTRODUCTION
Once investment in this work to establish a good supervision scheme has been made, there should be lasting benefit, enabling supportive supervision to become a regular, robust and beneficial part of a trust’s life.

The previous parts of this series discussed the first two phases of incorporating clinical supervision into trusts: the systemic structure (Waskett, 2010a); and teaching supervision skills (Waskett, 2010b).

The next phase of work falls into two sections. The first is to support supervisors who have been trained, so their skills are welcomed and become useful to the trust, and their abilities are nurtured and continuously developed. The second part is to make plans for the whole project’s sustainability. The aim is to maintain an evolving, enthusiastic, competent cohort of supervisors who support colleagues regularly and effectively.

SUPPORT Practice
Practitioners finishing training are likely to be enthusiastic and eager to use their new skills and understanding to support colleagues. Being able to carry out supervision soon after training, and regularly thereafter, will build their confidence and continue the process of learning by practice.

The first level of support is therefore to ensure that: staff who want supervision are able to contact supervisors for group or one to one sessions; and that sessions can begin as soon as possible after training.

Developing any new skill involves making mistakes – which can also be seen as learning opportunities.

Supervisors often worry, quite reasonably, that they have not learnt enough or become expert enough on the day course. However, the real expertise develops as they relax, learn and realise they do not have to have the answers for supervisees, while still upholding the ethical responsibility inherent in the role.

Supervisors are therefore encouraged to be transparent with supervisees about their developing abilities as well as their uncertainties, so both can learn together and develop what works in practice over time.

Facilitating supervision soon after the end of training will depend on some of the lead group’s work before the courses (Waskett, 2010a). They will have:
- Agreed that the trust will offer group or one to one supervision, or both;
- Raised practitioners’ awareness so they know that trained supervisors will soon be available and how to contact them;
- Ensured that managers and team leaders are aware of the imminent change and understand what supervision is (compared with line management or mentoring); that the trust has approved it; and that middle managers are expected to allow their staff to take the protected time outlined in the policy.

The lead group should be prepared to keep the issue in high profile throughout the trust for some time; the bridge between trainee supervisors finishing training and allowing them to start practising is crucial. It should be clear to both supervisors and potential supervisees exactly how the structure works – how a group is formed, when and where they meet, and how an individual supervisee can contact a supervisor and what happens next. Some of this responsibility may fall on supervisors’ shoulders – if so, this should be clear.

Other parts of the system should be woven into the scheme: for instance, a question could be built into appraisal about whether appraisees are using supervision or practising it. Alongside this, the skills of those both offering and receiving supervision can be mapped onto the Knowledge and Skills Framework (KSF) (Department of Health, 2004) so these skills can be added to individual portfolios (Table 1).

Once staff begin to connect all this up and work together, new supervisors will grow in their abilities and supervisees will begin to benefit. Better practice will result and as time goes by, the trust will begin to profit.

Maintaining a systemic view of the whole issue throughout the trust is important.

The supervisor’s supervisor
Once practice has begun, supervisors will be doing something stimulating and different from their usual work. To make the most of learning from these experiences, they will need to do some active reflection.

Maintaining supervisees’ confidentiality is crucial in the supervision relationship, so care must be taken with this. Each supervisor should have their own supervisor, to whom anything can be expressed in the certainty that it goes no further. Again, this applies to one to one supervision or a group of peer supervisors. Supervisees’ names should not...
be disclosed to the supervisor’s supervisor in this supervision, and every effort should be made to protect their confidentiality.

Supervisors should be able to discuss their everyday clinical work as well as their supervision work during supervision. If possible, trusts should ensure someone is available to act as a back-up who can be consulted confidentially on any acute supervision issues with which new supervisors may need help. While this may be rarely used, it gives a sense of security. Bor and Miller (1991) provided a helpful outline of the way such a person might go about consultation.

Table 1. How Supervisor Skills Connect with KSF Core Dimensions

<table>
<thead>
<tr>
<th>KSF dimension</th>
<th>Up to level</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (communication)</td>
<td>4</td>
<td>Develop and maintain communication with people about difficult situations</td>
<td>Supervisors maintain open, responsible, respectful and skilled communication with supervisees, even in complex situations; liaise appropriately with others if necessary regarding the supervisee; develop the practice of supervision with others as part of the trust’s care of staff.</td>
</tr>
<tr>
<td>2 (personal and people development)</td>
<td>4</td>
<td>Develop others and oneself in areas of practice</td>
<td>Collaborate with supervisee to stay on track; learn and constantly improve specific language/questioning skills; maintain boundaries and know when to break them, with overall aim to help supervisee do the best possible job.</td>
</tr>
<tr>
<td>3 (health, safety and security)</td>
<td>3</td>
<td>Promote, monitor and maintain best practice in health, safety and security</td>
<td>Alert the health, safety and security issues, especially psychological issues such as stress, bullying, burnout/retorsive function of supervision. May occasionally need to act outside the supervision session on knowledge/understandings gained within sessions.</td>
</tr>
<tr>
<td>4 (service improvement)</td>
<td>3</td>
<td>Appraise, interpret and apply suggestions, recommendations and directives to improve services</td>
<td>Supervisors stay updated with policy/directives regarding supervision and apply these where appropriate in practice. Supervisors learn from supervisees and actively value their ideas about service improvement.</td>
</tr>
<tr>
<td>5 (quality)</td>
<td>3</td>
<td>Contribute to improving quality</td>
<td>Practice of supervision aimed at helping supervisee improve the quality of their work and maintain and progress in. It is all too easy to let supervision conversations slip and revert to a familiar didactic position. A psychoanalyst described the great temptation for a member of his profession to become “the magician,” and this also applies to supervisors’ role: “The patient [supervisee] often looks to the psychotherapist [supervisor] not only for effective support in the fight against neurosis [for example blind spots, risk, incompetence and so on], but also for access to secret knowledge which will find a solution to all of life’s [one’s patients’] problems” (Guggenbuhl-Craig, 2004). Most healthcare practitioners have been trained in the medical model in which advice is given and problems are fixed (if possible). Conversely, in the solution focused approach, the skill lies in making space and facilitating the other person to think for themselves. To maintain the supervisors’ curiosity about and faith in supervisees, it is essential that they maintain their own self-awareness and learning, perhaps by talking to others using the same approach, reading, maybe attending conferences or joining an organisation (such as the United Kingdom Association for Solution Focused Practice: see <a href="http://www.ukasfp.co.uk">www.ukasfp.co.uk</a>).</td>
</tr>
<tr>
<td>6 (equality and diversity)</td>
<td>3</td>
<td>Develop a culture that promotes equality and values diversity</td>
<td>Supervisors respect individual supervisees and treat them equally, valuing the differences and adapting their supervision practice accordingly. Also, supervisees/patients/caregivers are respected equals and supports supervisees in treating them as such.</td>
</tr>
</tbody>
</table>

Table 1. How Supervisor Skills Connect with KSF Core Dimensions

Regular supervisor meetings
In training, groups frequently express the hope that they can meet together again. Many say that being able to discuss supervision issues with others in the course is invaluable.

Sometimes, supervisors express concern that once the course is finished, they will be out on their own. If they receive their own supervision in a peer group of up to eight members, this will be taken care of to some extent. Nevertheless, a supervision group is a small group with a specific function which does not include top-up training, discussing practical arrangements surrounding supervision and similar matters.

This gap may be filled by arranging for all supervisors in the trust to be invited to a support group twice a year, where they can benefit from the larger pool of practising supervisors and draw up an agenda according to their needs. The original trainer could facilitate this group at first, although eventually supervisors will take responsibility for this and become self-sufficient.

The group may decide to have an overview of the whole scheme. Problems always occur in any scheme and it may be necessary to adapt or innovate to keep it running smoothly. Supervisors may do this themselves or pass their recommendations to the lead management group. They could also, if they wish, use this time for refresher training.

Discussion and reading
In some trusts, it may be possible to set up an online discussion group where supervisors can share ideas, successes and problems, as well as reading and other ways to maintain interest and learning.

The solution focused model is easy to learn, but takes practice and discipline to maintain and progress in. It is all too easy to let supervision conversations slip and revert to a familiar problem oriented way of talking, particularly as supervisees in the NHS will initially expect this. However, awareness raising and the first few sessions of supervision will help supervisees to tune into the general stance of this approach and begin to take more responsibility for their own decision making.

The other temptation is to revert to the familiar didactic position. A psychoanalyst described the great temptation for a member of his profession to become “the magician,” and this also applies to supervisors’ role: “The patient [supervisee] often looks to the psychotherapist [supervisor] not only for effective support in the fight against neurosis [for example blind spots, risk, incompetence and so on], but also for access to secret knowledge which will find a solution to all of life’s [one’s patients’] problems” (Guggenbuhl-Craig, 2004). Most healthcare practitioners have been trained in the medical model in which advice is given and problems are fixed (if possible). Conversely, in the solution focused approach, the skill lies in making space and facilitating the other person to think for themselves. To maintain the supervisors’ curiosity about and faith in supervisees, it is essential that they maintain their own self-awareness and learning, perhaps by talking to others using the same approach, reading, maybe attending conferences or joining an organisation (such as the United Kingdom Association for Solution Focused Practice: see www.ukasfp.co.uk).
used in Agenda for Change job outlines, appraisals and portfolios. Table 1 suggests how these connect for the supervisor’s role.

Newly trained supervisors should steadily become more competent, adaptable, confident and effective in their supervision work, through adequate supervision (one to one or in groups), twice yearly gatherings of all supervisors and managerial encouragement to reflect, read and discuss the craft of supervision on an ongoing basis, including mapping these skills onto KSF dimensions.

Box 1 outlines the main points on supporting supervisors.

**SUSTAINABILITY**

Hawkins and Shohet (2003) were right to state: “Supervision is likely to be established in a more sustainable way if the whole organisational process is carefully designed and monitored.”

This is the part that is so often neglected, as the final S – sustainability – in the 4S model is probably the most difficult to pin down. In the constant turmoil of changes imposed on the NHS from within trusts and (politically) from outside, it’s challenging to consistently maintain and improve a practice that supports staff, year after year.

In addition, thinking of supervision as part of a wider culture of systemic supportive activities is unusual. The literature tends to have a narrow focus on supervision practice, relationship dynamics, group working, evaluation and so forth – the “how to” of supervision itself. This narrow view may echo the understandable NHS culture, which has in the past been paralleled by supervision (where it exists), focusing on individual supervisee difficulties rather than systemic, positive support and encouragement. It is the processes, systems and structures of enabling supervision and other supportive activities within a trust’s culture that enables supervision to work in the long run.

Hawkins and Shohet (2003) introduced and expanded on systemic ideas, pointing out the beneficial connections between supervision and learning. They suggested expanding on systemic ideas, pointing out the beneficial connections between supervision and learning. They suggested supervision itself; the need for new generations of supervisors. The traditional health service “see one, do one, teach one” orthodoxy has created an almost cavalier approach to skilled activity, and it can be tempting to throw new supervisors into teaching others with barely a pause to build up any experience. Doing this is unfair on supervisors, and would degrade the teaching of the next generation and therefore the whole practice of supervision itself. Teaching others the skills of supervision requires substantial experience in both teaching and supervision.

The first cohorts of supervisors often include experienced teachers and trainers. After at least a year’s experience in practice, these may be the first to volunteer to train the next generation. Train the trainer courses can help staff develop ideas about the most important elements of supervision skills and how to enable trainees to learn them. These trainers will develop the most effective and lively courses from, again, plenty of experience of teaching, aided by feedback from participants. Awareness raising for new supervisees should not be neglected; supervisors may be able to take some of this. Steadily, the scheme should become self-sustaining in house, and further generations of supervisors and supervisees are guaranteed.

**REFERENCES**


Waskett C (2010a) Clinical supervision using the 4S model: considering the structure and setting it up. Nursing Times; 106; 16, 12-14. tinyurl.com/4s-model-1

Waskett C (2010b) Clinical supervision using the 4S model 2: training supervisors and developing effective sessions. Nursing Times; 106; 17, 18-20. tinyurl.com/4s-model-2