Clinical Supervision; beyond the first flush

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Nearly two decades ago, Smith (1999) recognised that little had been published on the implementation and usefulness of Clinical Supervision in the operating theatre. Accordingly, she conducted a small Action Research project and reported its findings. These were deemed to have been in a positive direction and a number of benefits were listed, essentially clustered around better communication between operating department practitioners (ODPs). Prophetically, however, she thought *'it would be interesting to observe if this enthusiasm and motivation continues after the project is completed'* (p308). Two years later, Smith (2001) lamented that Clinical Supervision was no longer practised in theatres and that its introduction in other areas had *'met with little success'* (p436). She believed the reasons to be the 'culture of the NHS, the negative attitudes by enough members of staff to have an impact and hidden agendas and micro-politics'.

Such telling accounts have continued to dominate the international Clinical Supervision literature. Indeed, so common have similar messages become, that it has long since been unnecessary to endlessly replicate these reviews and/or rehearse their revelations, in the unlikely expectation that novel insights may yet still emerge. However, akin to the first flush of a metaphorical rainstorm, during which polluted water typically enters drains in a more concentrated form compared to the remainder of the storm, it may be helpful to regard CS enquiries of this type as having cleared the ground for a raft of second generation research investigations.

Arguably, a fresh and bold approach to CS is now required. The implementation of local CS, and the evaluation of the benefit(s) anticipated to accrue, will require the realistic separation of the fact from the fancy; for there is little doubt of a public and private face. The public face of Clinical Supervision can often be found espoused in the policy positions of the health professions. However, these can be seen to cherry-pick the literature, whether innocently or intentionally, to keep on-message and ensure the [contested] medical/managerial conceptualisation of CS becomes firmly established. The private face can be found in published articles that arise from high quality outcomes-orientated research, undertaken by *bona fide* researchers, who remain appropriately faithful to reports of their findings, including occasions when these are silent, parsimonious, or contradictory about the benefits of Clinical Supervision (White 2017).

Based on mounting creditable research evidence, there is decreasing doubt that Clinical Supervision, when delivered to a demonstrable quality standard, may indeed benefit the well-being of Supervisees. Benefits that have been claimed for (say) higher levels of skill and/or

improved patient reported outcomes, however, are noticeably less well credentialed. Thus, future endeavours must surely focus less on, say, the collection of data on the level of uptake of CS at local level (often used as a managerial key performance indicator -*the more, the better* mindset) or, say, attempts to tinker with the nomenclature (for example, *'professional support'* was the interchangeable term adopted by Smith 1999), but rather on the development of a national CS research agenda, to prioritise studies devoted to the outcomes of nominated variables. That is, for there no longer to be a preoccupation with how much but, rather, on whether or not it works and, if so, in what ways and at what cost. The present folklore relies on the assumption that it does work and that it is worth it. Sound professional clinical practice, however, deserves to be predicated on much firmer footing, lest scarce public money is unknowingly wasted and/or the safety of staff and patients are innocently put at risk.

And yet, robust research methods have been known about since the turn of the millennium, to measure the *quality* of Clinical Supervision provision. For example, about 135 evaluations have taken place in 15 countries, worldwide, using the Manchester Clinical Supervision Scale© (MCSS©; Winstanley 2000); about half of them in the United Kingdom. The results of some of these have been reported in the public domain. Moreover, with the use of mathematical models and sophisticated software, contemporary analytic methods of real CS data have been developed (Winstanley and White 2014), that can not only indicate whether local arrangements meet the hypothesised threshold for efficacy, but can also predict the conditions under which the best outcomes are likely to be achieved, given local factors. It is already known, for example, that the frequency and length of CS sessions optimise the MCSS© total score. These techniques are readily available to guide CS policy decision making, but have become subjugated by the chanting of mantras by innocent enthusiasts, or to the censure of detractors. The froth must be blown off the recurring empty rhetoric, in either/both direction(s), to carefully study what remains as the substance (to refine what is already known) and how it might be then translated in practice and regularly evaluated.

Amid continuing reports of nurses working in ever stressful settings (BBC 2017), of not uncommon reports of care failings (CQC 2017) and at a time when the Nursing and Midwifery Council revalidation requirements include practice-related feedback, written reflective accounts, reflective discussions and the like (N&MC 2017), demonstrably efficacious Clinical Supervision has a significant fit, with implications for both education and service sectors. It is timely moment, therefore, to draw a line under studies which, from their outset, seek to identify the barriers to successful implementation (because they are now so frequently documented) and seek to concentrate on outcome studies which seek to strengthen the evidence base and to report them publicly. Whilst such studies are notoriously difficult to design, conduct, interpret, and fund

(White and Winstanley 2011), a number of methodological exemplars have been identified (Watkins 2011) which may assist.

Although the general CS literature is replete with accounts of the barriers, there remains a dearth of creditable research accounts of the benefits arising from the implementation of sustainable Clinical Supervision particularly, it seems, in the perioperative environment. It may be telling to observe that in their recently published textbook, Abbott and Booth (2014) again make unreferenced claims to threefold benefits of CS; to the practitioner, the team and the patient. Indeed, they assert that *'ultimately, the patient benefits most, as they will receive high quality care, as the ultimate aim of Clinical Supervision is the improvement of practice'* (p5). Arguably, therefore, the first flush may not yet be complete and extravagant aspirational claims will continue to be propagated.

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