**Evaluation of the Non Managerial Clinical Supervision (NMCS) Model and Protocol**

**This additional Material includes**

* **Rationale for and instruments used to evaluate NMCS**
* **Extracts of results from 2002 and 2012 evaluations**
* **Brief history and explanation of the NMCS model and protocol**
* **Selected extract from the NMCS training materials**

Despite clinical supervision being mandatory for healthcare professionals we did feel hearts and minds would need to be won over in order to make this a sustainable model. Therefore in devising a new model, protocol and training programme for clinical supervision we wanted to make sure that the final result was thoroughly evaluated. It needed to be evidence based, repeatable and progressive.

Did NMCS,

* Reduce sick leave?
* Increase job satisfaction?
* Improve recruitment?
* Improve retention?
* Reduce stress?
* Improve patient care through skills, knowledge and, or quality of service provided?
* Encourage formal reflection of complex clinical situations?
* Provide support?
* Allow personal issues that were affecting work to be discussed?
* Encourage and honest, open dialogue?

And finally did profession, age, grade, role, gender, experience, personal circumstances, post profession qualification training, impact on the effectiveness of NMCS?

Three questionnaires were used, the Maslach Burnout Inventory, Human Services Survey (MBI). The MBI should be used in conjunction with the Human Services Survey, (HSS) Demographic Data Sheet; these are an American set of questionnaires and the publisher advised that the original data sheet was heavily weighted towards Americans and to use the data sheet as a template to produce an English version. This was done. Training to administer the Maslach Burnout Inventory was completed in Oxford England. The Manchester Clinical Supervision Scale (MCSS) was used to measure the effectiveness of supervision. No training was required to administer the MCSS.

These three questionnaires covered the above list except retention, recruitment and job satisfaction; these issues have not been formally evaluated.

**Extracts from the results 2002 and 2012**

In 2002 there were 136 subjects in the study. They had to have completed the basic NMVS training and carried out at least 6 NMCS sessions in the workplace to be eligible. In 2012 there were 108 subjects. We could not use the original study group as the participant information was anonymized; so our criteria for the 2012 study was that all participants had completed the NMCS training and had been practising NMCS for 5 – 10 years.

It was with some trepidation we awaited the statistical analysis of the results on the most recent evaluation. In 2002 it had evaluated positively but in 10 years much had changed within the NHS leading, we believed, to increased pressure on time, increased expectations from clients, more job insecurity and more frequent changes within organisations.

We would not have been surprised if the results showed a downward trend in burnout and dissatisfaction with clinical supervision.

In fact the results largely mirrored those of the first post training group.

**Extracts from MBI analysis**

This is how the NMCS groups compared to the mean for medical professionals.

Emotional Exhaustion (EE) - Mean 22.9 NMCS 20.97 (2002), 22.1 (2012)

Depersonalisation (DP) - Mean 7.12 NMCS 3.6 (2002) 3.84 (2012)

Personal Accomplishment (PA) - Mean 36.53 NMCS 36.9 (2002) 37.21 (2012)

It is interesting to note that none of the variance in figures is statistically significant. This is despite the increase in pressure on clinician as suggested above. These figures do establish we had a normal representation in our study population and we take heart that depersonalisation is slightly lower and personal accomplishment slightly higher than the norm.

We would like to draw your attention to the following results from the 2012 MBI analysis.

* Therapy managers scored slightly higher than the mean for EE in 2012, where they had scored slightly less in 2002.
* Support workers scored higher for PA in 2012 than they did in 2002.
* Hospital based staff show a slight increase in EE and DP in 2012.

Time will tell whether these findings denote a trend. It would be interesting to know whether the participants in the evaluation would subjectively identify with the findings.

**Extracts from Manchester Clinical Supervision Scale (MCSS) analysis**

The MCSS comprises 36 questions. As extracts we have mainly chosen those that represent the quality and outcomes of clinical supervision.

Clinical supervision should offer the individual practitioner support. 10 years ago it was much easier for clinicians to move jobs; in 2012 is there is a greater feeling of having to ‘stick it out’ when a job is stressful?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Strongly agree | Agree | No opinion | Disagree | Strongly disagree |  |  |
| (1) | (2) | (3) | (4) | (5) |
|  | Reversed scores |  |  |
|  | Strongly disagree | Disagree | No opinion | Agree | Strongly agree | Mean | Std. Deviation |
| Q8 My supervisor gives me support and encouragement ( 2002) | 1 | 5 | 7 | 75 | 48 | 4.20 | 0.759 |
| 0.7% | 3.7% | 5.1% | 55.1% | 35.3% |  |  |
| Q8 My supervisor gives me support and encouragement ( 2012) | 4 | 5 | 9 | 66 | 24 | 3.85 | 1.119 |
| 3.5% | 4.4% | 8% | 58.4% | 21% |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Q32 I feel less stressed after seeing my supervisor (2002) | 4 | 22 | 28 | 62 | 19 | 3.51 | 1.030 |
| 3.0% | 16.3% | 20.7% | 45.9% | 14.1% |  |  |
| Q32 I feel less stressed after seeing my supervisor (2012) | 6 | 20 | 21 | 54 | 7 | 3.25 | 1.177 |
| 5.3% | 17.7% | 18.6% | 47.8% | 6.2% |  |  |

Clinical supervision should offer time to reflect and reflective practice is a requirement of health professionals.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Q11 CS gives me time to 'reflect' (2002) | 2 | 4 | 6 | 78 | 44 | 4.18 | 0.780 |
| 1.5% | 3.0% | 4.5% | 58.2% | 32.8% |  |  |
| Q11 CS gives me time to 'reflect' (2012) | 3 | 8 | 7 | 60 | 30 | 3.89 | 1.152 |
| 2.7% | 7.1% | 6.2% | 53.1% | 26.5% |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Q13 CS sessions facilitate reflective practice (2002) | 3 | 1 | 11 | 73 | 46 | 4.18 | 0.789 |
| 2.2% | 0.7% | 8.2% | 54.5% | 34.3% |  |  |
| Q13 CS sessions facilitate reflective practice | 1 | 7 | 9 | 62 | 29 | 3.94 | 1.069 |
| 09% | 6.2% | 8% | 54.9% | 25.7% |  |  |

Clinical supervision is relevant and necessary for all grades of staff

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Q25 CS is unnecessary for experienced/established staff (reversed) (2002) | 3 | 4 | 10 | 59 | 59 | 4.23 | 0.890 |
| 2.2% | 3.0% | 7.4% | 43.7% | 43.7% |  |  |
| Q25 CS is unnecessary for experienced/established staff (reversed) (2012) | 2 | 5 | 15 | 55 | 31 | 4 | 0.886 |
| 1.8% | 4.4% | 13.3% | 48.7% | 27.4% |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Q28 CS is for newly qualified/inexperienced staff only (reversed) (2002) | 1 | 7 | 50 | 77 | 135 | 4.50 | 0.671 |
| 0.7% | 5.2% | 37.0% | 57.0% | 100.0% |  |  |
| Q28 CS is for newly qualified/inexperienced staff only reversed)(2012) | 2 | 3 | 9 | 59 | 35 | 4.13 | 0.821 |
| 1.8% | 2.7% | 8% | 52.2% | 31% |  |  |

Does Clinical supervision make you more effective? A number of questions measure this. We have picked out one.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Q29 Clinical supervision makes me a better practitioner (2002) | 1 | 7 | 30 | 74 | 23 | 3.83 | 0.805 |
| 0.7% | 5.2% | 22.2% | 54.8% | 17.0% |  |  |
| Q29 Clinical supervision makes me a better practitioner (2012) | 6 | 8 | 15 | 62 | 16 | 3.56 | 1.253 |
| 5.8% | 7.1% | 13.3% | 54.9% | 14.2% |  |  |

Lastly, as finding time for clinical supervision is an ongoing issue for many, we have included these two questions. It appears although marking out the time for clinical supervision is problematic, once there it does not lead to additional work pressure.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Q2 It is difficult to find the time for CS sessions (reversed) (2002) | 17 | 61 | 4 | 44 | 10 | 2.80 | 1.232 |
| 12.5% | 44.9% | 2.9% | 32.4% | 7.4% |  |  |
| Q2 It is difficult to find the time for CS sessions (reversed) (2012) | 34 | 45 | 5 | 22 | 2 | 2.19 | 1.148 |
| 30.1% | 38.8% | 4.4% | 19.5% | 1.8% |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Q6 Fitting CS sessions in can lead to more pressure at work (reversed) (2002) | 12 | 72 | 13 | 31 | 8 | 2.67 | 1.110 |
| 8.8% | 52.9% | 9.6% | 22.8% | 5.9% |  |  |
| Fitting CS sessions in can lead to more pressure at work (reversed) | 13 | 55 | 8 | 31 | 1 | 2.56 | 1.062 |
| 11.5% | 18.7% | 7.1% | 27.4% | 0.9% |  |  |

**In conclusion**

The importance of these results are that there is very little variance in the statistical data gathered from 2002 and 2012 evaluation. To the authors this demonstrates that the NMCS model and protocol have stood the test of time and support reflective practice of clinicians.

In summary the NMCS clinical supervision model and protocol now has a 10 year evidence base with statistical backing. The authors are not aware of any other model and protocol with this statistical evidence base and would welcome contributions from others who may have carried out equally rigorous analysis of their model and protocol of clinical supervision.

The authors hope this evidence based NMCS model and protocol provide clinicians, managers and commissioners with a useful resource to facilitate the requirement of clinicians to carry out clinical supervision.

**A brief history and explanation of the NMCS model and protocol**

In the year 2000, out of the necessity described in the main article, the Non Managerial Clinical Supervision (NMCS) model and protocol was successfully researched and piloted over an 18 month period. The outcome was that the training was rolled out to Occupational Therapists, Speech and Language Therapists, Physiotherapists and Dieticians in Birmingham, Solihull and the Black Country.

It was felt by those involved in the pilot, that the time had come where they needed a structured forum to reflect on the day to day issues that were raised by carrying out their work which required not direction from a supervisor, but open, honest reflection about their possible, probable or actual interventions as clinicians. Additionally stress levels were high and support was needed to manage stress and improve retention.

The revolutionary aspect to this model, protocol and training was that **everyone** would be trained as both supervisor (facilitator) and supervisee (reflector) and that in each clinical supervision session they would assume both roles, everyone taking a turn as reflector and facilitator in equal time slots. To achieve equal status, and to create an environment where the reflector would not feel judged, the traditional supervisory relationship had to be challenged. The emphasis of the model minimises advice giving and instead seeks to equip the reflector with better problem solving skills derived from their own learning. It can be practised in small groups (no more than 4) or 1:1.

The definition of NMCS is as follows;

It is a facilitated process that focuses on the needs of the reflector. It is a non-judgemental and mutually respectful process that supports positive challenges and celebrates professional practice.

It provides an opportunity to explore feelings and thoughts about work related issues enabling personal, professional and clinical development through analysis and reflection in a formal setting.

Non-managerial clinical supervision is complementary to but not a substitute for management led supervision.

The aim of Non-managerial clinical supervision (NMCS) is to support the development of knowledge and competence, enabling reflectors to assume responsibility for their own practice and enhance the quality of services provided to clients.

The training programme is now part of Birmingham City University’s CPD short courses portfolio. It has remained unchanged in indicative content but has been regularly reviewed and updated with changes in government and publication of new NHS white papers.

Below is the model as developed by the participants over the 18month period described above.

#  The Model of Non-Managerial Clinical Supervision

Relationship

- non-managerial - reflector led

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Ref. Proctor. B (1986) *Supervision A Co-operative Exercise in Accountability* in Marken, M. and Payne, M. (eds) *Enabling and Ensuring* Kadushin, A. (1976) *Supervision in Social Work.* New York, Columbia University Press Nicklin, P. (undated) *A Practice Centred Model of Clinical Supervision* (Abstract) The University of York. Department of Health Studies Hawkins, P. & Shohet, R. (1990) *Supervision in the Helping Professions* Open University Press

Appendix A

**Reflection**

# Agenda

- Restorative - Dual responsibility of Reflector & Facilitator for the dynamics between themselves and the reflectors agenda

- personal growth - professional development - empowerment

# Explanatory Notes for the Model of Non-Managerial Clinical Supervision

**Reflection**

This is at the heart of the process and will enable the reflector to grow and develop and feel empowered to deliver quality services.

**Agenda Centred**

Reflectors agenda decides the content of the session, which should aim to be non-managerial.

**Relationship Centred**

The facilitator and reflector have a dual responsibility:

1. to attend to the relationship dynamics between themselves
2. to attend to the relationship dynamics identified by the reflectors agenda.

When carrying out this responsibility the overriding aim is to provide a restorative environment in which the facilitator can help the reflector to explore their thoughts feelings and actions.

**Professional and Trust Frameworks**

Good practice

Ethics

Local and national standards

Policies and procedures

Continuing Professional Development (CPD)

This includes all frameworks that practitioners are required to abide by to deliver safe accountable practice.

**Wider organisational context**

NHS directives

Government directives

Multi-professional issues

User involvement

Client centred practice

Cultural norms

Community values

**Boundaries**

The boundaries between all these areas should be fluid; this is represented by dotted rather than solid lines.

**NMCS Training**

NMCS training is now a three day course with a half day follow up after six months.

The content of the training is as follows:

*The model, protocol & method*

* With particular emphasis on confidentiality, roles and responsibilities of reflector and facilitator.

*Communication Skills*

* To include, Transactional Analysis, Six Categories of Counselling Intervention, Assertiveness, Negotiation.

*Reflective Practice*

* To include, Learning Styles, Problem Solving and Decision Making and Models of Reflection.

*Leadership skills required for NMCS*

To include, Leadership Styles, Managing Change, Risk Management, Managing Conflict.

*Skills Practice Sessions*

The training is repeatable and designed principally to equip participants with the knowledge and skills to become effective reflectors and facilitators. It also seeks to highlight the more difficult areas of professional life, those where an individual’s self confidence may not match the expectation of their job role.

To give one example:

Management of Change, in day three of the training, includes material and exercises to include all adult learning preferences, theory, reflection, an activity and practical steps to follow in the workplace. The extract below is taken from the participant manual.

# Management of Change

**Introduction**

Oxford Dictionary definitions of change include:-

1. to make or become different
2. to replace with or exchange for another
3. to transform or convert or be transformed or converted.

The first definition particularly suggests that one mechanism is natural evolution, the other a situation brought about with some effort. The ageing process can be ascribed to the natural evolution category as can wear and tear of machinery. Making things different is generally a way of improving a situation; however it is almost inevitable that there will be disruption involved. The following authors writing about change have said:

“There is nothing more difficult to carry out nor doubtful of success nor more dangerous to handle than to initiate a new order of things”. – Machiavelli

“Change used to be something that happened every ten years or so. Now it seems it’s always with us. Always different and not always what we’d like”. – Charles Handy

We must adapt to constant change. Indeed, we must learn to **love** change as much as we’ve hated it in the past. – Tom Peters – “Thriving on Chaos”

**NHS Changes**

Recent changes include the move to foundation trusts, Agenda for Change and more emphasis on partnership working between agencies.

Changes that we have been required to make over the last 10 years are still with us. We must continue to strive to improve quality, and respond to the imperative of being leaders.

The accountability and responsibility of each individual clinician has been clearly stated and our increased involvement in shaping and influencing the NHS of the future is demanded. We are promised there will be no centrally decided targets to adhere to (High Quality Care for All, 2008). Instead individuals must plan and prove their contribution to service improvement under core dimension 4 in their KSF outline. (Ref. The Knowledge and Skills Framework and the Development Review Process, 2004)

In the supervisory relationship too, this applies. Kadushin (1976) describes the facilitator as an agent of change. It is appropriate to apply this term to the reflector, as well, who brings their material to the session in order to improve/manage outcomes.

##

## Strategic Change Model

Strategic change is the approach often applied to major organisational change, to include *technical* system changes, *political* system changes and *cultural* system changes.

This model places emphasis on the time required for the change process, illustrated by the transition state. This state may be a difficult period of an undetermined length and acknowledging this can be reassuring. Some change agents (leaders) may be better at handling the i) initiation state ii) transition state iii) transformation state than the other states. It is important for all concerned that the transition state is handled well during any change.

##

## Force Field Analysis

This is an approach used to identify i) the extent of resistance to a change and ii) the forces which favour it. In order to achieve the desired change driving forces may need to be strengthened or the strength of the resistance reduced.



There are 10 steps for using a force field analysis which are:

1. Specify the change need.
2. Define the ‘present’ and ‘ideal’ situations.
3. List the helping and hindering forces.
4. Rank the strength of each force.
5. Explore how to weaken the hindering forces.
6. Explore how to strengthen the helping forces.
7. Ask ‘can I add new helping forces’.
8. Decide on your initiatives.
9. Put your actions into a plan.
10. Define how you will check progress.

Drivers/resistance reducers to change may include:

* Full support and commitment of senior management
* Ideas coming from the team that has to change
* The change appears to reduce workloads
* The change does not threaten livelihood income
* The changes are interesting and exciting i.e. of benefit to the participants
* The changes are in harmony with the values and ideas of the participants

## Individual response to change

Depending on the individual and the change proposed there is likely to be a continuum of attitudes. Some will accept the proposal, others will resist and others will be indifferent.



Those who accept may adopt the change with enthusiasm and encourage its implementation or they may merely harness the change and quietly apply themselves to it.

Those who are indifferent may cope with it when it arrives. Others may avoid it for as long as is possible. People who take an indifferent attitude, may not perceive that their own state will be affected; an assumption which is probably incorrect.

Those who resist may do so passively i.e. avoid being faced with something different, or actively i.e. express their resistance by a go slow, strikes or sabotage.

##

## Factors to consider regarding attitudes to change

In a supervision session, or any setting where resistance to change is identified the following factors may be relevant to the individual and need to be explored as necessary.

Personality – All individuals are likely to have a general bias towards either resistance or acceptance of change.

Cultural values and beliefs – the proposed change may clash with these for one individual and not another. This may be with regard to moral or religious beliefs or to a practice which has been appreciated and taken for granted (i.e. leaving work a little early on a Friday) and is now threatened.

Insecurity – this may be real or perceived, rational or irrational.

Relationship with organisation/leader – if the individual has a high regard for the organisation and trusts the leader/manager this will influence their attitude to a proposed change.

Pattern of past events – if the individual has previous experience of a similar change which was either success or failure this will influence their reaction.

Change or implication? – it may be the implication behind the change rather than the change itself that the individual is resistant to for example:-

Economics – income may be affected.

Inconvenience – life may be made more difficult (? Location change)

Freedom – changes may introduce more control checks on productivity or tighter controls on working hours?

Security – long term security of employment may be threatened?

##

## Skills for Handling Change

The model below, created by Leigh and Walters (1998), suggest that different skills are required, or need to be acquired, to successfully manage change.

This does not mean that one person needs to possess all the skills. It may be more appropriate to harness the expertise of more than one person to ensure the change is effectively made. A leader needs to have an awareness of the strengths of every member of the team

* Transforming skills – the ability to create a supportive, risk taking environment, self awareness, self-confidence.
* Mental skills – ability to think holistically, see the big picture and help others to do so
* Empathy and feeling skills – which include tolerance of ambiguity, ability to tolerate stress

