A healthier health visiting workforce: findings from the Restorative Supervision Programme

Sonya Wallbank
Associate Professor Child Health
South Warwickshire Foundation Trust

Georgina Woods
Assistant Psychologist
South Warwickshire Foundation Trust

Correspondence to: s.wallbank@nhs.net

Abstract
The restorative clinical supervision programme has been delivering a cascade model of restorative clinical supervision to over 1800 professionals across the UK. Currently, it is rolling out the programme to 246 health visitors across the West Midlands to enable them to experience the model for themselves and to prepare them to supervise other health visitors in the model. The programme has also been commissioned in other trusts across the UK to reduce burnout, stress and improve compassion satisfaction (the pleasure one derives from doing their job) among a range of professionals. This paper explores how clinical supervision is being delivered and experienced by professionals within different trusts, and shares quantitative data to show how the specific restorative model used which differs from usual clinical supervision has been significant in improving the capacity of professional to function at their optimum level.

Key words
Health visitor, clinical supervision, staff stress, burnout, restorative supervision

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Aims of this paper

This paper will describe the restorative model of supervision, which has been rolling out in the West Midlands for over a year and is being delivered in a number of other locations across the UK. Results of the programme will be shared, in addition to their implications for the way in which community professionals use their supervisory space.

Background

What is known about clinical supervision?

There are vast amounts of studies covering the topic of clinical supervision but as is frequently noted, the term itself is often written about as an umbrella term with little clarity around function and purpose (Gonge and Buus, 2011) and with little empirical evidence of effectiveness. Although clinical supervision is often reported as a good thing, calls for more robust implementation strategies, which use evidence-based models as in other areas of practice are being made (Buus and Gonge, 2009; Vlachou et al, 2011; Wallbank, 2011). The difficulty may be in finding models with a robust evidence base.

Clinical supervision has been identified as able to increase nurses' sensitivity towards themselves and the families they care for (Jones, 2006). It has been noted that where nurses attend clinical supervision they have an increased level of satisfaction with their psychosocial work environment through increasing job satisfaction and wellbeing (Begat and Serverisson, 2006). The essential aim of clinical supervision should be to increase the resilience of the professional ensuring they can act on risk appropriately as well as guaranteeing and improving the quality of care delivered to families.

Clinical supervision is not a new concept for nursing. However, the focus of much of the literature is on nurses working with mental rather than physical health. This is perhaps following a presumption that professionals working within the mental health sector are more likely to be impacted by their work. Less scholarly consideration has been given to sectors of community public health nursing despite their key role in mental health.

Those studies that have been conducted tend to be from outside the UK, but still show that access to clinical supervision that remained separate to administrative or managerial supervision was rated as significant to community staff. Additionally, having a supervisor who was not the individuals line manager was also key to achieve a successful supervisor/supervisee relationship (Cutcliffe and Hyrkäs, 2006). This is further supported by Hansebo and Kihlgren, who noted that 'supervision might be essentially, and most usefully, about nurturing practitioners' (Hansebo and Kihlgren, 2004: 279).

In attempting to clarify the benefits of clinical supervision the restorative element has been regarded as an essential ingredient to increase job satisfaction, vitality and reduce stress and emotional exhaustion (Gonge and Buus, 2011). However, in the literature very few studies comment on what actually occurs in a supervision session or what model staff were being exposed to (Howard, 2008).

Supporting the health visitor

The role of the contemporary health visitor means frequent exposure to demanding emotional challenges, the pace of change within service as well as the rising demand from students needs as the Health Visitor Implementation Plan (Department of Health (DH), 2011) moves forward are all vulnerability factors for professionals working in this area. It is important to bear in mind that where a visit has been difficult or emotionally demanding the content of the work undertaken, especially within safeguarding, is not appropriate to be shared with colleagues, friends or family because of confidentiality other than in the context of formal professional information sharing. This can have an impact on the professional feeling alone within their work and not benefitting from the usual social support networks, which are key protective factors (Regehr and Bober, 2005).

The Health Visitor Implementation Plan (DH, 2011) sets out the framework to 'expand

and strengthen health visiting services' and highlights the challenges for the professional. There are three proposed levels for the implementation plan.

The Universal level requires the health visitor to support families who are likely to have limited needs. The emphasis for the health visitor is using their expertise to ensure that development is progressing normally and fine tuning their communication skills to provide reassurance and answer questions.

The Universal Plus level requires a rapid response from the health visitor meaning that other priorities have to be managed. The interaction with a family will be in supporting them with additional needs drawn from a wide spectrum. These may be problems with the adults within the family to issues around child development and/or child behaviour issues. Those needs will have to be identified and an appropriate intervention put into place. Given the criteria families often have to meet in order to access other services, the health visitor is highly likely to be working independently with these families and perhaps at the top end of their own capabilities. These are the families that appear to distress the health visitor most as they are often not subject to a child protection plan and have limited support around them; they are regarded by health visitors as providing the most potential risk.

The Universal Partnership level calls on the health visitor to offer a health perspective for families who have a number of complex issues and are likely to be working with a number of different agencies. This involves managing the relationships between the agencies and ensuring that access to the family is maintained often in difficult circumstances for example where it has been the health visitor who has made the initial referral to children's services.

The health visitor is required to work in a range of settings and the demand to be thinking about what they are about to engage with is a constant one. For any professional who works in the community the demands of travelling between different venues, judging traffic, weather and other impact factors to ensure you are on time makes mental demands.

This is not to suggest that professionals are unable to cope just that juggling these demands has an impact.

It is unlikely before the visit that the health visitor will know what type of family they are engaging with, as unlike other services they do not receive referrals for families who meet a certain criteria. The resilient health visitor moves between these environments with a swan-like grace and is often found exhausted but satisfied at the end of long day travelling between appointments.

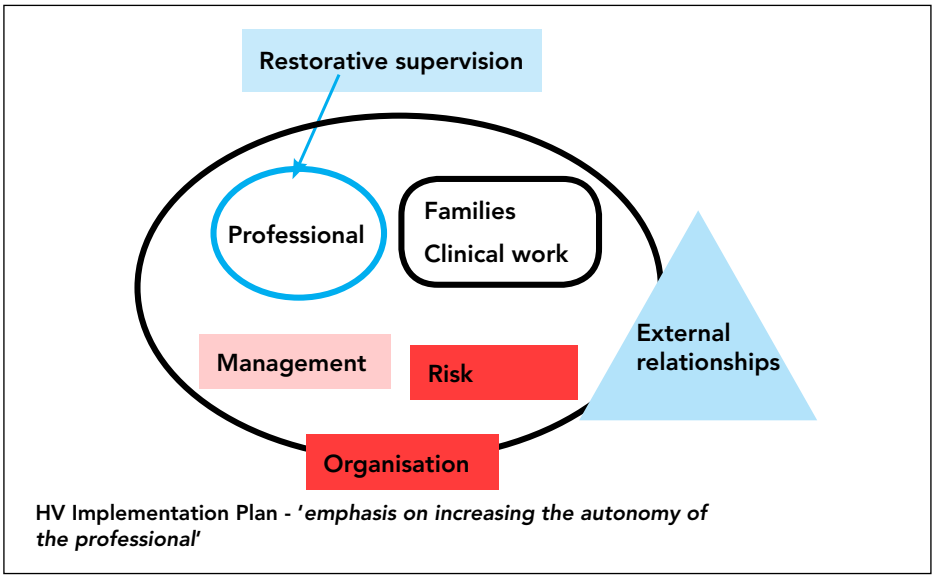

Figure 1. In relation to current supervision

The increase in demand for their services especially in child protection reviews and poor previous numbers has meant that health visitors are often not in a resilient mind set. We know that where the emotional burden of the role is not dealt with and processed it can impair performance (Wallbank and Hatton, 2011).

The restorative clinical supervision model

To deliver an effective programme of care, health visitors need a constructive space to think about and process their experiences. Too often within services the emphasis of clinical supervision is on the content of the work and seen as a managerial function rather than in building the resilience and autonomy of the professional.

The model of restorative supervision being rolled out within the West Midlands (Wallbank, 2007) ensures that professionals improve their capacity to engage with families with decreasing risk. They are able to build constructive relationships with their immediate management team and the wider organisation improving the workplace environment and ensuring that external relationships remain positive, meaning the health visitor can be supported within a wider team context (Figure 1).

Extensive piloting

The model was initially piloted in 2007 by Sonya Wallbank working with midwives, doctors and nurses working in obstetric and gynaecology settings (Wallbank, 2010). The pilot programme was designed to address the emotional demands of staff working in these areas and support them to build resilience levels reducing their own stress and burnout levels. The results showed restorative supervision increased compassion satisfaction (the pleasure one derives from doing their job) as well as reducing burnout and stress by over 40% (Wallbank, 2010).

Following the success of the initial pilot, further restorative programmes were commissioned working with health visitors and school nurses who were engaged in the NHS West Midlands leadership programme (Wallbank and Hatton, 2011). The supervision was considered important given anecdotal evidence both nationally, regionally and locally that within health visiting services morale was low, retention remained a real issue for several providers and high levels of long-term sickness and stress were resulting in a negative impact on their services (Wallbank and Hatton, 2011).

Baseline results of the pilot studies showed a lack of training in the delivery of supervision, high burnout and stress scores impacting on the professionals' capacity to think and make decisions in practice. Qualitative results showed participants valued the experience of supervision and it appeared to restore their ability to think clearly and make decisions. In summary, the model of clinical supervision used was effective in reducing the amount of stress and burnout professionals were experiencing and would restore their capacity to think and make decisions, potentially reducing

risk within their organisation (Wallbank and Hatton, 2011).

Staff participation in the development and piloting of the model meant that we had developed a programme of restorative supervision which contained the key ingredients to a resilient and effective member of staff.

What has been developed

The model uses the Solihull Approach, motivational interviewing and leadership concepts, among others, to support professionals working with complex families. The emphasis of the model is on the resilience of the professional, improving their own health and wellbeing and supporting their capacity to think and make complex clinical decisions.

Following investment from the NHS West Midlands leadership programme, a one-day training programme was developed. The day covers a range of topics including the theoretical basis for supervision, an outline of the model and how the participant can use the model to support them in their work. The programme is supported by a comprehensive manual to support learning beyond the training.

The second aspect of the training programme was for the professional to receive six sessions of supervision from a member of the supervisory team. Participants are then supported to cascade the model to no more than four of their colleagues using a supervisor readiness scale (Wallbank, 2011). This ensures that participants have gained the skills they need to deliver the model of supervision and that they are ready to do so. They are also not overwhelmed by the demand of taking on too many supervisees. This way of training also ensures that organisations commissioning the training are left with a sustainable model.

The training team consists of the programme lead, clinical psychologist, nurse consultant and a group of clinical supervisors who have health visitor backgrounds. The programme team have also attracted a number of other staff who work with us on a consultancy basis to deliver the programme in their areas. The team also has a full time assistant psychologist to support the research of the programme.

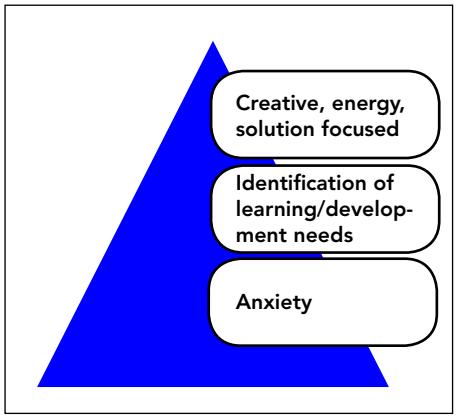

Figure 2. Model of development of supervisees (Wallbank, 2011)

A model of development which occurs within the supervisory session has been developed (Figure 2). This has been widely accepted (Wallbank, 2012) to provide a coherent understanding of why restorative supervision is needed when working with complex families. It shows how the professional moves between the anxiety of managing the risk and supporting complex families, being able to think about themselves and their own learning needs and then becoming creative and energetic enough to think about developing their service. Once participants have been through the programme of supervision they are much more likely to spend a consistent amount of time in the creative zone than the anxiety one as they are more resilient.

Traditional models of supervision tend to emphasise the content of the work being undertaken rather than on the professional delivering the care. This often means a managerial approach is taken through the use of checklists and targets for the supervisory space and the professional suspends their own autonomous decision making. This model of restorative supervision focuses the professional on their own capacity to think and make decisions. It helps the professional reflect on their own contribution to the situations they find themselves faced with and aids clarity of thought.

Current programme activity

The programme is currently being delivered to 249 staff across 13 trusts within the West Midlands. This brings the total number of professionals to have been trained in the model across the UK to over 1 800. The programme has been recommended in the DH service level agreement to Strategic Health Authorities and the Early Implementer site leads are all receiving training in the model from the programme lead.

Supervisors

The programme is overseen by a consultant clinical psychologist. The clinical supervision is delivered by senior health visitors who have varied backgrounds including specialist clinical roles, team management, professional lead role and safeguarding.

Participants

The programme participants are selected differently by trusts. Some have expressed their own interest in being trained, others have been nominated by their managers with the final group responding to a global trust invitation.

Methodology

The questionnaire used to evaluate the restorative programme consists of the Professional Quality of Life Scale (PROQOL) (Stamm, 2009). The ProQol comprises three discrete scales that measure:

- Compassion satisfaction – the pleasure that one derives from being an effective caregiver
- Burnout – feelings of hopelessness, difficulties in dealing with work or carrying out the work effectively
- Compassion fatigue – psycopathological symptoms associated with secondary exposure to stressful events. Stress was measured using the Impact of Event Scale (IES) (Horowitz, 1982). The IES has 15 items, seven of which measure intrusive symptoms (thoughts, nightmares, feelings and imagery) and eight that identify avoidance symptoms (numbing of responsiveness, avoidance of feelings, situations and ideas), and these are combined to provide a total subjective stress score.

Before the training day staff are given information about the restorative programme and the evaluation elements to allow them to give consent to their participation. During the training day they are asked to complete a baseline questionnaire which takes approximately five minutes to complete. This is completed again at the end of the sixth session. The questionnaire data do not contain any identifying features and data are processed anonymously by the programme researcher who analyses the results.

Programme results

Compassion satisfaction

The average score is 37 (SD=7; alpha scale reliability=0.87). About 25% of people score higher than 42 and about 25% of people score below 33. The average score on the burnout scale is 22 (SD=6.0; alpha scale reliability=0.72). About 25% of people score above 27 and about 25% of people score below 18 (Stamm, 2009).

The impact of events measure can be also used to identify levels of clinical concern with

Horowitz (1982) proposing low, medium and high symptom levels based on the IES total score: low=<8.5; medium=7.6 to 19.0; and high=>19 (Horowitz, 1982).

The results show that the restorative supervision model (Wallbank, 2010) has been successful in maintaining compassion satisfaction and even suggesting a slight increase in this area. Compassion satisfaction is a protective factor against stress and burnout; we know that when we gain pleasure from an activity, even if it is stressful, we cope better. Burnout has reduced by 43% and stress by 62%; this will mean a calmer workforce who are able to think more clearly.

Table 1. Latest programme results (n=1805)

Scale measure	Regional baseline (standard deviation)	Regional post supervision (standard deviation)
Compassion satisfaction	44.20 (4.18)	44.72 (4.17)
Burnout	42.81 (4.23)	24.71 (5.13)
Stress	43.35 (4.12)	16.86 (4.02)

Key: • 22 or less Low • 23-31 Average • 31+ High

Key points

- Clinical supervision is recognised as a helpful tool for professionals working within clinically demanding roles
- Less is known about the key ingredients for a positive supervision experience for health visitors
- The Restorative Clinical Supervision programme has evidenced a reduction in stress, burnout and increasing compassion satisfaction for nearly 2000 participants
- Training professionals to offer restorative supervision improves the capacity of supervisees to think and function at their best an essential requirement given the current demands on the health visiting profession

Learning from the programme so far

The effectiveness of the model is inextricably linked to the approach that organisations have taken in developing a more reciprocal relationship with their staff teams. Where staff perceive that they are being supported by the introduction of this model of supervision they are more able to build productive rather than adversarial relationships even where times are difficult.

Changes to fundamental elements of how professionals deliver their programme of care matter deeply to staff. Changes of base or where a member of staff completes their clinical work from; have a largely negative impact on staff productivity. This may be as a result of change fatigue within health visiting but needs to be thought about wisely to ensure that an appropriate balance between service need and staff wellbeing are weighed up. Often, changes are not essential and the status quo can be preserved to avoid unnecessary conflict. Where changes need to be made to meet service productivity levels, having a staff team who are on board with changes is crucial.

There are numerous pockets of good practice occurring across the profession and the motivation to support families and children is very high. Developing a model of service promotion and sharing good practice is fundamental if the benefits of the Health Visitor Implementation Plan are to be sustained beyond 2015. Raising the profile of individuals and celebrating the success of a service appears unusual within health visiting services, and this requires strong leadership to change the culture.

Future research

The programme will continue to research the impact of the investment within the West Midlands and beyond. We are looking at how the model has impacted upon the relationship between the professional and the family using a web-based questionnaire and formalising the anecdotal evidence of the impact for the wider organisation. This will form part of our final impact evaluation.

One of the inadvertent benefits of the programme is the professional being able to focus on their own health and wellbeing. Anecdotal evidence identified by supervisors suggests that professionals appear able to think about how they are functioning and spend more time thinking about what they eat and how they exercise, which is having a positive benefit to their health. The second phase of the programme research is, therefore, looking at measuring health behaviours with a questionnaire, cortisol, heart rate and blood pressure to determine the programmes impact on the physiology of the participant.

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