The characteristics of effective clinical and peer supervision in the workplace: a rapid evidence review

Final report

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Executive summary

This report presents the key findings from a literature review: to explore the characteristics of effective clinical and peer supervision in the workplace. The aim of this report is to provide evidence of what makes clinical and peer supervision effective and to highlight potential barriers. The review used the following definition for clinical supervision:

> *"This relationship is evaluative, extends over time and has the simultaneous purposes of enhancing the professional functioning of the more junior person and monitoring the quality of the professional services."* (p.8)(1)

The review used the following definition for peer supervision:

> *"Supervision and consultation in individual or group format, for the purposes of professional development and support in practice…includes a critically reflective focus on the practitioner's own practice."* (p.7)(2)

Research Aim

To understand the characteristics of effective clinical and peer supervision in the workplace.

Research Objectives

- To understand what makes clinical and peer supervision effective.
- To explore how systems of effective clinical or peer supervision may be implemented.
- To explore opportunities for the HCPC to engage and support stakeholders to enhance support and supervision for registrants.

Research Questions are set out below with the summary of findings.

Methods

A rapid evidence assessment (REA) has been used for this study using rigorous methods of appraising and synthesising evidence in a systematic way using inclusion/exclusion criteria.(3) It is a method usually adopted to help inform new policies.(4)

The following five databases were searched to ensure the correct professions were included: CINAHL, OVID Embase, OVID Medline, OVID Psychinfo and ProQuest. The criteria from included papers were: 1. Papers that include clinical supervision and/or peer support in the workplace, 2. Papers that include a regulated healthcare profession, 3. Papers published within the last ten years 4. Papers that include primary research and systematic reviews, 5. Papers with quantitative, qualitative or mixed methods, 6. Papers written in English, 7. Papers reporting on a western culture setting.

Summary of Findings

The search identified 15922 papers, which were screened using the criteria listed above. Following removal of the duplicates and exclusions, 809 full papers were read, leaving 135 full papers included in the review.

1. *What do individuals need from a system of clinical or peer supervision, and what areas should supervision focus on?*

The evidence highlights that a key factor is the relationship between the supervisor and supervisee. Ideally, this is based on trust. However, having a supervisor who is an expert in the field adds to their credibility. Receiving constructive and timely feedback was identified as important for future development.

2. *What are the outcomes of effective clinical supervision and peer supervision?*

It seems that benefits are evident for the individual, from reduction in stress and anxiety to improvement in job satisfaction. Effective supervision also benefited the team by creating a more supportive work environment, which in turn has led to improved patient care. There was also some evidence on the damaging effects for the individual when there is no or poor supervision in place.

3. *What are the barriers to effective clinical and peer supervision?*

There were several barriers to effective supervision, such as a lack of time and heavy workload which impacted on the level of support, quality and flexibility of supervision delivered. Supervision was not always perceived as a priority by supervisors or supervisees which affected uptake and engagement in supervision. There was not always management support or resources available for supervision such as support and training for clinical supervisors and peer supervisors. Moreover, there was a lack of understanding and clarity on what the supervision role entailed and its purpose.

4. *How much supervision is appropriate?*

There was scant evidence on the ideal length and frequency of supervision to be effective. However, most studies reported on the benefits of regular sessions ideally between weekly and fortnightly. There was also a suggestion that there was a place for ad hoc supervision to both meet the needs of service but additionally ensure staff wellbeing.

5. *Could distance clinical or peer supervision be effective?*

Supervision provided using technology when personnel are at a geographic distance has been found to be effective, particularly when no other options are available. However, distance supervision is limited to providing individual or career support as no external observations of clinical practice can be made, unless separate validated assessments can be shared with the supervisor.

6. *What should employers consider and focus on when offering or designing clinical or peer supervision?*

There were several key factors that employers should consider. These are building a good, quality relationship between the supervisor and supervisee, and the provision of protected time for supervision. In addition, on-going support for both supervisor and supervisee should be offered through training and recognition of the supervisory role. The way feedback is provided should also be considered for both the supervisee and supervisor. Employers need to have a clear focus on the purpose of the supervision to ensure expectations are met.

7. *How should a system of supervision be implemented?*

There are several considerations to take into account when implementing supervision. These include making sure the needs of the supervisee are understood and that supervision is tailored to those needs. There is a need for different supervisors to have different roles; such as a line management role or a more personal/reflective role. There is also a need for a person-centred approach with clear boundaries, tasks, ground rules and good record keeping. Another consideration needs to be given to the structure of the supervision; whether or not it is conducted on a one to one basis, group, or a mix of both. A mix of both approaches was found to work well as both approaches offered a different focus of support. There needs to be management support and buy in with organisational support, with some evidence suggesting that supervision should be mandatory to increase the value placed upon it.

8. *Is there any need to implement supervision differently for different professionals?*

There is some evidence that certain types of practice may require more self-care due to the emotional strain experienced by the service delivery. Staff who regularly face these challenges tend to already have supervision in place, but other professions may also need access to this support when the working environment is demanding. Having a supervisor who is willing to meet on an ad hoc basis to respond to staff issues was also recognised as an important attribute of effective clinical supervisors.

9. *Are there circumstances in which clinical or peer supervision is preferable to traditional models of managerial supervision?*

We have identified that line managers will also have to consider the organisation and flag up any risks or concerns identified from supervision. External supervisors can focus more on what the individual brings to supervision, and provide personal and career support. Supervision has been subdivided into three main areas: managerial/administrative, educational and supportive and it has been acknowledged that these three areas should overlap and that supervision needs to be flexible to meet the needs of the service and the individual.(5) However, finding a line manager who can balance the needs of the service with individual needs may be challenging given evidence about the need to choose or match the supervisor to the supervisee, particularly when there are cultural differences. Therefore, effective clinical supervision may best be delivered by several supervisors, or by those who are trained to manage the overlapping responsibility.

Key characteristics of effective supervision

This review has identified that effective clinical and peer supervision is based on the following ten characteristics:

1. When supervision is based on mutual trust and respect.
2. When supervisees are offered a choice of supervisor with regard to personal match, cultural needs and expertise.
3. When both supervisors and supervisees have a shared understanding of the purpose of the supervisory sessions, which are based on an agreed contract.
4. When supervision focuses on providing staff support the sharing/enhancing of knowledge and skills to support professional development and improving service delivery.
5. When supervision is regular and based on the needs of the individual (ideally weekly, minimum fortnightly). Ad-hoc supervision should be provided in cases of need.
6. When supervisory models are based on the needs of the individual. This may include one to one, group (peer supervision), internal or external, distance (including the use of technology) or a mix.
7. When the employer creates protected time, supervisor training and private space to facilitate the supervisory session.
8. When training and feedback is provided for supervisors.
9. When supervision is delivered using a flexible timetable, to ensure all staff have access to the sessions, regardless of working patterns.
10. When it is delivered by several supervisors, or by those who are trained to manage the overlapping responsibility as both line manager and supervisor.

Contents

1. Introduction

This report presents the key findings from a literature review: to explore the characteristics of effective clinical and peer supervision in the workplace. The aim of this report is to provide evidence of what makes clinical and peer supervision effective and to highlight potential barriers.

2. Background

As a regulator of health and social care professionals, the Health and Care Professions Council (HCPC) sets standards for the training, professional skills and behaviour of registrants to protect the public. The HCPC is committed to providing tailored guidance and support where appropriate to ensure that these standards are met. As of April 2019, the HCPC regulates approximately 370,000 individuals (registrants), including 16 varied professions in both NHS and private environments.

In 2016, the HCPC commissioned a study to understand the reasons for the disproportionately high number of complaints to the HCPC, looking at two professions in particular: paramedics and social workers.(6) Inadequate supervision was thought to be a factor associated with these findings, creating an environment in which problems and complaints are more likely. The report suggested that workplace supervision is integral to the provision of safe and effective healthcare systems, and the prevention of mistakes and problems in the workplace. The report also highlighted that many professionals report difficulties in the context of traditional managerial supervision that can be linked to organisational tensions, poor relationships between managers and subordinates, and a lack of resources. The research included a Delphi exercise in which many responses reflected a desire to 'create opportunities for peer support and appropriate professional supervision'. This was separately recognised in a study with paramedics, where over half of respondents rated peer support as being helpful or very helpful in dealing with stressful and traumatic situations.(7)

The HCPC are keen to respond to findings from this research, and to proactively engage with employers to help enhance support and supervision for registrants. However, it is crucial to firstly understand the characteristics of effective clinical and peer supervision in the workplace. This is also likely to be integral to engaging and supporting stakeholders in this area.

Clinical supervision

Supervision includes an ongoing professional workforce relationship, between two or more staff members with different levels of knowledge or expertise, for the purposes of support and the

sharing/enhancing of knowledge and skills to support professional development.(5) The desired outcome of this is improvement in service delivery.

Most definitions of supervision emphasise the promotion of professional development and ensuring patient and client safety. Clinical supervision focusses on the progression of clinical practice through professional guidance and support.(5) Nancarrow *et al.* outlined three functions of supervision – managerial/administrative, educational, and supportive. All three functions should be overlapping and flexible.(5)

The following quote by Bernard and Goodyear provides a good definition of clinical supervision:

> *"This relationship is evaluative, extends over time and has the simultaneous purposes of enhancing the professional functioning of the more junior person and monitoring the quality of the professional services."* (p.8)(1)

Peer supervision

Peer supervision differs from more traditional forms of supervision in that it does not require the presence of a more experienced, qualified or senior colleague. Peer supervision often refers to peers in the same organisation working together for a mutual benefit, for example, through provision of feedback, self-directed learning and evaluation.(8)

Peer supervision can be carried out in either a group or in a one to one format depending upon the organisation. Peer models of supervision support these definitions, for example The Psychology Board of Australia (2010) define peer consultation as:

> *"Supervision and consultation in individual or group format, for the purposes of professional development and support in practice…includes a critically reflective focus on the practitioner's own practice."* (p.7)(2)

Borders (2012) identified a number of peer supervision/consultation models which differed in several areas.(9) These included the number of participants, types of structure, qualities of supervisors as leaders (if present), the stated goals, the level of supervision that takes place during the session, and how supervision is implemented.

Need for this research

Supervision is at the core of practice for service-based professionals, in which there should be a sense of shared responsibility for the effectiveness and safety of the practice.(10) It is important to understand this complex process to ensure best practice for the sake of all of the participants involved (practitioner, service delivery manager, clinical supervisor, peers, clients and other service users, the profession itself).

The HCPC have commissioned this rapid evidence review to provide an evidence base to identify the characteristics of effective clinical and peer supervision in the context of regulated professions. These findings will then be used to direct future thinking, such as through the development of new guidance and materials for registrants and employers on the topic of supervision.

3. Research Aims and Objectives

Research Aim

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Research Objectives

- To understand what makes clinical and peer supervision effective.
- To explore how systems of effective clinical or peer supervision may be implemented.
- To explore opportunities for the HCPC to engage and support stakeholders to enhance support and supervision for registrants.

Research Questions

1. What do individuals need from a system of clinical or peer supervision, and what areas should supervision focus on?
2. What are the outcomes of effective clinical supervision and peer supervision?
3. What are the barriers to effective clinical and peer supervision?
4. How much supervision is appropriate?
5. Could distance clinical or peer supervision be effective?
6. What should employers consider and focus on when offering or designing clinical or peer supervision?
7. How should a system of supervision be implemented?
8. Is there any need to implement supervision differently for different professionals?
9. Are there circumstances in which clinical or peer supervision is preferable to traditional models of managerial supervision?

4. Methods

A rapid evidence assessment (REA) has been used for this study. A REA is similar to a systematic review in that they both use rigorous methods of appraising and synthesising evidence from previous studies in a systematic way using inclusion/exclusion criteria.(3) However, restrictions on the data retrieved are placed on the search at the data collection phase. This is important given that there is a large amount of literature on the topic of effective clinical and peer supervision and a limited time to complete the study. It is also a method usually adopted to help inform new policies.(4)

4.1 Search Strategy

Following advice from a data analyst at Newcastle University we refined our research strategy and the most appropriate databases to use for the search. The following databases were used to ensure the correct professions were included:

- CINAHL, Allied and Health Professionals literature
- OVID Embase, Medical literature
- OVID Medline, Medical literature
- OVID Psychinfo, Psychological literature:
- ProQuest, Social Science literature

A systematic search of each database was carried out in line with our search strategy. Search terms were developed using key words from the tender document and key papers, including healthcare professions, supervision type and effectiveness (see appendix 1 for a breakdown of individual search terms used for each database).

Restrictions were placed on the databases in line with our search strategy. These included:

- English language only papers
- Papers published within the last ten years
- Papers that are primary research or literature searches
- No commentaries, dissertations, thesis, letters, or opinion pieces

4.2 Procedure for screening of data

All citations were downloaded to Endnote (the reference management database) and duplications were removed (n=2683).Two researchers (AK & CR) independently reviewed the same 500 titles and abstracts to make sure that the same papers were being included/excluded. Any discrepancies were

discussed and the inclusion/exclusion criteria was refined as needed. All 13239 titles and abstracts were screened by the researchers and allocated to folders in Endnote – Include for full review (n=809) or excluded (n=12430).

4.3 Procedure for quality assurance

We conducted a pilot data extraction exercise to ensure quality assurance and that all researchers interpreted the papers and extraction form in the same way. From the titles in endnote two papers were randomly identified and all four researchers (AK, CR, JI, SF) independently reviewed several papers using the inclusion/exclusion criteria to ensure rigour and quality (see table 1). We then held a meeting to discuss the process. Following discussion, the inclusion and exclusion criteria was revised to exclude; papers from non-western countries, university settings, students or training contexts, non-formal or un-structured supervision, and one-off events (see table 1). This exercise of independently reading full papers was repeated with a further ten papers to check consistency of inclusion/exclusion and data extraction. The data extraction framework was revised following this initial review of papers. Barriers to supervision were added, along with characteristics of supervision, and a specific code for whether it is clinical supervision, peer supervision, both or other. (See appendix 2 for data extraction framework).

It is also important to note here that papers discussing professions outside of those that the HCPC regulate (such as doctors and nurses) were included. This was because the researchers recognised that much research has been conducted and published in the area of supervision amongst these other professions, further supporting the research question concerning what makes effective supervision.

Table 1: Revised Inclusion/exclusion criteria

INCLUSION CRITERIA FOR PAPERS

1. Papers that include clinical supervision and/or peer support in the workplace
2. Papers that include a regulated healthcare profession
3. Papers published within the last ten years (to be revised if necessary)
4. Papers that include primary research and systematic reviews
5. Papers which are quantitative, qualitative or mixed methods
6. Papers written in English
7. Papers reporting on a western culture setting

EXCLUSION CRITERIA FOR PAPERS

1 = Focus not on formal and structured clinical/peer supervision

2 = Not in healthcare context

3 = University setting

4 = Not evidence based

5 = Paper not written in English/outside review period

6 = Supervision of children/animals/patients

7 = Non-western culture

8 = Other (please describe briefly)

4.4 Data extraction and review of full papers

Any papers that were borderline as to whether they were relevant or not, at the initial stage of title/abstract screening, were included to read in full. Therefore, a very clear inclusion/exclusion criteria and detailed data extraction form was used to ensure rigour and effective screening of the papers (see appendix 2).

Full papers were retrieved from Google Scholar or University library databases held online. Any papers that we have not been able to retrieve in this way were requested through interlibrary loans. Full papers were allocated to each of the four researchers and a record was kept on Endnote using a specific ID key of who reviewed each paper. Papers were read using the inclusion/exclusion criteria and input onto the data extraction form by way of an excel database. Researchers held regular meetings to ensure that quality was maintained and to discuss any uncertainties or queries that arose from the papers.

4.5 Synthesis of papers

Once the data was entered onto the data extraction database, the data was analysed using a thematic synthesis,(11) which is a useful approach when aiming to pull out common elements across the heterogeneous literature. These themes were used to answer the research objectives and the research questions posed by the HCPC.

4.6 Project management

Meetings via teleconference were held every fortnight with members of the Policy and Standards team within the HCPC to provide updates on the project.

5. Findings

A full review of papers was conducted on 809 publications from nearly 16,000 initially identified (see Figure 1). The final number of included papers was 135, with 674 being excluded.

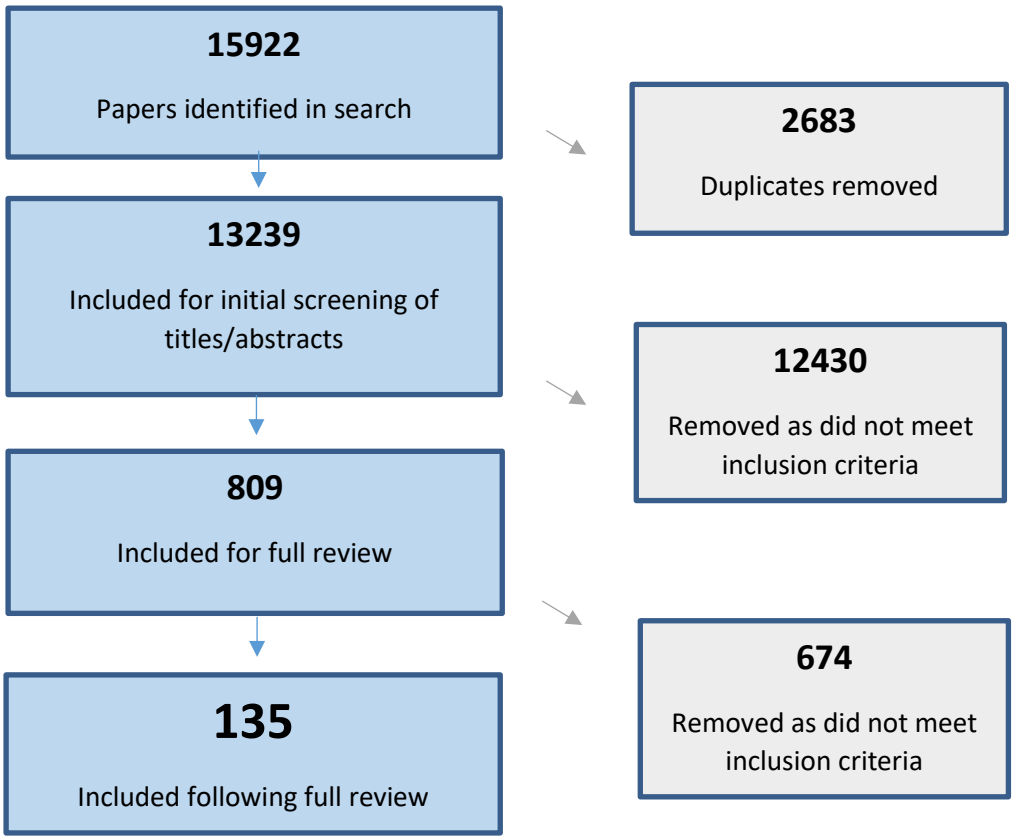

Figure 1: Flow Chart of Papers included in full review

5.1 Reasons for exclusion of papers

Of the 809 papers included for full review, most of the papers excluded lacked an evidence base, or the focus of the paper was not on formal and structured clinical/peer supervision. Instead, the focus was often on a specific training programme, assessment or technique, without the ongoing-relationship, which was identified as necessary in the literature. Many papers were also excluded as the focus was on students, within a university setting, or studies were conducted in a non-western culture.

5.2 Summary and demographics of papers included

This section of the report provides a summary of the demographics of the papers included in this report (table 2). The table below gives a breakdown of demographics with a more detailed table provided in appendix 3.

Table 2: Summary of demographics of included papers

Healthcare Profession	**Number of papers**
Nurses	42
Doctors	33
Psychologists	13
Social worker	12
Physiotherapists	9
Occupational Therapists	6
Midwives	5
Allied Health Professionals	3
Counsellors	3
Dieticians	2
Mental Health workers	2
Dentists	2
Health visitors	2
Speech-Language Pathology Assistants (SLPAs)	2
Ambulance Service	1
Music Therapists	1
Exercise physiology	1
Podiatry	1
Applied Behaviour Therapists	1
Audiologists	1
Radiation therapists	1
Emotionally focussed couple therapist	1
Home health aides	1
Cognitive behavioural therapist	1
Setting	**Number of settings**
Secondary care	50
Community	30
Mixed	26
Other	18
Primary	8
Social service organisations	3
Research Design	**Number of research designs**
Qualitative	53
Quantitative	50
Literature review	15
Mixed-methods	15
Action research	1
Case studies	1
Unclear	1
Type of intervention	**Number of types of interventions**
Clinical supervision (Inc Individual & Group)	110
Peer supervision	22
Mix	3
Country	**Number of countries**
Australia	38
UK	31
USA	24
New Zealand	11
Canada	7
Various	7
Denmark	5
Sweden	4
Norway	4
Finland	3
Belgium	1
Germany	1
Switzerland	1
The Netherlands	1

Setting

A range of countries were represented across all of the included papers, with the majority being from Australia, New Zealand, USA, Canada, and the UK. The findings were further diversified by the broad set of health and social care professions included in the review. The majority of papers included doctors, nurses, psychologists and social workers. Examples of other allied health professionals included were; music therapists, physiotherapists, occupational therapists, speech and language therapists, podiatrists, dieticians.

Research Designs

Papers included in the review were a mix of qualitative papers (n=53) utilising interviews or focus groups data and quantitative papers (n=50) utilising surveys and questionnaires. Several papers used a mixed methods approach (n=15) and literature reviews (n=15).

Type of supervision

Of the included papers, a large majority focussed on clinical supervision (n=110), with a minority focussing on peer supervision (n=22), or both (n=3). These included both individual and group supervision sessions. Within the literature there were several types of clinical supervision and peer supervision discussed. However, there was not always a clear distinction between different types of supervision, and terms were often used interchangeably such as peer supervision and peer mentoring. Whilst selecting and reviewing the papers we used the definitions outlined in the introduction of this report to help distinguish between the two main interventions. The two main interventions included:

- **Clinical supervision -** This was conducted either in a one to one or small group situation by a senior member of staff or by a more experienced member of staff. Clinical supervision included: action planning; reflection on clinical situations; role development and training; indirect and direct supervision, and included supervision from both internal and external organisations.

- **Peer supervision -** Examples of specific types of peer supervision (including those labelled as 'group' supervision) included: reflective supervision; sharing views on collaboration and teamwork; and advice and career planning and guidance. Interventions included discussion of interpersonal aspects of patient care and discussing areas of professional and career guidance. Peer mentoring was also discussed in the papers, which included: individual

sessions; simulation mentoring; group and distance mentoring/supervision; collaborative and facilitative mentoring tele-mentoring. Throughout the report, we refer to peer mentoring as peer supervision, as these definitions were used interchangeably by authors.

The following section addresses the research objectives and answers the specific research questions. Where applicable examples of specific studies and supervisory interventions will be highlighted from the literature.

5.3 Synthesis of data

5.3.1 What do individuals need from a system of clinical or peer supervision, and what areas should supervision focus on?

An open, supportive and safe environment

There was considerable evidence to highlight that having an open and safe environment, where supervisees feel comfortable and trust their supervisor and where they have the opportunity to reflect on practice and ethical issues was seen as an integral part of supervision.(12-36) For example, in a study involving therapists in an American primary care setting,(37) effective supervisors created a safe and secure environment, where they were approachable, respectful and had the interests of the supervisees' welfare at heart. This was reported as being important for supervisees to be able to understand and identify their own emotional experiences and relate them back to their clinical practice.(37)

Having the time to discuss personal issues based on the needs of the individual was identified as an important focus for supervision.(33, 34, 38, 39) A study by Wilson looking at clinical psychology therapists from several international countries in a range of healthcare settings reported the importance of having 'space' to discuss personal aspects of the clinical role in a confidential, open and non-judgemental environment where supervisees could discuss issues freely.(34) In addition, having the space to be able to have discussions confidentially was identified as important to help facilitate effective peer supervision in a UK dental study.(40)

Lastly, the literature emphasised that good supervision is determined more by process, rather than content.(13) Having the correct process generated energy and enthusiasm to face and work on challenges in practice; share clinical issues; build competence and develop new clinical insights.

Establishing a supervisory relationship based on trust and respect

Being able to develop and build a positive relationship, based on trust with the supervisor, was seen as very important to a wide range of professions.(5, 13-15, 37, 41-46) Developing a relationship based on trust was facilitated by having the opportunity to be able to explore each other's belief and value system in a neutral space, away from organisational hierarchies and the workplace, and was seen as helpful for social workers and psychologists.(8) Another aspect of this was reported by UK nurses, who recognised effective supervision provided support to manage emotions and feelings in an open and reflexive manner.(47, 48)

The literature suggested that effective supervision should be established through regular meetings with protected time and in a private space.(25) Supervisees appreciated spending time with supervisors to explore any differences between them, thus allowing the supervisor and supervisee to learn together, furthering supervisor credibility as they developed a shared understanding of work related issues.(34)

In addition, the supervisee needed to respect the supervisor,(34) both personally and professionally. Supervisors' self-disclosure was perceived as positive, particularly regarding their own experiences, knowledge and values. This helped to normalize supervisees' experiences and encouraged supervisees to share their own perspectives.(48)

Ideally, supervision should be provided by a credible supervisor, who is also an expert in their professional field. Supervisors who were respected in their own profession were more likely to be viewed as a credible and trusted supervisor, helping to foster respect. Supervisees maintained that these supervisors had a better understanding of work related issues and were better placed to support them.(15, 16, 34, 43, 49, 50, 51)

Lalani *et al*. reported that having a peer supervisor who was an expert or well-connected in their own field or area of interest increased both the credibility and the quality of the peer supervision experience.(49) It helped with sponsorship of the supervisee, for example, through helping to promote their career via networking opportunities and providing advice around publishing.(49) Having familiarity and experience of the cultural and organisational context in which the supervisee was working in, was also seen to add credibility to the supervision relationship, as identified by a study involving community psychologists.(43) Mutual trust and respect was also reported as an

important factor to enhance the quality of supervision by art therapists in a study by Daveson *et al*.(50)

Wilson conducted an analysis of supervisory encounters to identify what supported effective supervision (from a systematic literature review). Wilson found that the most important aspect of supervision was the quality of the relationship with the supervisor. The supervisor needed to be supportive, caring, open, collaborative, sensitive, flexible, helpful and non-judgemental.(34) Evidence suggests that being flexible in the approach to supervision (such as, having supervision at different times of the day to accommodate shift patterns and in content) was valued by individuals (see section 5.3.3).(5, 10, 14, 34, 41, 52-54)

Nancarrow *et al.* carried out a study with allied health professionals (specific professions were not provided) who worked in rural and remote settings in Australia. Findings showed that flexibility was important, as supervisees had different needs and required different types of support from the relationship. Needs may also change over time; hence supervision needs to be person-centred and focused on the needs of the supervisee. For example, participants from this study worked in rural and remote areas where face-to-face supervision would incur considerable time and travel costs and therefore the use of technology (see sections 5.3.5 & 5.3.7) could be used to support clinical supervision.(5)

Culturally aware supervisors

Supervisors must acknowledge the uniqueness of each person and understand that every person has their distinct self-identity, apart from the culture that shaped them.(14) Supervisors need to be aware of their own biases, as no one is culturally neutral, and working with colleagues from different backgrounds is considered a core supervision skill. Culturally competent supervision includes seeing different cultures as an asset: exercising humility, valuing diversity in the workplace and empowering workers by providing them with useful insights into practice with diverse and marginalised service users. Having cultural awareness can improve cultural diversity in the workplace and improve communication, reflection, sharing ideas and problem solving.(13, 14, 55)

Constructive and timely feedback

Many studies reported on the importance of receiving regular and constructive feedback during supervision (5, 18, 19, 34, 37, 56-60) and spending time to reflect on practice.(18, 19, 22, 44, 45, 61) Feedback must be: timely, of high quality, and delivered in a supportive manner. In many cases,

supervision was valued for sharing of tacit knowledge, hands-on learning and real-time feedback.(62) Brink found in a study with nurses and emergency medical technicians in an emergency service setting that feedback was important because it provided confirmation that staff had done the right thing.(19) Brink *et al.* also found that, through group supervision, individuals achieved preparedness for practice and it facilitated a change in their attitudes and behaviour in relation to both patients and colleagues. By hosting group supervision and having the opportunity to discuss clinical scenarios, individuals received affirmation from colleagues in the group. They also received feedback that they had handled the situation well or learned more about what they could do differently in the future. Similarly, Wilson found that feedback from supervisors facilitated learning and encouraged staff development. Findings showed that it was important, and that the supervisor was both able to provide feedback, and also receive it themselves. (5, 19, 33, 34, 45, 58, 62)

Key Domains of supervision

Nancarrow *et al*. sought to identify key domains of supervision, which could form the basis of a supervision framework.(5) Nancarrow *et al* identifies the thirteen key domains in the table below.

Table 3: A table to explain the thirteen key domains of a supervision framework (adapted from Nancarrow *et al* (2014)

Key Domains	**Summary of what needs to be considered**
Definition of supervision and support	There is a need to have a clear definition of the type of supervision and support.
Purpose and function	There is a need for supervisory frameworks to define the aim or intention of supervision.
Models of supervision	To be clear on the model of supervision being undertaken. There were 3 main types of supervision mentioned; normative, functional and restorative. However, not one size fits all situations in a healthcare setting.
Contexts of supervision	Where (context of) the supervision takes place (different situations/locations will need different planning and involve different issues e.g. travel, time, logistics). This domain may impact on the other domains.
Content of supervision	Two main types of content within supervision was identified: Practitioner-focused – the needs of the practitioner - or patient focused – practitioners' needs are accounted for but all issues discussed and addressed in supervision should relate to patient care. The two different focuses will drive the content.
Modes of engagement in supervision	How the supervision takes place e.g. face to face, at a distance or a combination of both. Each mode has a different way of engaging the supervisee e.g. face to face could be through shadowing in the workplace, whereas distance could be via email or skype.

Attributes of the supervisor	Attributes of the supervisor are usually broken into personal (e.g. warmth, caring/empathic, motivated to be a supervisor) or supervisory (organisational skills, awareness of safe levels of practice, knowledge of the policies and organisation, ability to provide and receive constructive feedback).
Supervisory relationships	There are three main types of relationships within supervision: one to one support, peer support and group support. There is also a fourth identified as the day to day support or informal support if a supervisee has real time access to their supervisor in a work situation (HETI Super guide for allied health professionals).
Responsibilities of the supervisor	Responsibilities of the supervisor e.g. awareness of and up to date on policies, procedures and practices of the supervisees' and supervisors' workplace; maintenance of up to date records of supervision sessions and confidentiality; being supportive etc.
Structures/process for supervision and support	For example, the development of an agreement of shared understanding of supervision and expectations between supervisor and supervisee. Having a standardised form(s)/document(s) to log information.
Facilitators and barriers to supervision and support	Facilitators could be initiated individually or initiated organisationally (e.g. *individually* -developing/maintaining a supportive network of clinical supervisors and documenting goals, not taking too many supervisees on, creating enough time for supervision. O*rganisationally* – providing funding, support and appropriate technology for supervision, having flexibility to meet the needs of all supervisees). Barriers (*Individually* e.g. professional isolation, lack of commitment from supervisor, lack of skills and competence of the supervisor. *Organisationally* e.g. cultural resistance, time, lack of access, frequency)
Outcomes of supervision	Measurable supervision outcomes around: *managerial/professional accountability* (e.g. improved patient relationships, improved confidence and competence in practice), *Educational/skills and knowledge development* (e.g. increased professional knowledge, improved communication skills and reflective practice) and *support* (e.g. being listened to, increased social support, stress relief, peer support).

Summary

The evidence highlights that the relationship between the supervisor and supervisee is a key factor of effective supervision. Ideally, this is based on trust. Supervisors also need to be aware of supervisees' individual differences and cultures. Having a supervisor who is an expert in the field also adds to their credibility, which in turn will likely lead to greater supervisee engagement. Receiving constructive and timely feedback was identified as important for future development.

5.3.2 What are the outcomes of effective clinical supervision and peer supervision?

Job satisfaction and staff retention

Several studies reported that effective supervision was found to have a positive impact on staff retention.(63-68) and a positive effect on professionals' job satisfaction.(17, 69, 70) There was also evidence that Continual Professional Development (CPD) and training for supervisors themselves meant that they were more likely to stay in their role.(71) A study on nurses working in secondary care identified that supervision was seen as a way of valuing staff.(72) Gibson *et al* found that regular and high quality supervision had a positive effect on therapists' wellbeing.(73)

Improvement in confidence and leadership skills

Supervision has been found to empower leadership, promote an innovative climate (23, 24) and promote self-development.(74) A study on physical therapists taking part in small group supervision reported that their confidence had improved and it had enhanced their critical thinking.(75) An improvement in leadership and innovation was also reported. Similarly, a study by McMahon & Errity (30) reported that supervision increased clinical and counselling psychologists' confidence in their role.

Reduced stress and anxiety

Stress and anxiety were found to be reduced through supervision in a number of studies.(13, 17, 19, 23, 24, 37, 51, 64, 76-80), particularly as it provides a medium for sharing skills, knowledge and resources, in a supportive environment.(19, 37, 51)

Group supervision was found to help reduce stress and anxiety in the following two studies. Brink *et al.* carried out a focus group study with nurses and emergency technicians who worked in the ambulance service.(19) The aim of the study was to evaluate the experience of group supervision, and to explore its impact on the participants' personal and professional development. Participants reported on the importance of these structured group supervision sessions, where they were able to talk through and reflect on professional scenarios both emotionally and rationally. They stressed the importance of supervision sessions for discussing professional situations and difficult issues in a safe, trustworthy and collegial environment. Participants emphasised that these structured work-related encounters reduced anxiety and stress.

Likewise, a study by Brunetto *et al*. with nurses found that group supervision provided the nurses with the opportunity to share resources (such as information, knowledge and skills), share their

issues and support one another.(65) This sharing of information and resources helped to reduce their stress and improved their ability to cope with the demands of the job. A reduction in stress for supervisors was also found, following the provision of training and CPD support for supervisors.(71)

Supervision was found to help with reducing stress and anxiety in the following studies. Dunsmuir *et al*. carried out an online questionnaire with psychologists who worked in the community and reported that high quality supervision helped them to maintain their wellbeing.(78) A literature review carried out by O'Donoghue & Ming-sum found that supervision and effective supervisors (those who planned, listened and reflected) had a positive influence on work stress and support.(17) Supervisors that had good listening skills were also crucial for effective supervision (33, 73, 81) and helping supervisees to problem solve.(81)

Social support (in this instance meaning support received from colleagues) and being listened to were reported by psychiatric nurses as a good way of sharing and increasing understanding between staff to help cope with the pressures of the job.(76) Palmer- Olsen *et al*. also highlighted that supervision enabled therapists to share and understand their own emotional processes and understand how these translated to their own clinical work, rather than be overcome by their clients' emotional experiences.(37)

It was reported that supervision helped participants to manage their feelings.(77) Supervision was also a way of identifying and signposting Occupational Therapist (OTs) and Social Worker supervisees to support services, if needed, and encouraging the use of self-care i.e. understanding the importance of wellbeing and learning to reflect.(79, 82) Beddoe *et al*., in an interview study with doctors working in the community, reported that supervision provided a buffering space between the individual and the impact of the organisation and the stresses of the job.(80)

Better working environment

Several papers highlighted that effective supervision and a supportive working environment can improve the uptake of workplace policies because supervisees understand the importance and reason for the policies.(60, 66-68) One study reported an increase in cultural diversity that led to improved cultural awareness amongst staff.(55) Allan carried out a qualitative study with overseas-qualified nurses exploring their experiences of employment mobility and career progression in the UK. The aim was to gain their perceptions of equal opportunities compared with locally trained staff.

The workplace introduced a peer supervision scheme (details not provided), which was reported to improve cultural awareness and cultural diversity in the workplace.

A study by Chiller & Crisp looked at supervision with Australian social workers and found that supervision helped with improving a better working environment through supervisees having better teamwork and relationships and more support in the workplace, which helped with professional development. This also helped with retention of social workers.(63)

Increased quality of care delivery

Several studies made links with the provision of effective supervision and an increase in quality of care.(20, 24, 77-79, 83-85) A study by Davis & Burke reported that supervision with nurse managers improved communication amongst staff and facilitated reflection, sharing ideas and problem solving.(20) Similarly, a study by Danielsson *et al*. reported that group supervision of supervisors was reported by supervisors to facilitate personal development both pedagogically and through their understanding of their professional thinking.(86) Brink *et al*. reported that group supervision sessions with ambulance service staff were found to foster a greater self-awareness of the way individuals worked in different situations as they were able to share their experiences in the group.(19) Group supervision sessions helped with personal growth as peers in the sessions could affirm that participants had done the right thing when discussing scenarios with patients. Other studies showed that group supervision provided the opportunity to learn from others (81, 87) and had the benefits of reducing time and cost.(88)

A study carried out with nurses in secondary care reported that group supervision had helped supervisees manage their feelings, which they linked to increase in quality of care for their patients.(77) Claridge *et al*. looked at whether direct supervision with resident doctors increased patient outcomes.(85) Results showed that with direct supervision there was a greater uptake of compliance with managerial protocols and patient outcomes were improved (more splenic salvage rates and lower mortality rates).(85)

Negative outcomes when effective supervision is absent

A study by Rodwell *et al*. examined public sector nurses using a cross sectional survey in five general acute hospitals in Australia to investigate forms of abusive supervision, (66, 68) for example, personal attacks and isolation. This was linked to outcomes for nurses, including poor job satisfaction, psychological strain and intentions to quit. The study reported that there was a need for

support for supervisors and supervisees to adhere to zero tolerance policies toward antisocial workplace behaviours and encourage the reporting of untoward incidents. One study also reported on the negative impact of a lack of supervision.(73) In a questionnaire study (including the Maslach Burnout Inventory and the Perceived Therapeutic Self-Efficacy Scale (PTSE)) 81 participants reported that high work demands and lower supervisor support led to lower levels of personal accomplishment scores on the Maslach Burnout Inventory, indicating burnout.

Summary

The research reviewed indicates that effective clinical and peer supervisions leads to benefits for the individual, from reduction in stress and anxiety to improvement in job satisfaction. Effective supervision is also seen to benefit the team by creating a more supportive work environment, which in turn has led to improved patient care. There was also some evidence on the damaging effects for the individual when there is no or poor supervision in place.

5.3.3 What are the barriers to effective clinical and peer supervision?

Lack of time and resources

A lack of time and heavy workloads were found to be the main barriers to effective supervision.(5, 20, 21, 26, 29, 30, 32, 38, 49, 52, 56, 62, 72, 76, 81, 86, 88-100) Many of the papers discussed how supervisors were unable to find time for supervision due to busy environments, which ultimately restricted supervisor flexibility and quality when they did find the time.(57, 83, 101) Some studies reported that there was a lack of opportunity and time for reflection within supervision, which could leave individuals feeling that they had to 'figure things out' for themselves without adequate support.(34, 52) Kutzsche *et al*. also identified that the supervisor role was hampered by supervisees not being directly involved in a specific patient case when working alongside their supervisor, again likely due to time pressures.(36)

Kilbertus *et al.* highlighted that a lack of continuity of feedback meant that it was easy for struggling residents to fall through the net(102) and were more vulnerable because they had less support at work due to their shift rotas.(53) Many noted that supervision was not a priority, for both supervisor and supervisee.(5, 30, 53, 78, 79, 98, 103) As a result, supervision was sometimes perceived to be a luxury.(15) One paper discussed how midwives felt somewhat "self-indulgent" if they took time-out to reflect on practice and examine their own interactions and actions.(59) Instead, they had become

accustomed to just dealing with issues and adverse events, feeling that they were expected to not 'dwell' on stressful workplace issues.

Kenny & Allenby further noted that supervisees perceived group supervision sessions as 'chatting' during work hours and they were not seen as part of work.(103) This type of supervision was perceived to be the lowest priority for both supervisee and employer. A study by Spackman *et al*. found that trainees and consultants gave the group sessions a lower priority than other aspects of the trainees' work.(35) A lack of leadership in the sessions promoted a lax view on attendance and punctuality. Phillips *et al*. also discussed how a lack of leader/facilitator in group sessions was found to hinder attendance. Group members arrived late or left early, which was both disruptive and disturbing. Some participants would also have liked the facilitator to encourage quieter members to contribute.

A lack of adequate resources could lead to an overstretched workforce within which colleagues are unable to support each other effectively.(22) Several participants in one study noted that the provision of formal clinical supervision had declined with resource cuts and pressures on staff time.(22) There was often an expectation that supervisors had the time to develop relationships and would take the time to complete the necessary paperwork prior to and following supervision, which could be time consuming.(84) Jelinkek *et al*. discussed how the level of supervision in their study decreased during unsociable shifts.(59) Supervision was dependent on service demands and was often not a priority if staff were facing insufficient staff numbers in busy environments. Kenny & Allenby also discussed a lack of monetary incentives for supervision, affecting how supervision was perceived and whether supervision was provided or attended.(103) Supervisees only wanted to attend supervision if they were being paid (given protected time during work hours).(103)

Management/organisation not supportive

Organisations therefore need to consider resource and cost implementations to support supervisory sessions.(40) A lack of commitment from organisations and managers can act as a barrier to providing the time and resources that are discussed above.(5, 32, 72) For example, not giving priority to supervision in the workplace or not providing a structure or resources to enable the delivery of effective supervision.(30, 96, 104, 105) In one study this led to supervision having little clinical impact and supervisees found the experience emotionally challenging as inadequate time was given to the process.(104) In busy agency settings, supervision can often be neglected or deferred to accommodate the latest crisis, unless it is made a priority by management.(10) In an Australian study

by Snowdon *et al.*, the authors highlighted that it was difficult for staff to find time to participate in clinical supervision (29), but especially in those professions where clinical supervision was seen as least effective i.e. offered no support, culture of no supervision. Such professions included physiotherapists, dieticians, podiatrists, and speech and language pathologists. Supervision practice had not become embedded in the culture and environment of these professions or in daily practice, with staff not being encouraged to have time to discuss issues with supervisors or work colleagues. Love *et al.* discussed that there needed to be a wider implementation plan of clinical supervision for midwives in Australia, which should include the restructuring of workforce models to create the time and space needed for midwives to engage.(28)

If the management or organisation do not encourage or recognise the importance of supervision, then it is unlikely that it will become embedded into the organisation, thus hindering supervision from becoming the 'norm'. In a study by Koivu *et al*., exploring which nurses decide to participate in clinical supervision, support from empowering and fair leadership was found to be crucial.(23) The study found that the nurse manager's personal view of clinical supervision, and their relationship with staff, largely affected the adoption and uptake of clinical supervision, both positively and negatively. Perception of high administrative burden was an evident barrier (which reduced participation).(24)

Lack of supervisor skills, training and support

A lack of skills and competence of supervisors were identified in a number of papers as being a barrier to providing effective supervision, including personal skills e.g. intolerance, blameful, inflexible.(5) Other studies highlighted issues with being able to deal with unmotivated supervisees;(77, 86) manage differing personality types;(106) a lack of ability to share feelings;(47) inability to give appropriate feedback (59) and inability to focus/understand personal issues.(38) Kilbertus *et al*. found that some supervisors reported not feeling able/comfortable in recognising a failing trainee.(102) Issues arose when either the supervisor or supervisees were unaware of the supervisee's lack of knowledge and skills.(14, 30, 35, 51)

Many papers discussed a lack of training for supervisors being a barrier, ultimately meaning individuals are unprepared and unable to fulfil the role of supervisor.(15, 21, 34, 54, 61, 77, 81, 90, 95, 97, 107-109) There were several papers that discussed a lack of quality supervision due to supervisors' unfamiliarity with professional guidelines (for example standards set by regulators), a lack of role clarity, a lack of ethical standards set in place by employers, and inadequate educational

preparation to gain the knowledge and skills required and understand the supervisor 'scope of practice' and responsibilities.(15) Therefore, a need for clearer guidelines and expectations for supervision was identified. Gonge & Buus (2010) also supported these findings, highlighting that supervisors had varied experience and were given no direction about how to approach supervision, it being down to the individual.(110) For midwives in Australia, although training was given to clinical supervisors, there was a large variation between the length and approach of training programs.(62)

A lack of support from employers when raising concerns about staff was also noted as a barrier to effective supervision.(59) Supervisors were not always told where to signpost supervisees if there were any concerns or they needed to seek support for themselves.(103) One study even discussed how clinical supervision was delegated to the most junior consultants, who also had the least experience to deal with complex underperforming trainees.(111) Supervisors themselves reported wanting more communication, structure and direction in supervision so that they could make sense of when they were making progress.(37, 53) A lack of tools/forms, (or inappropriate use), further hindered this process.(112) Using forms may help to overcome issues that arise when individuals do not work with the same staff each shift and supervisors change.

Supervisors also feared a lack of promotion in their career if they gave supervisees negative feedback (i.e. receiving poor teaching evaluations from supervisees). This could be addressed in supervisor training. Within peer supervision, mentees also reported a discomfort with the evaluation process.(62)

Issues for peer supervisors, as opposed to clinical supervision above, were specifically highlighted as a result of a lack of training. For example, not feeling confident in their role to offer support,(94) difficulty developing relationships,(49) and inadequate ability to develop peer supervisory skills and meet individual needs.(48) One study also highlighted the need for peer supervisors to receive more cultural awareness training.(55) The main barrier to effective and non-discriminatory supervision was the lack of preparation within both the NHS and the care home sector around how cultural differences affect supervision and learning for overseas nurses and their peer supervisors. A lack of cultural awareness also arose in other types of supervision, with one study in particular reporting quite extreme cases of discrimination and a lack of respect amongst social workers.(113)

Studies also reported additional training was needed for both external supervisors (supervisors who work in a different organisation to their supervisee) and those professions who were supervised by

supervisors who worked in a different profession.(10, 13, 14, 40, 103) For example, one study discussed how external supervisors were brought into the organisation, but were not experienced in rural hospital nursing and had difficulty keeping the group focussed and on topic.(10) Supervision which involved supervisees being supervised by a professional who worked in a different profession highlighted differences in: levels of training, their professional roles and responsibilities, misunderstandings between supervisor and supervisee about their professional training, absences of shared theory and language, and differences in professional decision-making processes. Codes of conduct may vary between professional groups,(10, 13, 114) and over sight of ethical practice may be weaker in a mixed professional model. Further disadvantages of supervisors working with different professions to their own were highlighted, including aspects of the professional role not being adequately addressed; not being able to raise all issues with the supervisor and disempowerment due to professional status differences.(13) This type of supervision places a burden of responsibility on the supervisor to have a good working knowledge of the context of practice of other professions. It has been suggested that inter-professional supervision should be in addition to same profession supervision, rather than the only form of supervision in place.

Lack of relationship and trust

Supervisees need to feel that they can trust their supervisor or peers and that they have built up a relationship with them. However, this was often lacking.(16, 20, 21, 42, 52, 63, 115, 116) Palmer-Olsen *et al.* found that supervisors who did not establish a secure supervisory alliance were less effective in helping their supervisees learn to implement a specific therapy.(37) Brunetto *et al*. (2011) reported that if nurses were dissatisfied with their supervisory relationships, they experienced role ambiguity, and were less committed to their hospitals.(64) Further findings indicated that the supervisor relationship explained almost 50% of nurses' lack of commitment to their hospital and increased intentions to leave.(65)

If supervisors are not committed, or supervision feels like a 'tick box' exercise or is too bureaucratic, it is less likely to be effective.(5, 63, 91) It was also noted that sometimes people just do not 'fit' with their supervisor.(34, 45, 46) It was suggested that if the safety of the supervisory relationship was greatly impacted, this could lead participants to cease addressing clinical issues with their supervisor and affected their sense of being 'good enough'. Words used to describe unhelpful supervisors included 'impatient', 'uncommitted', 'late', 'inconsistent' and 'not empathic'. Unhelpful and untrusting relationships led participants to distrust their supervisor's advice, or self-criticise. Where

participants did not experience safety, they often chose not to disclose their own feelings, which could impact on their clinical development.

Lack of understanding about what supervision was and its purpose

Some studies discussed a lack of a common understanding about the role and purpose of supervision.(5, 53, 81, 103, 117) When this was the case, supervisees faced anxiety and sometimes perceived that supervision equated to surveillance.(15, 34, 37, 72, 87, 103) Negative associations with the term 'clinical supervision' also led to a lack of engagement.(15, 40) Love *et al*. discussed that whilst most clinicians understood 'reflection on practice', the majority had never heard of, or been exposed to, the concept of 'clinical supervision'.(15) The word 'supervision' was a negative detractor with midwives conceptualising this as something similar to being 'watched over'. As a result, midwives were initially 'wary' of becoming involved. This study demonstrates that when midwives trust the process and are aware of the benefits that could be gained, they are more likely to engage in supervision. Love *et al*. suggested an implementation strategy be put in place, firstly to include clinical supervision awareness sessions for supervisees and organisational leaders; to inform potential supervisors, supervisees and managers about the supportive nature of the model. This would likely reduce the negative connotations associated with the term 'clinical supervision'. In addition, the name of the supervision process could be clarified, for example, adding the word 'reflection' in some way.(15)

Taylor (2013) reported that group supervision sessions could be unsettling, as the format was more intense and open than anything experienced before.(87) The novelty of the sessions caused supervisees to question the purpose and express doubt over its benefit. During the settling in stage, supervisees lacked confidence and felt uncertain about their role, meaning that they were reluctant to contribute to discussion. Another observation highlighted in the literature was that group sessions could revert to 'moaning'.(40) A lack of engagement arose when sessions were dominated by unrelated personal issues or workplace conflict.(15, 35) Spackman *et al*. also reported that if group discussions became an informal chat, they lost the supportive benefits. Consultant one on one supervision sessions were deemed more appropriate for other issues, which trainees said they would not discuss in a group setting. Individuals that were unaware of the purpose of such sessions did not value this kind of supervision.(35, 51) Training and clear guidelines could aid with this (see section 5.3.2 for additional information), helping supervisees understand the importance and use of supervision.

Contextual factors

Contextual factors were found to either facilitate or hinder supervision. One study highlighted that the type of clinical environment either facilitated or hindered clinical supervision.(110) The key areas identified were organisation location, work shift patterns and work-environmental factors (meeting targets, tempo, cognitive demands, influence at work, and social support). In this study, exploring differences between mental health community staff and general psychiatry ward staff, it was found that only half of those included in the study participated in supervision. Interestingly, it was the ward staff who did not participate in supervision; all community staff attended supervision sessions. It was suggested that this was because supervision was not always offered to ward staff (despite policy at departmental level asserting its importance). Shift work also reduced the amount of clinical supervision that was received (staff working day shift were more likely to take part in supervision because they were able to attend during the day). Supervision can be difficult to implement in rural communities where there may be less staff, yet support is crucial due to professional isolation.(5, 35, 103, 104)

Summary

The evidence found several barriers to consider and overcome when planning and implementing effective supervision. A lack of time and heavy workloads were found to be the main barriers to effective supervision. This impacted on the support offered, and on the quality and flexibility of the supervision being delivered. There was evidence to suggest that supervision was not always perceived as important or seen as a priority by supervisors or supervisees which affected uptake and engagement in supervision. There was a need for management and organisational support to consider both time and resources of supervision. The evidence suggested that this was not always the case and that there was a lack support and resources which impacted on the implementation and effectiveness of the supervision offered.

There was often a lack of support and training on offer for clinical supervisors (one to one) which hindered their delivery of supervision. They felt unprepared and did not understand their role, guidelines, regulators' standards or organisational policies. Peer supervisors also viewed a lack of training in their role as a barrier. Supervisors who were external to the organisation may not be aware of organisations' guidelines. Likewise, supervisors supervising supervisees from a different profession to their own may also find it difficult to know the professional practices and guidelines. Moreover, there was a lack of understanding and clarity on what the supervision role entailed and its purpose.

A lack of trust and positive relationships between supervisor and supervisees acted as a barrier to engagement and commitment to supervision. Contextual factors such as the working environment, work patterns (e.g. shift work and rotas), geographical location and quantitative targets, such as service demands, also had an impact on the delivery of effective supervision.

5.3.4 How much supervision is appropriate?

There was very little evidence available on the ideal frequency of clinical supervision.(110) Most of the literature did not specify an optimum frequency or length for supervision. However, some studies did report that supervision should be regular (74, 98) and that regular supervision increased retention of staff.(63) Gonge *et al*. reported that supervision frequency also varied depending on the individual supervisor.(115) Dilworth *et al*. reported that to ensure sufficient support and avoid ongoing concerns there was evidence that supervision should occur at least monthly.(88) McMahon & Errity reported that supervision that was less than fortnightly was insufficient(30) and Saxby *et al*. reported that spending at least 60 minutes in supervision led to a perception of more effective supervision.(118) Chiller & Crisp also referred to the importance of ad hoc and unscheduled discussions to support the ongoing needs of the service but also to ensure staff wellbeing.(63)

A study by Taylor (2013) reported on the benefits of weekly supervision delivered in a group setting.(87) Overtime the nurse participants became more familiar with the format of presenting a case, and felt bereft if they occasionally missed the opportunity to participate in the group session, which offered lessons on putting problems into perspective as well as ideas about how to deal with problems.

Time to discuss personal issues based on the needs of the individual was identified as an important focus for supervision.(33, 38, 39) There was also evidence of the value of spending time to reflect on practice (18, 19, 22, 44-46, 61) and of receiving feedback.(19, 33, 34, 45, 46, 58, 62) Weekly reflection was rare for most supervisory relationships,(58, 115, 119, 120) although O'Connor (2012) stated it was very much needed.(72)

Clinical supervision needs to provide the time and opportunity to upskill staff who are underperforming.(111) Effective supervision can also facilitate more learning opportunities when needed.(99)

Summary

There was scant evidence on the ideal frequency of supervision to be effective. However, most studies reported on the benefits of regular sessions, ideally between weekly and fortnightly. However, there was also a suggestion that there was a place for ad hoc supervision to both meet the needs of service but additionally ensure staff wellbeing.

5.3.5 Could distance clinical or peer supervision be effective?

There is some evidence that distance supervision (geographically distant, or via technology) is effective.(46, 75, 105) Nancarrow *et al*. carried out a study with professionals in rural and remote settings in Australia where face-to-face supervision would incur considerable time and travel costs and therefore the use of technology was used effectively to support clinical supervision in the absence of anything else.(5) Supervision in this context was likely to be successful when it focused on what the individual brings to supervision for discussion; when it follows a counselling format (suitable for emotional support and those dealing with acute and distressing issues) and/or is focused on providing personal or career development supervision, and when there is no need or requirement to observe professional practice.

When the focus is on supervising clinical practice, a distant supervisor is less able to share or feedback his or her own observations of the supervisee's clinical practice and this risks a failure to address underperformance or feedback observations. Pack *et al*. found, in an interview study with OTs and social workers, that supervision sessions were a way of identifying gaps in training.(79, 82) In distant supervision, the supervisee will set the agenda and issues to be discussed, however negative issues may remain concealed. This needs to be considered carefully, highlighting the weakness of self-assessment, which is a particular concern for those who are under performing.

In a study with surgical residents on one site, Claridge *et al*. compared direct supervision (when seniors were in the hospital at the time of the surgery) with indirect supervision (where seniors were at home with the residents doing the surgery themselves).(85) They found that indirect supervision was related to less compliance with management protocols, fewer patients undergoing initial operations, more ICU use, and increased hospital charges. Direct supervision was reported to improve efficacy and adherence with protocol.

There are models of educational supervision (i.e. UK specialty training in medical practice) where clinical and educational supervisor roles are separated. The clinical supervisor works with the trainee doctor in clinical practice, and the educational supervisor supports the trainee at a distance with more infrequent contact, focusing on educational development. Supervision from the educational supervisor is conducted with the trainee but without observation of practice. The supervisor receives reports on their practice from other senior colleagues, multi-source feedback from colleagues and patients and from clinical assessments using validated tools. Therefore, the educational supervisor is in a stronger position to assess and advise the trainee.

O'Connor (2012) also reported on a study involving independent supervisors, who were not part of the ward or management system.(72) Supervisees reported that the independence of the supervisors enabled them to offer 'fresh insights' and solutions. In some cases, external supervision arrangements increased the likelihood that supervision actually took place. Supervision provided externally from another organisation is less likely to be cancelled due to work pressures.(10, 12, 74, 121)

Summary

Supervision provided using technology when personnel are at a geographic distance has been found to be effective, particularly when no other options are available. However, distance supervision is limited to providing individual or career support as no external observations of clinical practice can be made, unless separate validated assessments can be shared with the supervisor.

5.3.6 What should <u>employers</u> consider and focus on when offering or designing clinical or peer supervision?

Relationship quality and trust

There was strong evidence to suggest that the quality of the supervisor and supervisee relationship is key to success (5, 13-15, 37, 41-46, 65) and, where feasible, consideration should be given to allow supervisees to choose their supervisor.(12) Ideally this should be based on supervisee needs. In addition, the matching of supervisors with supervisees on key characteristics such as values, cultural understanding, gender and age will facilitate the supervisor- supervisee relationship. (5, 10, 12, 14, 45, 46, 55) Consideration also needs to be given to setting up an open and safe environment and building trust (12, 15, 16, 33, 43, 47, 60, 68, 72) (see section 5.3.1).

Provision of time and ongoing support

The literature suggests that greater session frequency, with regular progress reviews, was significantly related to positive outcomes.(30) Supervisory relationships develop over time and are complex,(122) therefore supervision should not be a one-off activity, instead, it needs to be sustained over time and from early on in a career.(83, 103) West suggests that supervision is not sufficient on its own, and should be part of a package which includes training, quality control, careful selection of staff and peer support.(51)

O'Connor (2012) stated that providing staff with supervision was an indication that the organisation valued employees and when this was supported by providing clear protected time, this ensured the message was translated into action and benefits were realised.(72) Koivu *et al*. further illustrated that nurse managers played a key role in facilitating clinical supervision through the provision of protected time, and provided an appropriate environment for it to take place. The authors suggested that in order to help nurse managers achieve this, organisations should include clinical supervision in their corporate agenda or business plans and in the job descriptions of nurses.(23) A major consideration by employers should be to have protected time for supervision (29, 66, 97, 101). Consideration should be given by employers to ensure equal access to supervision, particularly those who work night shifts.(110)

Supervisor training and feedback

There is a substantial body of evidence that states that supervisors should be trained in supervision (31, 40, 61, 66, 69, 95, 101, 107) and that supervisors themselves should also receive feedback to improve supervisory skills.(123) Training needs to explore how supervision should be developed following an explicit contract setting out a framework with agreed terms and providing a shared understanding of clinical supervision.(14, 45) One study found that the provision of support such as Continual Professional Development and training for supervisors themselves meant that they were more likely to stay in their role (71) (see section 5.3.3 for more information).

The qualities of 'successful supervision' (both peer and clinical) should be emphasised during training and are reported by Bogo and McKnight as involving clinical supervisors who:

> *"(a) are available,*
> *(b) are knowledgeable about tasks and skills and can relate these techniques to theory,*
> *(c) hold practice perspectives and expectations about service delivery similar to the supervisee's,*
> *(d) provide support and encourage professional growth,*
> *(e) delegate responsibility to supervisees who can do the task,*

(f) serve as a professional role model, and
(g) communicate in a mutual and interactive supervisory style.

Bogo and McKnight; p. 59(124)

Identifying the focus of supervision

Many forms of supervision have been identified in the literature: including internal managerial (14), internal reflective, external professional, and external personal.(10) At one end of this continuum, managerial supervision takes place inside the organisation and is mostly focused on task and process. At the other end, personal supervision is worker-focused and centres mainly on the narrative brought into the supervision space by the worker.(10) This last type of supervision (personal) was highly valued for workers to air their feelings; providing a safe place to connect and self-reflect. Personal supervision allowed a more intensive focus on clinical issues and personal professional development rather than organisational concerns.(14)

Goldszmidt *et al*. (53) discussed four types of supervision with doctors in secondary care. These were:

I. *direct care* supervision, which is learning from doing and is more suited to a competence based supervision
II. *empowerment style* supervision where supervisees are empowered to deliver direct care
III. m*ixed practice style* – which is a balance of direct care with oversight
IV. *teaching based on individual need*.

Goldszmidt *et al*. reported that for doctors in secondary care a mix of these styles was effective for the supervisees but that there needed to be a discussion with supervisees and supervisors on expectations of the supervision.(53)

Supervision provided by a supervisor who is not from the same profession as the supervisee, requires both the supervisor and supervisee to spend time exploring each other's belief and value systems, as well as understanding different roles, especially where there is a history of conflict and rivalry.(13) Time also needs to be spent tailoring the supervision to the needs of participants. In a study involving health visitors who were working with at risk children, they reported benefits from having supervision with someone who had a different professional background,(74) perceiving this brought additional insights and advantages, such as questioning assumptions made by the supervisees and offering greater challenge about practice.

Supervisory relationships, focus and processes should be made explicit and roles within the supervisory relationship examined to ensure expectation management. It was highlighted on a number of occasions that supervisees were not always clear about the purpose of the supervisory sessions. There is a need to define the aim and intention of the supervision. For example, one study highlights that supervisees were unaware that sessions were intended to be reflective rather than assessing their competence.(15)

Summary

There were several key factors that employers should consider when managing the setup of effective supervision. These included building a good, quality relationship between supervisor and supervisee, the provision of protected time for supervision, and having equal access to supervision; for example, for those who have different shift patterns. In addition, on-going support for supervisors should be offered through training, along with recognition of the supervisory role. The provision of feedback should also be considered for both the supervisee and supervisor. The supervisor should give constructive feedback to their supervisees but equally there should be a feedback loop to the supervisors built into the process to provide feedback to the supervisors. Lastly, there needs to be a clear focus on the aim of the supervision, for example, whether it is focused on task and process or if it is more personal in its approach and focuses on what the supervisee brings to the supervision. The aims and expectations need to be discussed within supervision so that everyone's expectations are clear, and met, and that both supervisor and supervisee understand the purpose for the supervision. Employers can support this process.

5.3.7 How should a system of supervision be implemented?

Tailored to the needs of the supervisees

Supervisory relationships develop over time and are complex, which suggests that there needs to be more consideration given to developing programmes to meet the needs of the supervisors. As stated above, supervision needs to be specific to the needs of each individual and their profession, to meet the demands of a range of settings, and to take into account experience, ability, and stage of training. Priority areas may include clinical practice, skills development, career development, or confidence building. Individuals may require different supervisors to support development over time. However, there is ultimately a need for supervision to be 'person-centred', placing the supervisee at the centre. Ideally supervisees should be able to choose their supervisor(125) (see

section 5.3.6). However, having more than one supervisor for different tasks could also be considered to support different learning needs,(31) but there needs to be clear boundaries and a record of supervision.(13)

Structure and type of supervision (group or one to one supervision):

Supervision can be provided on a one to one basis, in groups or both. However, both types of supervision (one to one and group) benefit from a structured approach and a shared vision and commitment.(5, 16, 103) With regard to group supervision, groups need to be kept relatively small to allow all members to contribute(106) and need to be set up with group rules to ensure safety and encourage participant ownership.(16)

Team (group) supervision was found by O'Connell *et al*. to help with reducing anxiety in nurses and midwives who work in the private and public sector.(81) A group of nurses who had been nominated by their managers went on a supervision training course for six months and were then able to supervise group supervision outside their area (or via the phone if in rural areas). By implementing group supervision in this way resources could be shared amongst each other, which improved communication, enhanced working relationships and empowered nurses to challenge existing practices.

Consideration needs to be given to the type of supervision that will be appropriate. Philips *et al*. found that a mix of one to one and group supervision was the most beneficial for dentists, dental nurses and dental therapists who worked in the community.(40) However, Philips *et al*. found that more issues were resolved through group discussions than one to one supervision as supervisees had the ability to learn from each other, compare practice and share issues in group supervision.(40) Philips *et al.* found that feedback and follow up of the groups were seen as important to help maintain the supervisee-supervisor relationships. There was a feedback loop implemented as part of the group sessions, and any practice issues were fed back to heads of service and any issues that could inform policy. Feedback and follow up also helped to overcome any misunderstandings about what clinical supervision is for. Having clear definitions of what supervision is and the roles of the supervisor and supervisee clearly stated, helped with engagement from supervisors and supervisees. The research also found that highlighting the importance of supervision and the benefits of it helped both supervisor and supervisees, and helped to change their attitudes more positively toward supervision. Having a greater understanding of the importance of engaging in group supervision through interactive and experimental models also helped engage staff. The importance of ensuring

confidentiality and trust in the supervision groups were seen as very important within group supervision.(40)

Spackman *et al*. further reported that a mix of one to one and group supervision was found to be the most beneficial for community nurses, rather than alternatives, such as paired peer supervision.(35) Cox & Araoz (2009) also reported that a mix of one to one and group (team) supervision was beneficial to OTs and Physiotherapists.(58) Similarly, Love *et al*. carried out a mixed methods project utilising a survey and interviews with midwives and found that a mix of one to one and group supervision yielded higher scores on performance and satisfaction than just one type of supervision on its own.(15)

Management support and buy in

Organisational culture and attitude toward supervisory practice are an important component in improving the practice of supervision. There needs to be managerial support and buy in for supervision to be successful.(104) Supervision needs to be supported at both a management and individual level.(103) For example, training bodies need to encourage and value the work of peer supervisors.(105)

There were challenges around time and resources in many cases (see section 5.3.3). Organisations must ensure a minimum timeframe for supervision is allocated, create clearly defined roles and objectives, allocate funding and support for supervision (5, 79, 82, 108), provide technology such as Skype calls to overcome distance barriers and ensure that there is support in place to support the technology used. Gray *et al*. discussed the use of smartphones with doctors and their supervisors to provide supervision.(56) Being flexible in the supervisory process to meet the needs of all those concerned such as having supervision at different times of the day to accommodate rota and shift patterns was found to be helpful with engagement, and recognising clinical supervision in the workload. Providing a coordinated approach with clear criteria and a structure for supervision were important components to effective supervision as reported by nurses.(89) Furthermore, establishing clear ground rules was also found to be appropriate.(5, 35, 87) In addition to the details set out in the above sections, it has been argued that to ensure supervision is successful it should be mandatory and supported at both a management and individual level.(87)

Summary

There are several considerations to take into account when implementing supervision. These are: making sure the needs of the supervisee are understood and that supervision is tailored to those needs. For example, supervisees may require career or skills development rather than discussion of personal issues. There may need to be different supervisors for different roles; such as a line management role or a more personal/reflective role. However, clear boundaries, tasks, ground rules and good record keeping need to be considered for this to be successful. Supervisors may need to change over time to meet the changing needs of the supervisee. However, all supervision should be person-centred. Consideration also needs to be given to the structure of the supervision whether or not it is conducted on a one to one basis, group, or a mix of both. However, any approach to supervision needs to have a clear structure and aim. A mix of both approaches was found to work well, as both approaches offered a different focus of support. There needs to be management support and buy in with organisational support being important for the successful delivery of supervision through time, training, and financial or technological resources provided. There was also some evidence to suggest that supervision should be mandatory to increase the value placed upon it.

5.3.8 Is there any need to implement supervision differently for different professionals?

It is clear that some professions may need more supervision depending on the grade and type of practice. There was scant literature that looked specifically at the implementation of supervision related to the profession. However, the literature did clearly identify some common themes around what makes effective supervision, which were evident across all professions included in the literature review.

Pack *et al*. suggests that some professions need more focus on self-care and support to maintain wellbeing.(79) Professions such as therapists, social workers and mental health nurses who are dealing with and responding to situations of crisis such as child sexual abuse, domestic violence, severe mental illness and the removal of adults and children into care may need more self-care. Many professions such as counsellors recognise the need for debriefing, both to provide case management support and to provide individual support to manage the personal distress and emotional upset experienced by the casework. Palmer-Olsen *et al*. found that managing emotions effectively can be challenging.(37) However, Simpson-Southward *et al.* found that supervision with clinical psychology therapists had less of a focus on emotional aspects of work and focussed more on supervisee learning and development.(98)

This is not to say that those in primary and secondary care practice, such as nurses, midwives or doctors, do not face difficulty and therefore require less support. For example, Spackman *et al*. discussed how doctors were struggling with the emotions evoked by working with a patient group with disabilities.(35) Kilbertus *et al*. also discussed the impact of trauma environments such as accident and emergency.(102) However, working in such a fast-paced environment means that opportunities for supervision and feedback can be infrequent and challenging. Such environments may do what they can to provide support, but are unable to provide the additional support that may be needed for wellbeing and self-care.(51)

Often it is assumed that more junior practitioners require more supervisory support than their senior colleagues, however this was not apparent in the literature. McMahon & Errity found that there was a perception by clinical and counselling psychologists that senior grades did not need support.(30) However, this is very much dependent on individual needs.(30) Chiller & Crisp also reported that seniors who were providing supervision for their junior staff, rarely received it themselves.(63)

There may need to be different ways of delivering supervision for different professions working in, for example, more rural and less accessible geographical areas. These issues have been discussed elsewhere in the report, for example, through the use of technologies such as Skype calls.(5)

Daveson & Kennelly found that art therapists were happy to receive supervision from other professionals whom they worked with, such as social workers and psychologists, to help overcome their lack of access to supervision.(50) However, this needs careful consideration of supervision guidelines about working across inter disciplinary professions, internal supervision guidelines and clear boundaries, whilst recognising the dual roles of supervisors.(50)

Summary

There is some evidence that certain types of practice may need more self-care due to the emotional strain caused by service delivery. Staff who regularly face these challenges tend to already have supervision in place, but other professions may also need access to this support when the working environment is demanding. Having a supervisor who is willing to meet on an ad hoc basis to respond to staff issues was also recognised as an important attribute of effective clinical supervisors.

5.3.9 Are there circumstances in which clinical or peer supervision is preferable to traditional models of managerial supervision?

Supervision is subject to different interpretations by managers, who tend to focus more on service delivery rather than on staff development.(10, 13) As discussed above (see section 5.3.3), issues arose with supervision when the focus was perceived to be monitoring performance, rather than on the provision of support.(10, 12, 13, 45, 46, 74) Johns (2001) has argued, in the risk averse cultures of contemporary health and social care, that supervision is clearly underpinned by a managerial and political agenda of performance management.(126) The current preoccupation with oversight of practice has arguably strengthened the necessity of supervision; however, there is concern this might threaten its integrity as a learning-focused activity. A management focus on quality assurance may reduce the support that the individual practitioner requires.

Beddoe (2012) discussed how managerial supervision would create a shift from practitioner-focused facilitation to the promotion of a monitoring agenda.(10) The management of risk and scrutiny of practice decisions can become a constant source of stress for supervisors. Beddoe (2012) has argued that; "*line management supervision might be characterised by rules, risk assessment checklists, in the realm of compliant bureaucracy*" (p202) and reflects a hierarchy and power differential that can inhibit the honest sharing of problems during supervision.(10)

Authors have argued that line managers need to focus on protecting the employing organisation and their patients/clients from risk,(79, 82, 100) compared with (external) supervisors who can be more focused on the personal development of the supervisee in front of them. Which model of practice is best is a source of continued debate.(82) Beddoe (2012) has defined external supervision as:

> *'Supervision that takes place between a practitioner and a supervisor who do not both work for the same employing organisation. The physical space in which this occurs may be different from the worker's normal workplace and it is bounded by complex expectations, which may or may not be covered in a written contract'.* (p. 199)(10)

Beddoe (2012) states that a significant factor that differentiates external supervision from a line management approach is the expectation that an external supervisor will hold less information about the practitioner (including administrative, educational, career, and personal issues), which may be known by an internal supervisor.(10) Internal supervision was thought to be dominated by managerial concerns. External supervision can keep management at 'arm's length' and would not be involved in any internal organisational issues, however, it may diminish professional efficacy if there

are organisational changes to be made.(12) In addition, the organisational and shared professional aspirations may be less visible to an external supervisor.

Pack (2012) states that in New Zealand social workers must be supervised by their own profession in the first five years of practice to support role modelling, professional conduct, and the development of professional identity(82), a view supported by others.(13, 124) Yontef (1996) also reflects that new professionals need supervision in a non-shaming and affirming supervisor relationship that facilitates honest talk without fear or censorship.(127) However, Pack reported that experienced social workers preferred external supervision as this enabled discussion about the organisation and interpersonal dynamics within it.(82) Therefore, the internal-external debate may be best answered by the stage and seniority of the practitioner who may well have differing needs.

Gillingham's (2006) research in Australia highlighted that when supervisors used risk assessment tools, rather than reflection, supervision became mechanistic and lacked creativity.(128) The use of checklists during supervision reduced supervisor anxiety but did not lead to an improvement in practice.(128, 129) Stanley (2010) argued the checklist approach increased risk, as supervision became superficial.(130)

Another paper suggested that clinical supervision should not be kept separate from line management.(125) The study of physiotherapists suggested that clinical supervision should not be separated from the performance appraisal process because the learning needs of the supervisee may not be identified using an external supervisor. The authors reported that clinical supervision based on an external supervisory model might not support the needs of the employing organisation. Gardner *et al.* reported that in their study supervisees disagreed as to whether unsafe practice should be reported back to managers, thus identifying an ethical concern.

Beddoe (2012) highlighted a number of pitfalls in the separation of supervision from clinical accountability,(10) including: an ambiguous mandate for dealing with issues of poor performance; lack of clarity about the duty of care; potential for collusion; deepening of the gulf between 'management' and 'practice'; and concern that dissonance between organisational goals and individual focus and direction may remain unaddressed or widen.

Two types of supervision tend to co-exist when the line manager is also the clinical supervisor— a focus on practitioner learning and development, and another focused on risk-management and underperformance. This split underlines the need for supervision training.

Summary

We have identified that line managers will also have to consider the organisation and flag up any risks or concerns identified from supervision. External supervisors can focus more on what the individual brings to supervision, and provide personal and career support. However, poor knowledge of practice may be hidden and practice concerns may not be addressed. Earlier in this report, we reported that Nancarow *et al*. stated that there were three main areas of supervision: managerial/administrative, educational and supportive and that these three areas should overlap, and that supervision needed to be flexible to meet the needs of the service and the individual.(5) However, finding a line manager who can balance the needs of the service with individual needs may be challenging given the evidence about the need to choose or match the supervisor to the supervisee, particularly when there are cultural differences. Therefore, effective clinical supervision may best be delivered by several supervisors, or by those who are trained to manage the overlapping responsibility.

6. Discussion

This rapid systematic review aimed to identify the characteristics of effective clinical and peer supervision. The specific research questions have been answered within separate sections throughout the report. Below we highlight some key messages that have emerged throughout the literature.

What makes clinical and peer supervision effective?

The main research objective of this report was to answer the question 'what makes effective clinical and peer supervision'. Evidence from the literature review indicates that the organisation plays a key role in ensuring supervision takes place, that it is valued and expected, and that supervisors are trained, and time for it is protected. Supervision needs to be provided in a neutral, open, supportive environment to facilitate discussion and reflection on clinical practice, career development and any personal issues that may arise in the workplace.

Having a relationship based on trust in the supervisor was also found to be key. This relationship was built on a number of key factors: a positive attitude, integrity, listening skills, critical probing and

questioning, commitment, motivation, being supportive, maintaining confidentiality, objectivity, flexibility, attention to communication, and being respectful, caring and empathetic.(34)

There was evidence on the benefit of reflecting on practice (22, 44, 61) and on receiving feedback.(33, 58, 62) Having regular but flexible supervision that fitted around all stakeholders' needs was also highlighted as important. Clinical supervision provides the opportunity to facilitate learning opportunities when needed (99) and to up skill staff who were underperforming.(111)

Positive outcomes

There was much evidence about the benefits of clinical supervision, in that those who received support from clinical supervision were better able to cope with the demands of the job(23, 24, 110, 115) and were less likely to leave the job(70, 131). Good clinical supervision also increased resilience (80) and job satisfaction.(17, 69, 70) There was also strong evidence to suggest that supervision helped with reducing stress and anxiety in the workplace, leading to a positive effect on the wellbeing of staff.(73) Supervision was also seen to help drive up the quality of care delivery and have a positive effect on the working environment.(20, 24, 77-79, 83-86)

Barriers to effective clinical supervision and peer supervision

A number of barriers were highlighted within the literature that should be taken into consideration when exploring how to implement effective supervision practice. These included a lack of time, heavy workload, a lack of resources, unsupportive management and colleagues, a lack of supervisor training, a lack of a trusting relationship and a lack of ongoing support. Supervisees were also sometimes unaware of the purpose of the supervision practice, impacting upon engagement, particularly in group settings.

Implementation of effective clinical and peer supervision

Another research objective was to explore how systems of effective clinical or peer supervision may be implemented. There were several key areas identified as necessary when implementing systems of supervision. These were creating and protecting time for supervision, training and the provision of feedback to supervisors, having a clear understanding of what the supervision is for, and whether it has a managerial or more personal and reflective role.

Some evidence has suggested that having a mix of one to one and group supervision (including peer supervision) was beneficial. This may largely be because more than one supervision type will offer more support overall and target differing needs of the supervisee. However, it is apparent that any

type of supervision (whether group or individual) will be most effective if implemented using the characteristics suggested in this report.

Evidence illustrating the use of technology, particularly with distance supervision, was not covered in great detail in the included papers. However, it is clear from the evidence that support from management is needed to enable implementation (particularly to cover the cost of implementation) and training for staff is also needed to ensure this type of supervision is implemented effectively. Online and hybrid models of education have become increasingly common in counsellor education,(132) particularly the delivery of real-time distance supervision (e.g. live observations, video links etc.).

Opportunities to engage and support stakeholders

A final objective was to explore opportunities for the Health and Care Professions Council (HCPC) to engage and support stakeholders to enhance support and supervision for registrants. This specific objective could not be answered directly from the literature. However, the evidence from this review has helped to identify the characteristics of effective clinical and peer supervision (see section 7) which the HCPC may wish to consider. The HCPC may wish to encourage and highlight the importance of guidelines for supervisors, supervisees and organisations. This will help to overcome barriers to effective supervision (see section 5.3.3).

The guidelines suggested by Nancarrow *et al*.(5) (see table 3) could be utilised by organisations to highlight the areas to consider when implementing supervision. As evidenced throughout this report, any guidance suggested will need to be tailored to the needs of the supervisee and the organisation. A range of supervisory models can be considered depending upon individual, grade, and context of practice. Finally, the literature has highlighted similar characteristics and needs for both clinical and peer supervision (particularly when provided by a group).

Considerations

This report was based on evidence identified in the international literature using a rapid review, which involves a systematic search and rigorous analysis. Although in many places there was a vast amount of information which provides strength to the findings, a rapid review necessarily pays less attention to study design and sample sizes. Although the literature identified different types of supervision (e.g. group, individual), there was limited evidence to suggest what type of supervision

would be most successful for different professions. There were also a small number of specific supervision types, such as inter-professional and distance supervision, and therefore not enough evidence to generalise how successful these were. Much of the data was heterogeneous in nature, and this also hindered our ability to relate the findings to specific professions and settings. However, we can draw from the overall themes that were evident across all of the literature.

7. Key characteristics of effective supervision

This review has identified that effective clinical and peer supervision is based on the following ten characteristics:

1. When supervision is based on mutual trust and respect.
2. When supervisees are offered a choice of supervisor with regard to personal match, cultural needs and expertise.
3. When both supervisors and supervisees have a shared understanding of the purpose of the supervisory sessions, which are based on an agreed contract.
4. When supervision focuses on providing staff support the sharing/enhancing of knowledge and skills to support professional development and improving service delivery.
5. When supervision is regular and based on the needs of the individual (ideally weekly, minimum fortnightly). Ad-hoc supervision should be provided in cases of need.
6. When supervisory models are based on the needs of the individual. This may include one to one, group, internal or external, distance (including the use of technology) or a mix.
7. When the employer creates protected time, supervisor training and private space to facilitate the supervisory session.
8. When training and feedback is provided for supervisors.
9. When supervision is delivered using a flexible timetable, to ensure all staff have access to the sessions, regardless of working patterns.
10. When it is delivered by several supervisors, or by those who are trained to manage the overlapping responsibility as both line manager and supervisor.

8. Appendices

Appendix 1: Search terms used for each database

Pro QUEST ASSIA

(social worker*) AND (effective* OR qualit* OR enhanc* OR good OR ineffective* OR poor OR satis* OR success* OR support*) AND (peer OR mentor OR buddy* OR buddies OR supervis*)

Psych Info

1. art therapy.mp.

2. psychologists/ or clinical psychologists/ or counselling psychologists/ or educational psychologists/ or social psychologists/ or psychiatrists/ or psychotherapists/ or social workers/

3. exp therapists/

4. chiropodist.mp.

5. podiatrist.mp.

6. dietician.mp.

7. hearing aid dispenser.mp.

8. health psychologist.mp.

9. operating department practitioner.mp.

10. orthoptist.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

11. paramedic.mp.

12. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11

13. (peer* adj2 (mentor* or buddy* or buddies or supervis*)).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

14. supervis*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

15. 13 or 14

16. (effective* or qualit* or enhanc* or good or ineffective* or poor or satis* or success* or support*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

17. 12 and 15 and 16

18. 12 and 15 and 16

19. limit 18 to (human and english language and yr="2009 -Current")

OVID Medline

1. Art Therapy/

2. exp Psychology/

3. practitioner psychologist.mp.

4. (practition* adj2 psycholog*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

5. exp Health Personnel/

6. biomedical scientist.mp.

7. chiropodist.mp.

8. podiatrist.mp.

9. hearing aid dispenser.mp.

10. Social Workers/

11. (speech and language therapist).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

12. exp "rehabilitation of speech and language disorders"/

13. orthoptist.mp.

14. operating department practitioner.mp.

15. paramedic.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

16. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15

17. (peer* adj2 (mentor* or buddy* or buddies or supervis*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

18. supervis*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

22. 17 or 18

29. (effective* or qualit* or enhanc* or good or ineffective* or poor or satis* or success* or support*).mp. [mp=title, abstract, original title, name of substance word, subject heading word,

floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

31. 16 and 22 and 29

32. limit 31 to (english language and humans and yr="2009 -Current")

OVID EMBASE

1. art therapy.mp.

2. psychologists/ or clinical psychologists/ or counseling psychologists/ or educational psychologists/ or social psychologists/ or psychiatrists/ or psychotherapists/ or social workers/

3. exp therapists/

4. chiropodist.mp.

5. podiatrist.mp.

6. dietician.mp.

7. hearing aid dispenser.mp.

8. health psychologist.mp.

9. operating department practitioner.mp.

10. orthopist.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

11. paramedic.mp.

12. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11

13. (peer* adj2 (mentor* or buddy* or buddies or supervis*)).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

14. supervis*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

15. 13 or 14

16. (effective* or qualit* or enhanc* or good or ineffective* or poor or satis* or success* or support*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

17. 12 and 15 and 16

19. limit 18 to (human and english language and yr="2009 -Current")

CINAHL

(MH "Health Personnel+") OR psychologist OR physiotherapist OR therapist OR paramedic OR Dietician OR dentist OR podiatrist

AND

supervis*

OR

"peer buddy" OR "peer mentor"

AND

enhanc* OR effective OR support* OR success OR quality OR ineffective OR poor

Appendix 2: Data extraction Form

First author:	**Year:**	**Source (Journal title, thesis, etc):**	**Reviewer Initials:**

Paper title:	
Code and exclusion criteria	
1 = Include *2 = Exclude [PROVIDE EXCLUSION CODE]* *3 = Background ref (state why important and what to look for in re-reading)* *4 = Follow-up (Describe, eg. look for future results)* ***CODE:***	*1 = Focus not on formal and structured clinical/peer supervision* *2 = Not in healthcare context* *3 = University setting/students* *4 = Not evidence based* *5 = Paper not written in English/outside review period* *6 = Supervision of children/animals/patients* *7 = non-western culture* *8 = Other (please describe briefly)* ***EXCLUSION CODE:***

RESEARCH AIM: To understand the characteristics of effective clinical and peer supervision in the workplace.

Research Objectives:

- To understand what makes clinical and peer supervision effective.
- To explore how systems of effective clinical or peer supervision may be implemented.
- To explore opportunities for the Health and Care Professions Council to engage and support stakeholders to enhance support and supervision for registrants.

Overall aim/research design/sample etc.
Country
Population of interest (doctors, nurses, allied health professionals, social workers, dentists, psychologists etc.)
Healthcare setting of interest (primary, secondary, private, community etc.)
CONTEXT - What is the intervention, how supervised, resources? **Clinical, peer, inter-professional supervision?**
Outcomes
Limitations (sample size, design, power etc.)
Characteristics of effective supervision
Barriers to effective supervision
Summary of what paper adds to research (what makes effective/ineffective supervision?) **Anything else to add related to research questions?**

Appendix 3. Demographics of included papers

Reference	Country	Research Design	Healthcare profession	Setting	Type of intervention *Supervision = Clinical **Peer supervision includes peer mentoring
Akhigbe (2017)	Various	Literature review	Doctors - neurosurgeons (trainees, consultants, remote neurosurgeons, simulators and technological models)	Various	Peer supervision
Allan H (2010)	UK	Qualitative & ethnography	Nurses	NHS and private sector	Peer supervision
Annan J (2013)	New Zealand	Qualitative	School psychologists	Psychologists in a school	Supervision
Artinian H (2013)	USA	Qualitative	Doctors (Paediatric Interns and Residents)	Secondary Care	Peer supervision
Ayres (2014)	UK	Quantitative	Occupational Therapists	Community	Supervision
Baines (2014)	Various	Qualitative	Social worker	Community	Supervision
Balmer D (2011)	USA	Qualitative	Doctors (Paediatrics)	Not mentioned	Peer supervision
Beddoe (2010)	New Zealand	Qualitative	Social workers	Social service organisations	Supervision
Beddoe (2012)	New Zealand	Qualitative	Social workers	Social service organisations	Supervision
Beddoe (2012)	New Zealand	Quantitative	Social workers and Psychologists	Social service organisations	Supervision
Beddoe (2014)	New Zealand	Qualitative	Doctors	Community	Supervision

Appendix 3. Demographics of included papers

Reference	Country	Research Design	Healthcare profession	Setting	Type of intervention *Supervision = Clinical **Peer supervision includes peer mentoring
Bell (2017)	UK	Qualitative	Cognitive behavioural therapist	Community	Supervision
Bethell (2017)	Canada	Quantitative	Personal Support Worker	Community	Supervision
Binnie (2011)	USA	Mixed methods	Physiotherapists	Secondary care	Supervision
Bondas (2010)	Norway	Qualitative	Nurse	Secondary care	Supervision
Brink (2012)	Sweden	Qualitative	Ambulance Service	Secondary care	Peer supervision
Brody A (2016)	USA	Qualitative	Nurses	Secondary Care	Peer supervision
Brown (2018)	Australia	Qualitative	Doctors	Primary care	Supervision
Bryant A (2015)	USA	Quantitative	Nurses	Primary care	Peer supervision
Bucky F (2010)	USA	Qualitative	Psychologists	unclear	Supervision
Brunetto (2011)	Australia	Quantitative	Nurses	Community & Secondary care	Supervision
Brunetto (2013)	USA	Quantitative	Nurses	Community & Secondary care	Supervision
Bulman C (2016)	UK	Action research	Nurse educators	Secondary care	Supervision
Bullington (2017)	Sweden	Qualitative	Doctors	Primary care	Supervision
Buus N (2009)	Denmark/UK	Qualitative	Nurses (psychiatric)	Various	Supervision
Buus N (2011)	Denmark/UK	Literature Review	Nurses (psychiatric)	Secondary care	Supervision

Appendix 3. Demographics of included papers

Reference	Country	Research Design	Healthcare profession	Setting	Type of intervention *Supervision = Clinical **Peer supervision includes peer mentoring
Bullington (2017)	Sweden	Quantitative	Doctors	Community	Supervision
Binnie (2011)	USA	Literature Review	Physiotherapists	Secondary Care	Supervision
Carless S (2012)	Australia	Qualitative	UG Nurses and PG psychologists	Various	Supervision
Churchill J (2017)	Australia	Qualitative	Doctors (Urologists)	Secondary care	Supervision and Peer supervision
Cheung G (2017)	New Zealand	Quantitative	Doctors (Psychiatry)	Secondary care and community	Supervision
Cheung W (2017)	Canada	Quantitative	Doctors (Junior / resident doctors)	Secondary care	Supervision
Chiller (2012)	Australia	Qualitative	Social workers	Community	Supervision
Claridge (2011)	USA	Qualitative	Doctors (Surgical residents)	Secondary care	Supervision
Cox D (2009)	UK	Quantitative	OTs & Physiotherapists	Various	Supervision and Peer supervision
Cross W (2010)	Australia	Qualitative	Senior Nurse	Secondary care	Supervision
Cross W (2012)	Australia	Case studies	Nurses	Secondary care	Supervision
Danielsson A (2009)	Sweden & Norway	Qualitative	Nurses	Secondary care and Care Community	Supervision
Daveson B (2011)	Australia	Literature review	Music Therapists	Community	Supervision
Davies J (2016)	Australia	Qualitative	Physiotherapists	Private practice	Peer supervision

Appendix 3. Demographics of included papers

Reference	Country	Research Design	Healthcare profession	Setting	Type of intervention *Supervision = Clinical **Peer supervision includes peer mentoring
Davis C (2012)	UK	Qualitative	Nursing Managers	Secondary care	Supervision
Dawber (2013)	Australia	Mixed-methods	Nurses and Midwives	Secondary care	Supervision
Dawson M (2012)	Australia	Quantitative	Allied Health Professionals	Various	Supervision
Dexter F (2015)	USA	Quantitative	Doctors (Anaesthesia residents) and nurse Anaesthetists.	Secondary care	Supervision
Dilworth S (2013)	Various	Literature review	Nurses	Various	Supervision
Dilworth (2013)	Australia	Qualitative	Nurses, physiotherapists, radiation therapists, occupational therapists.	Community	Supervision.
Dunsmuir (2015)	UK	Quantitative	Educational psychologists	Community	Supervision
Elfering (2017)	Switzerland	Quantitative	Nurses, physicians, medical therapists, technical and administrative staff	Secondary care	Supervision
Ellis M (2014)	USA	Quantitative	Psychologists	Community	Supervision
Farnan J (2010)	USA	Qualitative	Doctors	Secondary Care	Supervision
Fellow (2014)	UK	Quantitative	Doctors (Paediatric)	Secondary Care	Peer supervision
Gardner (2018)	Australia	Quantitative	Physiotherapy, occupational therapy, social work, speech	Various	Supervision

Appendix 3. Demographics of included papers

Reference	Country	Research Design	Healthcare profession	Setting	Type of intervention *Supervision = Clinical **Peer supervision includes peer mentoring
			pathology, dietetics, psychology, podiatry, exercise physiology, audiology, and AH assistance		
Gagliardi A (2010)	Canada	Qualitative	Doctors (Surgeons)	Secondary care	Supervision
Gibson (2009)	UK	Quantitative	Applied Behaviour Therapists	Schools	Supervision
Goldberg & Weatherston (2016)	USA	Quantitative	Infant mental health specialists	Community	Supervision
Goldszmidt (2015)	Canada	Qualitative	Doctors	Secondary care	Supervision
Gonge H (2010)	Denmark	Quantitative	Psychiatric nurses	Secondary care	Supervision
Gonge H (2015)	Denmark	Quantitative	Nurses	Secondary care psychiatric wards	Supervision
Gonge H (2016)	Denmark	Quantitative	Psychiatric nurses	Secondary care	Supervision
Grant J (2012)	Australia	Qualitative & literature review	Senior psychologists, therapists and social worker	Secondary care or Community Care	Supervision
Gray O (2016)	UK	Qualitative	Nurses	Secondary Care	Peer supervision

Appendix 3. Demographics of included papers

Reference	Country	Research Design	Healthcare profession	Setting	Type of intervention *Supervision = Clinical **Peer supervision includes peer mentoring
Gray (2015)	UK	Quantitative	Doctors	Secondary care and Community	Supervision
Greenway (2013)	UK	Qualitative	Health visitors	Community	Supervision
Griggs C (2019)	UK	Qualitative	Assistant practitioners	Community	Peer supervision
Hair (2015)	Canada	Mixed methods	Social work	Various	Supervision
Harrison N (2009)	UK	Quantitative	Mental Health workers	Primary Care	Supervision and Peer supervision
Heijden (2010)	Various	Quantitative	Nurses	Secondary care	Supervision
Henderson A (2011)	Australia	Quantitative	Nurses and students	Secondary care	Supervision
Ingham (2015)	Australia	Qualitative	Doctors (GP)	Community	Supervision
Iwanicki S (2017)	USA	Quantitative	Psychologists	Psychology organisations	Supervision
Jarrett P (2014)	UK	Qualitative	Health visitors	Primary Care	Supervision
Jelinkek (2010)	Australia	Mixed-methods	Doctors	Secondary care	Supervision
Kaihlanen (2013)	Finland	Quantitative	Nurses	Community	Supervision
Kenny (2013)	Australia	Qualitative	Nurses	Secondary care	Supervision
Kilbertus (2019)	Canada	Qualitative	Doctors (Emergency Medicine)	Secondary care	Supervision

Appendix 3. Demographics of included papers

Reference	Country	Research Design	Healthcare profession	Setting	Type of intervention *Supervision = Clinical **Peer supervision includes peer mentoring
Koivu A (2011)	Finland	Quantitative	Nurses	Secondary care	Supervision
Koivu (2012)	Finland	Quantitative	Nurses	Secondary care	Supervision
Kutzsche (2013)	Norway	Qualitative	Doctors	Secondary care	Supervision
Laschober T (2012)	USA	Quantitative	Addiction Counsellors	Community	Supervision
Lalani (2018)	USA &Canada	Quantitative	Doctors	Secondary care	Peer supervision
Lewis (2017)	USA	Qualitative	Genetic counsellors	Various	Peer Supervision
Love (2017)	Australia	Mixed-methods	Midwives	Various	Supervision
Lusk (2017)	USA	Quantitative	Social workers	Community	Supervision
MacLaren (2015)	UK	Qualitative	Nurses (Recently qualified)	Secondary care	Supervision
MacLaren (2018)	UK	Qualitative	Nurses	Community	Supervision
Martin P (2014)	Australia	Literature review	Doctors	Community	Supervision
Martin P (2015)	Australia	Qualitative	Occupational Therapists	Secondary care & Community care	Supervision
Manuela (2014)	Portugal	Qualitative	Nurses	Secondary Care	Peer supervision
McBride (2017)	USA	Quantitative	Nurses	Secondary care and Community Care	Peer supervision
McGilton K (2013)	Canada	Quantitative	Nurses	Secondary care	Supervision

Appendix 3. Demographics of included papers

Reference	Country	Research Design	Healthcare profession	Setting	Type of intervention *Supervision = Clinical **Peer supervision includes peer mentoring
McMahon & Errity (2014)	UK	Quantitative	Clinical and counselling psychologists	Various	Supervision
Milne (2010)	UK	Quantitative	Psychologists	Secondary Care	Supervision
Morgan (2014)	UK	Literature review	Doctors	Primary	Supervision
Nancarrow (2014)	Australia	Literature review	Allied health professionals	Various	Supervision
Noelker (2009)	USA	Mixed method	HR directors, nursing assistants, resident assistants, home health aides.	Community	Supervision
O'Connell (2013)	Australia	Mixed methods	Nurses and Midwives	Private & public secondary care	Supervision
O'Connor (2012)	New Zealand	Evaluation but unclear on how they evaluated it	Registered nurses	Secondary care	Supervision
O'Donoghue (2015)	New Zealand	Literature Review	Social Workers	Various	Supervision
O'Donoghue (2014)	New Zealand	Mixed-methods	Social Workers	Community	Supervision
Ostergren & Aguilar (2012)	USA	Mixed methods	Speech-Language Pathology Assistants (SLPAs)	Community (schools, clinics)	Supervision
Pack (2012)	New Zealand	Qualitative	Social workers & occupational therapists	Various	Supervision

Appendix 3. Demographics of included papers

Reference	Country	Research Design	Healthcare profession	Setting	Type of intervention *Supervision = Clinical **Peer supervision includes peer mentoring
Pack (2015)	Australia	Qualitative	Occupational Therapist & social worker	Community	Supervision
Palmer-Olsen (2011)	USA/Canada	Literature Review	Emotionally focussed couple therapist	Primary	Supervision
Paulin (2010)	New Zealand	Qualitative	Dieticians	Secondary care and community	Supervision
Pethrick (2017)	Australia	Literature Review	Medical residents	Secondary care	Peer supervision
Perron N (2009)	The Netherlands	Qualitative	Doctors	In-patient services	Supervision
Phillips (2012)	UK	Mixed-methods	Dentists, dental nurses, dental therapists	Community	Supervision
Pohl (2016)	Belgium	Quantitative	Nurses	Secondary care	Supervisor
Redpath (2015)	Australia	Qualitative	Physiotherapists & Physiotherapy assistants	Various	Supervision
Reichelt (2013)	Norway	Qualitative	Clinical psychologists	Community	Supervision
Rodwell (2009)	Australia	Quantitative	Elderly care nurses	Community	Supervision
Rodwell (2013)	Australia	Quantitative	Nurses	Community	Supervision
Rodwell (2016)	Australia	Quantitative	Nurses	Community	Supervision
Rodwell (2014)	Australia	Quantitative	Nurses	Secondary care	Supervision

Appendix 3. Demographics of included papers

Reference	Country	Research Design	Healthcare profession	Setting	Type of intervention *Supervision = Clinical **Peer supervision includes peer mentoring
Roseghini & Nipper (2013)	UK	Mixed methods	Midwives	Secondary care	Supervision.
Samuel (2018)	Australia	Literature Review	Doctor (GP)	Community	Supervision
Saxby (2015)	Australia	Quantitative	Allied health professionals	Community	Supervision
Sexton (2013)	Australia	Qualitative	Genetic counsellors	Various	Peer supervision
Shultz (2014)	USA	Quantitative	Neuropsychologists	Various	Supervision
Simpson-Southward (2016)	UK	Qualitative	Clinical psychological therapists	Not stated	Supervision
Snowdon (2017)	Australia	Quantitative	Allied Health professionals - speech & language pathologists, physiotherapists, social workers, psychologists, podiatrists, occupational therapists, dieticians	Secondary care	Supervision
Snowdon (2015)	Australia	Quantitative	Physiotherapists residents	Secondary care	Supervision
Snowdon (2017)	Australia	Literature review	Multi-professional – medical, nursing, allied health, combination	Secondary care	Supervision
Spackman (2017)	UK	Qualitative	Doctors (Psychiatry)	Community	Peer supervision
Stark (2009)	UK	Mixed methods	Forensic psychologists	Police forces	Supervision

Appendix 3. Demographics of included papers

Reference	Country	Research Design	Healthcare profession	Setting	Type of intervention *Supervision = Clinical **Peer supervision includes peer mentoring
Szabo (2019)	Australia	Quantitative	Doctors	Secondary care and community	Peer supervision
Taylor (2013)	UK	Qualitative	Bio feedback therapists	Community	Supervision
Taylor (2014)	UK	Qualitative	Bio feedback therapists nurses & physiotherapist	Community	Supervision
Walbank (2010)	UK	Quantitative	Midwives & Doctors	Secondary care	Peer supervision
Webb (2015)	UK	Quantitative	Doctors	Secondary care	Peer supervision
Welch (2016)	USA	Quantitative	Doctors	Secondary care	Peer supervision
West (2010)	UK	Mixed-methods	Counsellors/ psychotherapists	Primary care	Supervision
Westervelt (2018)	USA & Australia	Mixed methods	Physical therapists	Secondary care	Supervision
Wharton (2011)	Australia	Quantitative	Nurses	Secondary care (Private hospitals)	Supervision
Whitfield (2018)	UK	Mixed methods	Doctors	Secondary care and Community	Supervision
Wilson (2016)	Various	Literature review	Therapists	Various	Supervision

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