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A semi-open supervision systems model for evaluating staff supervision in adult care
organisational settings: the research findings

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Abstract

This paper offers an original examination of the interrelationship between organizational arrangements, supervisory practices, and outcomes from supervision in a study funded by the Social Care Institute for Excellence. The study aimed to capture examples of good supervision. Researchers used systems theory to develop a supervision model, which informed the research design and evaluation (Lambley, 2018). Good supervision was identified by 136 on-line survey participants, and all emerging themes were examined in 19 interviews, within four case study settings. Social workers within an 'integrated' case study setting and health workers in a 'partnership' setting, said that 'good' supervision was supported by organisational policies, supervisor training, and devolved management and professional practice. In the care home and social enterprise settings, supervision was similarly supported, but its delivery was a management performance target. In all four case study settings, good supervision could be negatively transformed by a supervisor's action (e.g., rigid responses to performance issues) or supervisor's inaction (e.g., cancelled supervision sessions). Service user feedback on supervision is an underdeveloped area that needs further research. This paper concludes by considering the implications of the research findings for the study of supervision.

Key words:

Clinical supervision, professional supervision, management supervision, adult care, service users

Introduction

The functions of supervision include management (also referred to as administration), education and support activities (Kadushin and Harkness, 2002). In UK health and care settings, supervision is normally available for all staff. Service users are 'indirect beneficiaries' and are not normally present in supervision. The direct beneficiaries of supervision are workers and managers. The supervision literature is often critical of what happens in supervision. Wilkins (2017) suggests that supervisors do not enable opportunities for critical reflection, which social workers need. In health settings, Northcott (2000) suggests that clinical supervision needs more emphasis on 'super (greater than) vision (insight/wisdom) and less on 'to supervise' (to oversee or control)'. Lawler (2015:266) suggests that managerial approaches have led to a reinterpretation of supervision where;

'supervision refers to the overview of work, checking that the employee is operating effectively, following prescribed processes utilising resources efficiently and achieving the required level of productivity (Hales, 2005)'.

Bartoli and Kennedy (2015: 243) suggest that when supervision goes wrong, i.e., instead of supervision being an 'anchor that holds in place the organisational processes necessary', it;

'can produce extreme outcomes as epitomised in the Victoria Climbié enquiry where the allocated social worker gave evidence stating that supervision was infrequent

and when it did take place the supervisor talked about herself and her own personal problems' (Laird, 2013).'

In short, it is often suggested that managers may have a distorting effect on supervision (Wilkins, 2017, Lambley, 2010).

In the UK, social work practice takes place in many settings e.g., schools, general hospitals, specialist mental health services, etc. Social work services are separated in the UK into adult social care services or children and family services. Social workers may co-work in either services with other professionals or services may be provided by other professional in addition to social work services. Tasks traditionally associated with social work may increasingly be undertaken by non-social workers e.g., detaining patients under the Mental Health Act 1983 & 2007 (Barlett and Sandland, 2013) or by vocationally trained workers, who may or may not be supervised by social workers. Supervision policies in any setting are informed by documents such as 'Providing Effective Supervision' (SCIE and CWDC, 2007) and more recently by Knowledge and Skill Statements (e.g., DH, 2017). These documents provide the frameworks and practice language to enable all staff to articulate what supervision is, what supervisors and supervisees do, and to engage in supervision. Skill mix developments in many organisations, mean that social workers may supervise non-social work staff, particularly in 'adult services' where smaller number of social workers work directly with service users (Beresford, 2007), and social workers may be supervised by managers with or without a social work qualification.

There is some evidence that supervision plays an important role in supporting all workers. Mor Barak et al (2009:3) found that the “supervisory dimensions of task assistance, social and emotional support, and supervisory interpersonal interaction are positively and statistically significantly related to beneficial outcomes for workers”. Carpenter et al (2013: 1843) were critical of Mor Barak et al (2009) paper however, because the studies lacked ‘high quality evidence for outcomes of supervision’. Carpenter et al, (2013:1843) suggested that the studies used were ‘weak and samples limited; supervision rarely defined’. Goldman (2013) also criticized the weak evidence base suggesting it would fail to satisfy international research standards. Supervision studies tend to be narrow in focus e.g., service users are not routinely included in research (Lambley, 2018), and supervision is poorly conceptualised (Milne et al, 2008). The evidence base has been described as foundational (Bogo and McKnight, 2005, O’Donoghue and Tsui, 2013) and weak (Milne et al, 2008, Carpenter et al, 2012, Goldman, 2013). And yet, supervision is generally considered an important for the delivery of high quality services.

It is within this context that the Social Care Institute of Excellence (SCIE) funded a research study, seeking to capture evidence of good supervision. This paper presents the findings from the SCIE funded study into good supervision in adult care settings in the UK. A semi-open supervision systems model, (the ‘supervision model’) was developed using systems theory. The supervision model enabled the research team to think about supervision in a new way (Lambley, 2018) and a summary is now provided, including how the model informed the research design.

Supervision was conceptualised in 'system' terms, i.e., a supervision system includes the 'conditions' that support supervision (or inputs), 'supervision processes and supervisor/supervisee practices' (throughputs), and the 'effects' (or outcomes) from supervision. Feedback loops connect these different parts of a supervision system, which is informed by, and can inform broader systems, e.g., human resources, finance, performance management, quality systems, policy, legislation, and professional accountability systems, etc. (fig 1).

Figure 1: Semi-open supervision systems model

(adapted from Katz and Kahn 1978)

The SCIE study collected data from an on-line survey and four health and social care 'case study' settings, each of which constituted a supervision system. Respondents in each case study setting were asked 'about areas of practice in supervision that seem to deliver positive outcomes' (Lambley and Marrable, 2013:4). Service users were

asked about good supervision, but as they were not recipients of services in the four case study sites, their views on supervision systems are not included in this paper.

The research design

The SCIE research study consisted of an on-line survey, semi-structured interviews, and two focus groups with service users. The on-line survey generated baseline data that informed an understanding of a 'good' supervision system (inputs, throughputs, outcomes and feedback loops). The themes that emerged from the survey, were explored more fully in semi-structured interviews with 19 staff in the four case study settings, 3 of which were social workers. Staff were asked to provide feedback on behalf of service users, mirroring what happens in these practice settings. A mixed methodological approach was used in the online survey (Johnson and Onwuegbuzie, 2004) to capture normative statements and actual experiences. Contradictions that emerged were explored more fully in the semi-structured interviews. The research plan was approved by SCIE, and ethical clearance was granted by a University Ethics Committee. The Association of Directors for Adult Social Services (ADASS) also granted approval for the multi-site online survey and interviews. A virtual stakeholder advisory group was formed, and a stakeholder group was convened by SCIE. Both groups provided guidance on protocols for the research, and ongoing advice. The case study sites were chosen by the SCIE advisory group based on participant willingness to engage further in the study, and where evidence of 'good supervision' had been identified by participants in the on-line survey. Participants had responded to invitations placed in a SCIE newsletter, and from invitations placed on an on-line

Choice Forum. The on-line choice forum was an online discussion group organised by the Foundation for People with Learning Difficulties in England. Extensive professional contacts and networks were also used to generate a 'purposeful' sample of research participants.

The online survey

There were 28 sites represented in the on-line survey, generating 1 – 47 participant responses per site. The research team used Survey Monkey and responses were tagged for site identification. 55 on-line participants were employed in an integrated or partnership organisation, whilst 81 worked in organisations that directly provided services (e.g., care homes). 31 respondents worked in support roles (day care workers, care workers, administrative assistant), 38 in professional roles (social worker, occupational therapist, community nurse, psychologist) and 54 worked in management roles (social work managers, team leaders, community mental health managers, day managers, registered managers and deputy managers). Just over half (51%) said that they provided, as well as received, supervision. Whilst there were a range of 'types of supervision (group, peer, clinical, ad-hoc consultation), most on-line respondents received formal 1-1 supervision i.e., 1 supervisor and 1 supervisee in a meeting designated for supervision. The evidence from the on-line survey was collated by inputs, throughputs, outputs/outcomes, and feedback loops, and themes identified in each of these parts of the system. The themes were used to design the semi-structured questions in the interviews undertaken in the case study settings that followed.

Semi-structured interviews

The semi-structured interviews took place after the on-line survey data was collected and analysed, and themes identified. Four case study sites were chosen by the SCIE advisory group, which included;

- * A Local Authority enhanced partnership health team
- * A large (not for profit) Social Enterprise
- * A local Authority and NHS joint funded Care Home
- * A community integrated mental health team.

19 face-to-face semi-structured interviews were completed with participants who had identified themselves from the on-line survey as willing to further participate in the research study, as identified in table 1 below.

[Table 1: Semi-structured interviews]

In the four case study sites supervision policies mirrored the framework in ‘Providing Effective Supervision’ (SCIE and CWDC, 2007), and at the time of the research, the three social workers in the integrated settings (and those who took part in the on-line survey) did not have access to specialist social work standards for supervision, which were introduced after the research was completed. The interviews lasted between 45 minutes to 1 hour 30 minutes. Participants were sent consent material, and the semi-structured questions in advance of the interviews. Examples of supervision policies, proforma’s used in supervision, and details of the services provided

to service users in each case study site was provided to researchers. The evidence from the interviews was collated as inputs, throughputs, outputs/outcomes and feedback loops, and any similarities and differences between sites identified. Conclusions were drawn and a report produced for SCIE.

The SCIE study had its limitations. Firstly, not all 'types' of services could be included in the study, but the four that were chosen were 'typical' of the range of services found in health and social care. Secondly, research participants were purposively identified, and therefore they were not representative although, the research did include a mixture of managers, professionally registered workers, care and support workers, and service users. Thirdly, service users did not take part in the online survey and semi structured interviews in the case study settings, which meant that it was not possible to verify worker claims about the effectiveness of good supervision on service users. Fourthly, evidence of the costs associated with different models of supervision was sought, but participants were unable to isolate supervision costs. Therefore, it was not possible to evaluate which supervision model provided the best value for money. Finally, the language used in the on-line survey may have been an issue, because a small number of respondents who selected 'other' category, when they could have chosen a category made available to them.

The Findings

The on-line survey data generated a 'list' of themes that respondents identified as good supervision in each area of the conceptual model (inputs, throughput, outputs

and feedback loops). These findings represent a broad 'picture' of supervision across the 28 health and social care settings in this phase of the research.

Supervision was most commonly a formal 1-1 meeting between the supervisor and supervisee, although there were other models of supervision (e.g., group supervision). Good 1-1 supervision was a structured, systematic process, that was led and managed to support individuals in their work with service users. Supervisors received organisational support, and provided a supervision environment that they believed, benefitted all stakeholders. Supervisors believed supervision had a positive impact on workers, and that supervision generated positive outcomes for service users. Differences were found between case study sites. Sometimes these differences reflected supervision practice e.g., leadership behaviours and the importance of protected time for supervision, or there were differences within the supervision systems e.g., 'emotional containment' had a specific meaning in the integrated and partnership settings which was not found in the other two case study sites. The case study interviews also produced examples of when supervision was negatively transformed by a supervisor although this data wasn't actively sought.

The findings from the case study sites and the data produced from the on-line survey are summarised below. The presentation reflects the four components of a supervision system:

Supervision conditions (inputs):

In the on-line survey, supervision policy and procedures were in place to guide supervision practice. 91% (n=122) of respondents said that they were familiar or very familiar with them.

In the care home and social enterprise, the supervision policy informed the delivery of supervision, which was a 'management' task. A manager from the care home setting said s/he had;

'a good policy that obviously comes from the human resources service. We have them on our system and this is updated. I think one of the Ops managers had updated some of the policies and procedures that are available.'

In the Integrated and partnership settings, National Health Service (NHS) rather than Local Authority (LA or county council) supervision policies were used by all professionals because 'clinical governance' was monitored by the NHS, and staff worked mainly with NHS patients. One approved mental health social worker said, 'It feels like we are working for the Trust rather than the county council'. In the partnership setting, nursing staff used NHS supervision policy, because it met their professional needs; 'supervision reports were signed by a community nurse supervisor and could be used for professional re-registration purposes' (community nurse). These conditions were important because 'if we change them (policies), then it becomes like our job changes, so its gets complicated' (Health facilitator, partnership setting). All supervision policies were aligned with other internal policies (e.g., human resources) to

meet the needs of the the organisation and the workers. No supervision policy required direct feedback from service users to be used in supervision.

In the on-line survey, 91% of on-line respondents said that they received formal 1-1 supervision (1 supervisor and 1 supervisee in a formal supervision meeting) which they said was about the right amount. Supervision lasted between 30 minutes, and 1 hour and 30 minutes, with most (n=87) receiving supervision monthly. Supervision contracts were commonly used and most respondents said that they were supervised by someone from the same background, who was also their line manager. 71% (n=47) said that supervision time was protected, with 18% (n=12) saying that it was protected 'in some cases', and 15% (n=7) that it was not protected.

In the care home and social enterprise, 'supervision data' was used to 'check it was happening', support contract monitoring and financial management. Supervision data was used in 'quality' audits in the partnership and integrated setting. There were differences in the level of strategic support for supervision. In the social enterprise, supervisors were allocated 'hours' each week to supervise staff and were closely monitored to ensure they delivered it. 'Within the budget it's part of the administration time we have got, so it's considered' (senior support worker social enterprise). In the care home setting, managers were expected to make time for supervision, but there was peer pressure to deliver regular supervision, and performance targets had to be met. One manager said that it wasn't always possible to hit a 100% supervision target due to staff holidays, sickness etc., but this was accepted,

as targets were mostly met. In the social enterprise one supervisor had concerns about how supervision was monitored.

‘Supervision is monitored so it’s a key performance indicator. There is a lot of checking that they take place. My concern would be that it is a quantitative check, not a qualitative check’ (Senior support worker, social enterprise).

In the integrated and partnership setting’s supervision was said to be important, as missing supervision could ‘lead to standards of work slipping’ (senior approved mental health social worker). However, individual supervisors were responsible for protecting supervision time. One supervisor had been on sick leave for 12 weeks in the partnership setting, and staff were not receiving formal 1-1 supervision. One worker described the impact of this situation;

“Its only recently where there have been occasions where we have to consult other disciplines, or of there isn’t anybody else, try and make the best judgement and look at policies and reflect on guidance that you have, any procedures that are there, just to make sure that you cover everything. Doesn’t always feel comfortable but you have to. You then copy everyone in an email to say what you have done” (Community nurse – partnership).

When the supervisor was in work, supervision was ‘always the last thing that will get cancelled if there were any time constraints, it’s taken very seriously.’ (community

nurse – partnership). However, no cover had been arranged and workers went without supervision.

Devolved organisational arrangements therefore did not ensure protected time for supervision. Supervision was sometimes treated as less of a priority when workloads were high, even though workers knew that they needed supervision. An approved mental health social work professional said;

‘yes, it’s useful at times, but by and large it’s something that goes to the bottom of the list when you are dealing with service users. And that’s the way it should be but I think if anybody sits down and thinks about it they think, well actually you need the supervision before you can go and do the work with service users effectively.’

These workers therefore held two positions. Firstly, they expected and valued supervision to support good practice, but they also knew that there were times when it was not available or that they were required to prioritise other activities over supervision. One senior approved mental health social worker said; ‘it’s not as frequent as it should be with one thing and another.’

There were a variety of supervision models found in the case study settings including ad-hoc and peer/group supervision. What happened in supervision was identified as follows by the on-line survey responses (Table 2).

[Table 2. Purposes of supervision]

Supervision focused on three agendas; clinical, professional and management concerns. Clinical supervision was described as; ‘discussions that are focused on clients and work with clients, whilst management supervision was described ‘as anything to do with human resources (HR) training, problems and management feedback. Clinical supervision was... also linked to personal and professional support.’ Professional supervision was described as work with service users which was ‘structured with clear protocols and competencies that have to be met’. Professional supervision supported personal and professional development.

There was some overlap between professional and clinical supervision;

“In our guidance for mental health social care staff its (supervision) referred to as professional supervision, so I wouldn’t refer to it as clinical supervision because we would refer to it as that.’ (Approved mental health worker- Integrated service)

Care staff working in the social enterprise and care home setting described supervision as ‘professional’, even though staff were not registered or qualified professionals.

In the on-line survey, 91% (n=71) of respondents said that different aspects of supervision were delivered simultaneously, and 80% (n=62) respondents said supervi-

sion was delivered by their line manager, rather than a clinical supervisor (6.5% n=5). 77% (n=105) of professionally qualified staff said that the supervisor was from the same professional background as themselves. 16% did not receive same profession supervision and this generated mixed reviews. Availability and access to same professional 1-1 formal supervision seemed to be less of an issue where other support was in place. This support included;

informal or ad-hoc supervision (unplanned 1-1 informal meeting)

Peer/group supervision (planned meeting with other professionals to discuss clinical/professional matters and provide personal support)

Team, group, staff meetings (planned meetings to discuss clinical/professional/service issues)

Informal networking (informal relationships across an organisation or virtual system to support the delivery of services and individuals)

Most on-line respondents were happy with the supervision training they received.

Case study participants gave examples. A senior support worker said 'I was on training here about supervision and how to give it, what kind of things you can discuss and how to approach staff', whilst an approved mental health social worker talked about training that kept you up to date with theories and practice developments. In the social enterprise supervision training was mandatory whilst it was expected you attended training in the care home, partnership and integrated sites. Case study respondents said that whilst training was available, sometimes 'you had to wait until there are enough people for them to run the training' (social enterprise). An ap-

proved mental health social worker said that you don't always get access to good training, because it was expensive, and highly specialised although it is needed to update clinical expertise. On-line survey respondents said they would like more supervision training on managing underperforming staff, conflict management, policy, theory and practice in clinical supervision, and coach training, group work and action learning. One respondent said they would like access to a two-day course on psychodynamic counselling, whilst another would like a Diploma in Supervision and/or coaching. An ongoing strategic challenge in all the case study sites was to match the specific training needs to individual needs, and to individual supervision responsibilities to support the delivery of good supervision.

Supervision process and practice

Typical comments from the on-line survey suggested that good 1-1 formal supervision was 'confidential', 'staff felt able to speak openly', and 'it was their protected time'. It was however, a formal meeting. A supervision agreement was put in place to keep supervision focused:

"you go through with them how they need to as an individual be supervised, what constitutes it, so you are not setting your own agenda and targets about what they need." (Senior Approved Mental Health social worker- integrated setting).

Supervisors in the care home and social enterprise settings used a supervision form provided by the organisation. It structured the supervision experience.

We work to that (supervision policy) when we are setting up our supervisions and obviously we have a procedure in place where we will discuss the purpose of supervision, what you are going to get out of it and we actually ask staff what do you want from supervision?”

(Supervisor – care home)

In the social enterprise, some supervisors complained it was a checklist and everything had to be covered, although most supervisors tailored its delivery, to build trust. In the care home setting each proforma's was specific to the worker's role. In terms of what happened;

“We use a form. There is a core amount of questions, all about personal stuff for me. Annual leave, any sick issues or home issues. Then you go on to service users, staff issues, problems. Its structured that way. Then obviously, anything else that isn't covered in a category you can bring up, but normally it's all covered there' (Care worker – care home).

The supervisors approach in all four case study settings was important to good supervision. One supervisor described this in leadership terms.

‘She's very fair, and will say no, but she will tell you why and if she asks you to do something, she would do it herself, so she is not asking you to do something that you

know she wouldn't be prepared to do, which means that people will do anything because they know she's the same.' (Health facilitator – partnership)

Good supervisors were trusted "I think it does help to have someone supervising you that you actually feel you can trust and discuss things with. (Social Enterprise, care worker). Good supervisors challenge, enable reflection and engage workers in the discussion. When asked to complete an NVQ in health and social care qualification the worker said to her supervisor;

It's a waste of time. So no, I'm not doing it. She looked at me and she went, ok, go and find something that would benefit you and our service and come back to me. So I did. I took it back to supervision and it was an exercise, physical activity and health foundation degree at Southbank University." (support worker – social enterprise)

Good supervisors help staff to take decision when they were struggling, often drawing from their own expertise.

'I think I also see supervision as the place where if you have come up against a brick wall. Your supervisor, your manager, is there to sort of facilitate maybe doing something to make things possible. Or else allowing you to kind of drop it because it's never going to work so why continue to bang your head against a brick wall.' (Senior lead, Integrated service)

Supervision discussions were reflective. In the social enterprise and care home for example, supervision discussion provided some relief because; it's just discussing and offloading oneself in any worries I might have. You can ask for advice and I have learnt a lot'. In the integrated and partnership setting's however, feelings stirred up in practice situations were addressed directly because the worker could be adversely affected by an issue or a clinical condition. Such discussions helped workers to remain emotionally contained, engaged and focused on improving their practice for the benefit of the service user.

"1-1 supervision enables me to think about my feelings in my work and to address my mistakes, which I might not feel comfortable doing in a group situation" (Integrated services; approved mental health social worker)

Supervisors managed poor performance drawing from human resource policies in supervision, but differences were noted;

"some staff, who within the team, are not productive enough.... So yes, it has to be discussed in supervision. And we put in place a plan for the person to show that they were more interested in their work doing what needed to be done and that was monitored on a regular basis (Senior support worker – Social Enterprise)

By contrast in the integrated setting, one social worker supervisee described how her supervisor helped her to manage a service user complaint. The worker was experiencing work related stress and had missed appointments. The supervisor en-

couraged the worker to think about the impact of her behaviour and to come up with a solution. This management approach was viewed very positively by the worker as it was aligned to the workers own values and aspirations of working with service users.

Another supervisor from the social enterprise had completed her coaching training and was enthusiastic about using this approach in supervision.

‘I think if we have somebody who has some transient behaviours or whatever, what I try to do is coach. I try to say ‘okay, what could we do? What are the options? And try to facilitate people being able to think more laterally; trying to get people to come up with their own solutions. But if I have got my own, I put them into the mix’.

(Senior support worker – Social Enterprise)

Supervision notes were kept as a record of meetings and the decisions made, which were signed by the supervisor and supervisee. This process was valued by supervisees.

‘It’s written down then so you just sign it, agree that is what you have said, and it goes on your file then. You can always look back at it and say, ‘That issues hasn’t been addressed. It’s been a couple of months now. What’s happening? I think it works really well.’ (care worker, Social Enterprise)

The manager in the care home said he was supported by senior managers to support workers and service innovation. However, the link between service and practice developments wasn't always easy to bring together as one manager in the social enterprise highlighted;

As an organisation we are talking a lot about being innovative and being different. My argument has been we can't be innovative when we have all these prescriptive ways of doing things. You get innovation where you give people a freer range, a freer role (Senior support worker, Social Enterprise)

Supervision was described by supervisees as 'service user focused'. In the integrated setting, one mental health social worker said that supervision helped her to gain 'confidence in my work with challenging clients, including being able to set my own boundaries around what is safe. I have also used the session to debrief and so feel contained with un-contained and needy clients'. This is a good description of the indirect benefit supervision has on service users. In the care home, the assistant manager said that 'After supervision I tend to deal with the service user with more confidence because I've got an action plan in place to help them and get them the service they need. This example, suggests that the outcome is service user focused.

Impact and outcomes from supervision

Staff found supervision to be very helpful for a variety of reasons, reflecting individual needs:

‘Supervision helps me cope with difficult situations that arise’

‘I’m not left feeling alone with something that can be sorted’

‘I don’t have to hold in my head or heart difficult sessions’

‘When carried out properly, it reduces stress, provides guidance and support and improves communication.’

It was difficult for some respondents to disentangle worker and service user impact and outcomes, from supervision. As one respondent suggested;

“But the whole thing interweaves the whole time, so from the supervisions I am discussing my needs; I’m also discussing the needs of the service user and what I need to support him and how you can support me and how I can support you and the whole thing works that way.’

One supervisee described how service users were indirect beneficiaries of supervision, but they were also present in supervision.

‘supervision helps me to put forward personal/professional viewpoints on service users and advocate on their behalf, and also allows for alternative perspectives on issues within cases’.

One participant provided an example of how supervision impacted on their work and on service users. A care plan was devised in supervision for a service user who had limited communication skills.

“... He wasn’t aware of it but because of his medication he was feeling hungry all the time, so he ended up eating loads of really bad food. We had to promote healthy living for him. So we introduced the gym, playing squash, walking; he joined the rounder’s club – so his walking has become more enjoyable for him.” (Care worker - Social Enterprise)

Other respondents found it difficult to consider how supervision could impact or affect service users.

‘I’m not sure that supervision itself has any direct impact on the service users as most decisions regarding their care are made at management level and this is expected to be followed through by the support workers’. (care worker - Social Enterprise)

When asked how supervision was evaluated one worker said; ‘we just simply use our gut instinct a lot of the time when something’s not working. We don’t really evaluate the service we are providing to clients’. (Community Nurse). Apart from management surveys, there was little evidence of systemic evaluation of supervision.

In the social care enterprise and the care home, issues from supervision could be discussed in residents meeting, and resident views would then inform supervision meetings, so opportunities were available for service users views to directly inform supervision.

Feedback loops

Examples were provided to the research team of system 'feedback'. For example; one supervisor and supervisee met for formal 1-1 supervision to discuss how to address a service users weight gain, which had become a health issue (input to throughput). The supervisor and supervisee considered solutions, having engaged the service user, their family, a General Practitioner, and the wider staff team to devise the care plan. Funding was made available to support the plan (input). The plan enabled the service user to take up squash, which increased their daily activities. The service user loved squash and began to lose weight, which was discussed in supervision (reflection on the impact and outcomes from the care plan). The supervisor was so pleased with the changes that she talked to senior managers about the possibility of supporting more service users in such activities (throughput discussion in supervision was then discussed with senior managers who could provide more resources).

Discussion

There were differences in how supervision was organised, managed and led in all four case study settings. In the care home and social enterprise settings for example, there was oversight of supervision meetings taking place, but less flexibility in its delivery compared to the integrated and partnership settings. Supervision was embedded within the wider organisational systems in these organisations, so that the delivery and monitoring of supervision was 'management' work. In the integrated and partnership settings, oversight of supervision and its monitoring was devolved to front line managers/supervisors. In the literature, Lawler (2015) describes supervision as a consultative practice, but suggests that it has been transformed by a production context and oppressive managerial practices. Supervision has become a surveillance operation (Wilkins, 2017). Lawler (2015) suggests that managers need to re-consider the negative impact that oppressive management practices can have on social workers. However, the idea that workers are compliant agents of managers (and policy makers) was not found in the SCIE study nor in research by Evans (2014). In the integrated and partnership settings, social workers and health professionals, chose the supervision policies they needed and because supervision was a devolved activity, they had the discretion to do this. However, supervision could be delayed or missed completely, and this could negatively transform supervisees views of supervision and their practice.

Little is understood about the relationship between the organisational design, and the delivery of good supervision, and most research is often undertaken in children and family social work settings, (e.g., Wilkins, 2017). Most supervision research does

not focus on how policy and organisational developments affect supervision, nor how supervision is evolving (Donoghue, 2015). There is no doubt that policy impact and organisational contexts for supervision is a complex area to study. Evans (2012) identified fractured organisations in Adult services in England, where some front-line managers identified with professional concerns rather than senior management and organisational concerns, and this affected how front line and senior managers worked together. Evans (2012:46) argued that front line managers/supervisors are 'active shapers of the way initiatives develop, making sense of policy and procedures in terms of their own understanding of the organisation', and that any organisational fractures does affect professional practices. In the NHS, managers and medical staff have sought ways to work more closely together. Rather than bringing professionals into management roles however, Kuntz and Scholtes (2008) suggest that doctors and managers should be encouraged to work alongside each other, because they have different mind sets and these can bring big improvements to service delivery (Table 3).

[Table 3: Clinical versus managerial role]

Kuntz and Scholtes (2008:2) suggest that there is a need to focus on 'the way in which medical professionals are involved in the decision- making process' because as Lawler (2015) argues; the management agenda often squeezes out professional con-

cerns, even though it is possible for managers and professionals to work together (Lambley, 2010).

In the integrated and partnership setting, good supervision was described as a reflective, thoughtful and a supportive process, which enabled professional goals and good outcomes for service users. Good supervision was a 'professional' practice, which met the needs of staff so that they could work effectively with service users, but it also addressed management concerns, and was the main decision making forum for casework. The supervisor and supervisees used theory, research and practice evidence, and they revisited working hypotheses, whilst reviewing progress, making decisions, and planning new pieces of work. The supervisor provided emotional support when difficulties emerged from the work and/or relationship with service users. The supervisor provided learning opportunities and access to training, and other forms of human resources support.

In the care home and social enterprise, supervision was shaped by individual service user care plans, often commissioned by professionals. Staff were supported personally and practically by the supervisor, whilst supervisors monitored the delivery of the services. Supervisors and supervisees read case notes and the supervisee built a relationship with the service user, drawing from life experience, from training and previous work with service users with similar issues. The supervisor used a 'problem solving' approach in supervision. Good supervision was therefore focused on the delivery of a contracted care plan. Personal support, access to training and career pro-

gression opportunities, as well as managing poor performance was an integral part of good supervision in these settings.

Bartoli and Kennedy (2015) argue that 'supervision' in any setting needs to be a transformative learning activity, which is reflective and empowering. However, there were examples of supervisors adopting rigid, or rule bound and narrowly focused approaches, which were presented by supervisors in the research as 'good supervision', particularly in the context of management concerns about staff performance. Rigid, rule bound and narrowly focused approaches may be the result of a manager's personal traits, values and/or views of some members of staff, or what has been learnt from other managers about how 'we manage supervision around here'. However, the evidence from the four case study sites suggested that managers who used a developmental approach were valued highly by staff, even when addressing performance issues, because these interventions were perceived as helpful.

The outcomes from good supervision were evaluated as they were in practice i.e., workers interpreted the 'good outcomes' for service users. The 'evidence' this produced however, was weak. Goldman (2013:2) said that the SCIE study provided 'no strong evidence on outcomes for people who use services or on outcomes for workers that are defined by people who use services' because the study did not include service users directly benefitting from services in the case study settings. Any future research on supervision needs to collect evidence directly from service users if international research standards are to be met (Goldman, 2013). However, as with Kuntz and Scholtes (2008) it will be important that the mind set of service users is

acknowledged in future research, i.e., how service users conceptualise supervision, understand its purpose and service user perspectives of the impacts and outcomes.

Conclusion

The SCIE study demonstrated that good supervision is well organised, carefully managed and delivered, and it is monitored. For participants, it can be a supportive and practical activity that is highly valued. However, this was a relatively small study, and more research is needed to develop insight into this complex activity. There is a need for greater scrutiny of the organisational context and behaviours that deliver good supervision and good outcomes for staff and service users. Including service users in supervision research would also improve our understanding of how to improve 'supervision systems', and any future supervision study needs to meet the national quality standards identified by Goldman (2013) to improve and develop this area of research study.

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Figure/Table Legend:

Figure 1: Semi-open supervision systems model

(adapted from Katz and Kahn 1978)

Table 1: Semi-structured interviews

Table 2. Purposes of supervision

Table 3: Clinical versus managerial role

Table 1

Social Enterprise	Partnership	Care Home	Integrated
Senior support workers (x5)	Community Nurse (x2)	Care officers (x2)	Approved Mental Health AMH (social worker) (1)
Support worker (1)	Health facilitator (1)	Registered manager (1)	Strategic lead Professional (social worker) (1)
Manager (1)		Supervisor (1)	
Team leader (1)		Administrator (1)	Senior AMH (social worker) (1)
Total = 8	Total = 3	Total = 5	Total = 3

Table 2

	%	n
Supervision for performance	83%	103
Supervision for personal and professional support	87%	108
Supervision for development	80%	99
Supervision for clinical practice	48%	59
Number of respondents who replied		124

Table 3

Doctor	Manager
Decision making in the interest of individuals	Decision making in the interest of the organization
Accountable to profession (peers)	Accountable to multiple stakeholders
Decisions led by professional rules and norms	Decisions led by organizational goals
Normative and autonomous decisions	Group decisions, political environment, bargaining, compromise

Figure 1

172x94mm (300 x 300 DPI)

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