Table 3.4 Reviewing supervision – a supervisor's perspective

For the supervisor
• Does the supervisee feel heard?
• Is supervision supportive?
• Do I assist the supervisee to reflect?
• If I hold a dual role (supervisor and line manager) is there a clear boundary?
• Is the contract still relevant?
• Do I do things the supervisee doesn't want me to do?
• Does the supervisee feel safe?
• Am I approachable?
• Do I impose my culture or values on the supervisee?
• Do I facilitate a learning environment?
• Does the supervisee feel that on leaving supervision his/her goals have been met?
• What areas need to be improved upon?
• Does this relationship work?
• What feedback do I want to give the supervisee?

At the end of a supervision relationship it is important to take the time to review and honour the time spent together. If this has been a relationship where significant moments of practice have been shared then the relationship may hold deep and sometimes painful moments of the practitioner's professional history. The ending of supervision relationships, as we have suggested above, occur for a number of reasons. Sometimes these are mutually timed and agreeable to all concerned. In other circumstances the timing may not suit one, or both parties and the very ending may create discomfort and ambivalence. What is important is that time is allowed for either party, but particularly the supervisee, to express his or her response to the change and to come to terms with the consequences. Marris (1974) cited in Ford and Jones (1987, p.149) identifies three tasks in response to change. When confronted with change people need to: have an opportunity to react, to articulate their ambivalence and to work out their own defence of it.

In supervision, time needs to be allocated to allow these processes to occur. Particularly where change has not been the choice of the supervisee it is important that the supervisee is given time to accommodate the implications of, and responses to, the impending change. Time must be allowed for the supervisee and supervisor to review and reflect upon the relationship and any significant development and learning which has occurred. Where relationships have been more problematic it is even more important for opportunity to be given for any unfinished business to be [illegible] and if possible put to rest before the relationship finishes.

Chapter 4

The Organisational Context of Supervision

Supervision is one significant component in the complex system of professional and organisational processes designed to ensure competent practice in health and social care. In the twenty-first century most helping professionals work in highly bureaucratic, organisational contexts and increasingly fewer can truly claim to be fully able to control their own work, or even their own knowledge. This is particularly so where their profession exists under the control of central government or local authority controlled services (Bierema and Eraut 2004). The nature of the climate in any given workplace has a major impact on the effectiveness of supervision and learning in that workplace. 'For supervision to work well within an organisation, its culture needs to be favourable. If the culture is unhealthy it is likely that the supervision will be affected accordingly' (van Ooijen 2003, p.221). This chapter examines the way organisational culture in workplaces supports or hinders supervision and the professional development of staff. The nature of workplace cultures will also be examined with consideration of external societal influences.

So what constitutes organisational culture? Schein defines 'culture' as a 'Set of basic tacit assumptions about how the world is and ought to be that a group of people share and that determines their perceptions, thoughts, feelings, and, to some degree, their overt behaviour' (Schein 1996, p.11). Most descriptions of organisational culture define it as the whole of the traditions, values, attitudes, work practices and policies that constitute an all-encompassing context in which the work of the organisation is carried out (Hawkins and Shohet 2006, pp.194–195). A commonplace definition is 'it's the way things work around here', and at its simplest it is grounded in the everyday life of a workplace: it may be about greetings, breaks, meetings, celebrations, welcomes and farewells. In its more complex dimensions it concerns the way workers relate to each other, the interpersonal dynamics and histories and the hierarchies, visible and invisible, that determine informal roles in the agency. Significant elements are found in the manner in which 'workplace relationships are

developed and maintained and how boundaries between work and private life are constructed. At a deeper level culture will include the taken for granted and shared meanings attributed to actions in the agency, and the values and beliefs which underpin those actions' (Beddoe and Maidment 2009, p.82).

Hawkins and Shohet (1989, 2000, 2006) have provided an often cited typology that delineates the impact of dysfunctional workplace cultures on the supervisory climate. It is clear that the best and worst features of the organisation often accompany the participants into supervision. Hawkins and Shohet (1989) described five common 'cultures' and their impact on supervision in their first edition of *Supervision in the Helping Professions*, adding a sixth cultural type, the addictive organisation, in their second edition (2000, pp.174–175). Their optimal culture is the learning and development culture (Hawkins and Shohet 2006, pp.202–203) in which there is a high degree of congruence between organisational polices, staff development goals and the actual day-to-day work practices which impact on staff.

As we have seen in earlier chapters contemporary authors have presented models and approaches to supervision in health and social services which strongly ground supervision within learning and development policy and practice. These approaches to supervision have been influenced significantly by ideas about how professionals learn in practice (Butler 1996; Eraut 1994; Schön 1987). Professionals are not empty vessels to be filled. From their own lives they bring to the practice context their beliefs, culture, values and relevant prior experience. Competence in professional practice requires practitioners to form 'judgements through a process of negotiating shared meanings' (Jones and Joss 1995, p.29). Individuals are constantly adding to their store of knowledge, where their formal knowledge, skills, experience and intuitive wisdom are augmented and refined through contact with colleagues, other professionals and of course patients and service users. In addition to ideas derived from knowledge about individual learning, another set of ideas has been employed from the study of organisational learning (Garratt 1986; Marsick and Watkins 2002; Senge 1990). The site of learning is of increasing importance and distinct accounts of learning for professional practice are identified in the workplace (Eraut 1994; Schön 1987; Wenger 1998). Health and social care service organisations do not exist in a vacuum; they are shaped by history, government policy, requirements of regulatory bodies and broad social trends. As we have noted in Chapter 1, the 'risk society' and conceptualisations of danger and vulnerability of service users and

communities we work with occupy our thoughts as we interact with each other and make decisions (Fawcett 2009; Warner 2008).

Bradley and Hojer argue that 'the worker/supervisor relationship may be constructed and viewed as an integral and interdependent part of a broader dialogue within the organisation and beyond, one that actively seeks feedback, interaction and improvement that is less reliant on the more usual form of hierarchical communication' (Bradley and Hojer 2009, p.82). To achieve its aims supervision must be held as a central component of a culture that nurtures learning. In an ideal workplace, in which the prevailing approach is the fostering of a 'learning and development culture', one would expect to see the following practices in place:

- greater engagement of frontline staff in determining local and personal professional development goals (Beddoe 2009)
- recognition of the emotional impact of constant exposure to illness, distress and trauma with effective processes to mitigate any deleterious effects (Cox and Griffiths 1996; Hughes and Pengelly 1997)
- professional learning as continuous throughout careers and including learning within practice activity (Schön 1991)
- facilitative, learning-focused supervision which is valued, supported and well resourced (Hawkins and Shohet 2006, p.202)
- all staff members, including the most senior, participating in supervision and professional development (Hawkins and Shohet 2006, p.202)
- reviews of mistakes and problems to provide opportunities for learning with a focus on practices and potential improvements, not on finding scapegoats (Green 2007, pp.405–406)
- good practice based on a balance in a cycle of learning – action, sharing stories of success and failure, reflection, experimentation, evaluation, planning and renewed approaches to problems (Davys 2001)
- individuals and teams making time to review their effectiveness (Hawkins and Shohet 2006, p.203)
- provision of ongoing feedback including 'immediate comment on aspects of a task or a role given on-the-spot or soon after the event by a co-participant or observer' (Eraut 2006, p.114)

- informal conversations away from the frontline of service delivery via supervision or formal mentoring; formal appraisal a more formal and less frequent process (Eraut 2006, pp.114–115)
- opportunities for feedback between the levels of the organisation (Hawkins and Shohet 2006, p.203)
- room for professional autonomy and discretion and practice which is not dominated by rule-bound proceduralism (Cooper 2001; Franks 2004).

Health and social care organisations frequently promote policy statements exhorting that they are 'learning organisations'. The rhetoric, however, is sometimes not matched by evidence of what really happens. Genuine commitment to cultural change in organisations creates 'spaces for generative conversations and concerted action. In them, language functions as advice for connection, invention, and coordination. People can talk from their hearts and connect with one another in the spirit of dialogue' (Kofman and Senge 1993, p.6). Similarly supervision policies can be acceptable on the surface but not meet their promises in reality. Gardner found that participants in a critical reflection process felt that there were problems with their supervision. Among the problems were: 'Supervision that's confusing, not clarifying', poor quality of supervision that does not help develop skills, a lack of direction, inconsistency, and the 'rules of supervision – that do not meet needs of team' (Gardner 2009, p.184).

Peach and Horner comment that low levels of public and political tolerance of mistakes in contemporary human services and health organisations mean that the main purpose of 'supervision is in danger of becoming the elimination of risk through the micro-management and surveillance of practitioners and their outcomes' (Peach and Horner 2007, p.229). This is far from the idealised nurturing restorative process in which supervision is the 'quiet profession' (Alonso 1985) focused on the provision of reflective, supportive, yet challenging facilitation of the supervisee's professional development. As Jones asserts, 'the nursing literature concerning clinical supervision is consequently anything other than quiet. There is a burgeoning discussion concerning many complexities of clinical supervision' (Jones 2006, p.579). What research tells us is that often the reality of the organisational culture is such that supervision is not happening in practice, or is under pressure (Stanley and Goddard 2002; Stevenson 2005). It is also the experience of many that supervision time or focus is inadequate or that it does not occur (Hunter 2009).

Reference is often made to supervision when practice is reviewed following child abuse tragedies. The Laming report on child protection practice, for example, includes supervision explicitly as a practice to be fostered:

> Regular, high-quality, organised supervision is critical, as are routine opportunities for peer-learning and discussion. Currently, not enough time is dedicated to this and individuals are carrying too much personal responsibility, with no outlet for the sometimes severe emotional and psychological stresses that staff involved in child protection often face. Supervision should be open and supportive, focusing on the quality of decisions, good risk analysis, and improving outcomes for children rather than meeting targets. (Laming 2009, p.30)

Health and social care agencies have faced many decades now of escalating demands, an adverse climate of scrutiny and public criticism. Such a climate is corrosive of core values of helping professions and undermines public confidence. The significant of these concerns is discussed in further detail in Chapter 11, where we explore supervision in child welfare and protection practice.

LEARNING AND WORKPLACE CULTURES

Workplace cultures can exert positive and negative influences on the attitudes of staff and their motivation to participate fully in learning activities, including supervision. Unhappy workplaces in health and social care organisations can be unduly bureaucratic and stifle innovation, or become crisis-driven, without time for reflection. They can be risk averse, with high levels of anxiety, or highly competitive environments which lead to severe overworking (Hawkins and Shohet 2006, pp.196–201). In the case of a 'workaholic' culture managers may collude with unsafe working conditions rather than challenge the leadership. Often dysfunctional workplaces have faced significant or continuous change that has placed many key processes beyond the control of professional leaders; for example, where the external decisions of funders and policy makers create a highly competitive environment that imposes targets (and sanctions) on individuals, teams or sites. Burke suggests that restructuring and downsizing have contributed to:

> the crisis conditions conducive to workaholism. As organizations strive to become more entrepreneurial, support for workaholism is fostered. Organizations rarely discourage such behaviors; some take pride in developing cultures where long hours and sacrifice are seen as requirements for success and advancement. (Burke 2001, p.639)

Casey describes how decades of change, manifest in such features as continuous or repeated organisational restructuring, downsizing, the introduction of flexible employment practices such as temporary jobs and changes to working hours have impacted on the nature of working life. She notes that 'many of these developments occur in conflict with other social and cultural aspirations, such as for secure employment, social inclusion, community development and quality of working life' (Casey 2003, p.622).

Awareness of the impact of organisational culture on learning, reflection and supervision practices has been informed by consideration of research and development happening in the broad fields of organisational development and lifelong learning. The past decade has seen a movement towards greater recognition of the importance of work cultures with regard to both pragmatic concerns about productivity and competence and to more altruistic efforts to ensure worker happiness and empowerment (Koppes 2008). Table 4.1 sets out features of dysfunctional workplace cultures and their impact on learning and development and contrasts this with features of resilient organisations. Developments in positive psychology (Collins 2008; Luthans 2002; Wright and Quick 2009) are encouraging workplace leaders to reassess and affirm values (Gardner 2009), and foster learning in order to promote resiliency and retain committed professional staff. In addition Western governments have placed commitment to post-school learning as a significant feature of economic and social development in the past few decades. There is sustained political support for whole societies to be engaged in continual learning and development. Policy driven terminology such as 'lifelong learning', 'the learning society' and 'the learning organisation' has entered everyday language in health and social services. In particular the ideal of the 'learning organisation' has taken firm hold.

Table 4.1 Contrasting the features of organisational cultures

Organisational type	Common themes	Impact on learning and development	Resilient organisations
Blame and shame culture dominates (Hawkins and Shohet 2006)	Defensive practice Risk averse Scapegoating Focus on identifying individual deficits Staff cover up any difficulties	Fearfulness about admitting mistakes. Surveillance dominates supervision (Peach and Horner 2007) Failure to reflect and change practice Supervision resisted and undermined Supervision focus on surveillance Low support for reflection	Collective responsibility for problems and mistakes Supervision and group consultation processes embed culture of collaboration (Jones 2008; Lietz 2008; Lindahl and Norberg 2002 and Lohrbach 2008)
Efficiency model dominates	Rigid hierarchies High on task orientation and low on personal relatedness (Hawkins and Shohet 2006)	Efficiency valued over communication (Cooper 2000) Audit processes create additional overload and limit learning activities Stifles innovation – seeks standardisation and routine Supervision focus on targets and output	Recognition that professionals in health and social care use their own personal emotional resources in the work and these resources need care, oversight and 're-stocking'
Perpetual crisis dominates (Hawkins and Shohet 2006)	Constant state of stress and vigilance Low social connectedness Little planning Problem solving focus	Little space for understanding, stories, reflection and exploration Supervision focus on debriefing and 'survival'	Hardy organisations (Collins 2008) foster hope and optimism (Koenig and Spano 2007) Strengths-based, positive approach (Luthans 2002)
'Workaholic' culture (Burke 2001; Hawkins and Shohet 2006)	Enthusiasm and commitment warps into 'missionary' zeal Denial, collusion or reward for overwork (Burke 2001)	Climate is overtly politicised or highly competitive Supervision and support for the 'needy' and less heroic Professional development support may be a reward not a right	Work–life balance and empowerment (Koppes 2008) Collaborative decision making and space for reflection

THE LEARNING ORGANISATION

The concept of 'the learning organisation' developed in the 1980s is often cited in supervision literature. The rise in prominence of this concept has been attributed to Peter Senge whose influential text, *The Fifth Discipline: The Art and Practice of the Learning Organisation* (Senge 1990) has gained a place on the bookshelves of many managers in health and social care. The origins of the learning organisation are found in the work on organisational development undertaken by Argyris and Schön in which organisational learning was viewed from a systems perspective (Argyris and Schön 1974, 1978). Senge's prescription for a learning organisation requires the mastery of five core disciplines: self-mastery, shared vision, team learning, mental models and systems thinking (Senge 1990). Common features include a systemic view of organisational learning and development, a cycle of continuous critical reflection on the business of the organisation, empowerment of individuals within the work world, emphasis on communication and the harnessing of knowledge and energy through commitment to teamwork. The learning organisation's influence beyond the business sector is indicated by articles that refer to it in professional contexts such as health, social services and education (see for example Eraut 2004; Gould and Baldwin 2004).

'Lifelong learning' and 'learning organisations' are interesting features of contemporary society as, on superficial examination at least, it seems that government policy and organisational practices are rather well aligned with the professional values of the helping professions, 'on the surface what could possibly not be "good" about "lifelong learning"?' Is there a dark side? (Beddoe 2009, p.724). Recent research finds that practitioners in social services were highly conscious of these 'discourses' and their impact on the workplace, but that they were rather cynical. Beddoe (2009) identified several problems in a study of social workers' ideas about continuing education. First, learning discourses are acknowledged as influential but practitioners recognise personal costs and may experience this as yet further encroachment of work on their time (p.728). Second, learning organisations aspire to foster learning from mistakes, however, practitioner perspectives suggested that feedback loops were unlikely in low trust environments (pp.728–729). Lastly, the social workers in this study felt that health and human services organisations were far too unstable to manage continuous improvement (Beddoe 2009, p.731).

A critical examination of the learning organisation suggests that it is vital to retain a sense of the value of learning for its own sake, where it is self-directed and free from manipulation by short-term political agendas

(Beddoe 2009). Other kinds of knowledge, cultural, transformative and personal, are valuable and contribute to the professional knowledge base. Knowledge is enriched by critical reflection and the wisdom uncovered by examining practice over time and its replacement with technologies of learning and practice (Reich 2002). These approaches risk objectifying both service users and the nature of the work by assuming that assessment tools and limited 'system' responses create sufficient skill to keep disasters from occurring and effect good enough practice. Again, the Laming report clearly identifies the importance of embedding regular time for reflection, supervision and peer learning:

> There is concern that the tradition of deliberate, reflective social work practice is being put in danger because of an overemphasis on process and targets, resulting in a loss of confidence amongst social workers. It is vitally important that social work is carried out in a supportive learning environment that actively encourages the continuous development of professional judgement and skills. (Laming 2009, p.30)

At the time of writing this book, announcements were being made about the development of extensive training for supervision, to ensure that the recommendations of the Laming report can be met. In examining various accounts of 'managed' implementation of supervision strategies, there are often problems with top-down approaches, see for example Froggett (2000). One enterprise, reported in Davies *et al.* 2004, described how a 'computerised auditing system is being used to track the occurrence of supervision and the nature of any events which prevent supervision from taking place' (p.41), perhaps indicating a concern that compliance might be patchy.

It is also important to consider the significance of the mediating capacity of supervision and its potential to contribute to multiple levels, and direction, of feedback within health and social care (Morrison 1996). Failure to communicate, anxiety and lack of trust within organisations can lead to poor or unsafe practice. Supervisors can assist through creating a conduit for feedback or what Morrison (1996) described as the mediation function of supervision within organisations. Austin and Hopkins (2004) cited in Kaiser and Kuechler (2008, p.78) have described this mediative function as having three parts: 'managing down' (transforming the vision of the administration into action); 'managing up' (advocating for the needs of clients and staff) and 'managing out' both in the agency (dealing with tensions between diverse professionals in an agency) and in the community

(addressing the interests of and pressures from multiple agencies who might be involved in client services). Table 4.2 suggests some questions which may assist supervisors to consider the context of their particular organisation.

Table 4.2 Organisational context

Considering organisational context
• Power – who decides the learning goals in this organisation?
• Collaboration – what processes are used to elicit employee ideas about learning needs?
• Do managerial interests dominate decisions about supervision?
• Are there opportunities to learn in groups?
• Is the use of group supervision or consultation used to tap collective learning power?
• Is there a continuous improvement strategy and, if so, does it focus only at the micro level, ignoring macro problems that frontline health and social care workers can't control?
• Is there room for honest reflection and evaluation of supervision and professional development to guide the organisation in its decision-making about development and improvement?

WORKPLACE LEARNING

It is part of a professional's personal obligation to remain competent. Increasingly this shifts workers' study time to their non-work hours and into their home life. As we saw in Chapter 1, many professional bodies have now embedded these expectations within requirements for annual practising certificates. One of the problems is that there is still a great deal of work to be done to understand how professionals do continue to learn during their careers and how to motivate practitioners who struggle to participate because of time constraints, costs and personal responsibilities. In reality most practitioners are learning all the time whether this is conscious or not! For most practitioners in the health and social services professions, their professional work is carried out within group and agency settings. Informal learning is constant, 'everyday' and sometimes accidental.

Much of this development of everyday knowledge occurs informally through trial and error, observation, discussion and sharing stories as well as more formal guidance and mentoring. Supervision is most effective when it is led by the supervisee's agenda and is learning focused. This makes practitioner narratives significant and locates learning centrally in the work context and not remote from practice. This does not mean that professional development via external training, study towards higher

qualifications and practitioner research do not contribute to learning, but all these are likely to be more successful and lead to change and improvement if supervision provides a conduit for their support. Dirkx argues that 'learning and change are conceptualized largely as cognitive, decontextualized, individualistic, and solitary processes' (Dirkx, Gilley and Gilley 2004, p.36). A consequence of learning activities being located in the world external to the practitioner's employing agency is that distance is created between the educational institution and the site of practice. This distance is unhelpful and limiting and does not align with practitioners' accounts of their learning.

Dirkx expresses this distance clearly:

> Practitioner stories suggest that lifelong learning and change in continuing professional development reflect an ongoing struggle to keep the rational deeply connected with the richly felt experience of practice.... From this perspective, the knowledge we use to inform our practices evolves in an ongoing way from dialectical relationships that involve the relevant technical or scientific knowledge, the sociocultural context of practice, and the practitioner's self. (Dirkx *et al.* 2004, p.36)

Table 4.3 suggests some questions which may assist supervisors to consider how the culture of their particular organisation affects learning.

Table 4.3 Organisational learning reflections

Organisational learning exercise
• What are the particular strengths in your workplace?
• What particular expertise do team members have?
• How do the learning activities in the workplace facilitate sharing of expertise in this workplace?
• What supports or hinders innovation in your workplace?
• What would you like to strengthen in 'learning' in your setting?
• What would you like to discard?
• What would you like to develop or create which is currently missing?

Supervision, given its location closer to the workplace, often in peer and professional relationships, offers considerable potential for promotion of a more practice-grounded learning. In considering the links between supervision and career-long learning, it is important to note an emerging agreement that professionals learn in the job through a combination of work experience, clinical practice, clinical or professional supervision and

in ongoing post-qualifying learning. Good facilitation though is needed to ensure that reflection and critical review assist professionals to turn this collected information into enhanced practice.

In an ideal health and social care organisation, supervision is valued and training and ongoing support encourages and maintains excellent communication amongst supervisees, supervisors and managers alike. The desire to build 'continuous conversation', reflective practice, feedback loops and time to share ideas and concerns in health and social care workplaces (Beddoe 2009) is increasingly leading to the examination of group and collaborative approaches to supervision (in nursing Lindahl and Norberg 2002 and Jones 2008; in social work Lietz 2008 and Lohrbach 2008). Group approaches are developing strength as organisations strive to create more participatory cultures. Baldwin 2008, for example, utilised cooperative inquiry methods working with social care workers to explore how the organisation could best foster innovation.

MANAGERIALISM, 'THE RISK SOCIETY' AND SUPERVISION

A survey of the supervision literature of the last two decades produces a gloomy view of supervision in which the impact of the current fiscal policy environment in health and social services has weakened the focus on the formative and restorative aspects of supervision (Hawkins and Shohet 2000; Hughes and Pengelly 1997; Morrison 2001; Payne 1994). Economic rationalism, managerialism and the growth of management as a new and distinct profession, the emphasis of outcome and output led service delivery, contracting, and consumer advocacy have all had an influence on the organisational contexts in which supervision occurs. At the time of writing this book, health and social care organisations around the globe nervously watch for spending cuts.

More recent discussion emphasises the links between the revitalisation of supervision and the impact of 'the risk society'. The term 'the risk society' is used to describe a society that is organised in response to risk (Beck 1992) and preoccupied with safety (Giddens 1999, p.3). We live in a world in which there is a belief that we must keep and be kept safe (Fawcett 2009). One of the consequences of this heightened awareness of risk is that professionals are expected to take particular responsibility for identifying, managing and reducing risks to which patients and service users are exposed. Risk features at all levels. Individual practitioners are recommended to develop a personal safety plan, whilst in health and social care organisations risk assessment of intake procedures and fiscal

accountability require organisations to identify the potential for costly risk. As we will examine further in Chapter 9, this concern extends to the role of supervisors in identifying the potential for supervisees to be harmed by their work and assisting in prevention.

The raised awareness of public accountability and the desire of governments and other health and social care organisations to avoid exposure to reputational and other risks has, in a rather paradoxical manner, led to a revitalisation of supervision. In 1994 Beddoe and Davys asked 'what is the future for social work supervision in crisis-driven bureaucratic agencies?' (p.21) as involvement in providing supervision training for probation officers had suggested that supervision had become captured by the gathering of information about case management and there was little room for practitioners to focus on their practice issues and even less to think about their professional development. Supervision had become a 'checklist' exercise that was essentially a managerial tool.

Payne suggested in 1994 that supervision was a practice in danger of becoming captured by 'unthinking adherence to politically and bureaucratically defined roles' (p.55). Payne's hopeful view was that there might be a reconciliation of managerial and professional supervision models through the increased focus on quality (pp.54–55), and indeed the extension of professional supervision as a practice which developed in social work, counselling and psychotherapy is very much underpinned by the risk-averse cultures within contemporary health and social care. Beddoe (2010b) argues that the revitalisation of supervision emerges during a period in which risk comes to occupy central stage in health and social care. Supervision has not always been welcomed as a consequence of this association with risk culture and the preoccupation with audit that has characterised much of the change in health and social services over recent decades.

The current preoccupation with 'quality' and the numerous mechanisms to interrogate professional practice has clearly strengthened the mandate for supervision. The links between quality assurance and clinical supervision have often been used to support and protect supervision. Recently a concern has emerged that this emphasis may threaten the integrity of supervision as a worker-centred and learning-focused activity. In social work Peach and Horner have cautioned that because of low tolerance of mistakes in contemporary human services and health organisations, 'the sole goal of supervision is in danger of becoming the elimination of risk through the micro-management and surveillance of practitioners and their outcomes' (Peach and Horner 2007, p.229). Statutory social work in particular has

a high public profile and is especially vulnerable to political scrutiny and public criticism. Supervisors in statutory child protection work face major challenges. They need to manage the expectations of multiple stakeholders in a high stress environment and yet find the time, skill and emotional energy to provide supervision to frontline workers. Bogo and Dill, in a study of child welfare supervisors, reported that 'walking the tightrope' was the metaphor for a significant theme of struggle in their supervision practice:

> One side of the tightrope relates to their relationship to the workers they supervise and indirectly to the workers' clients... They struggle to achieve enough trust about their workers' competence and practice so that they can share power with these workers. The other side of the tightrope refers to their relationship with those senior to them, their managers, the agency director, and the government ministry that decrees new legislation and policy. (Bogo and Dill 2008, p.151)

Chapter 11 will examine more closely the importance of supervision in child protection services.

Clouder and Sellars (2004) provide an interesting counter to the problematising of supervision as a spectre of increased surveillance. Their paper is described as a pragmatic response to Gilbert's important critique of supervision in which he argues that clinical supervision can be shown to operate as a 'mode of surveillance disciplining the activity of professionals' (Gilbert 2001, p.199). Clouder and Sellars argue that, rather than a consequence of new work practices, 'surveillance is ubiquitous and an inevitable concomitant of the social practices in which professionals engage', citing the numerous public encounters health professionals have with colleagues, managers, patients and others and which means that 'professionals are constantly in the spotlight under which competence is being evaluated' (Clouder and Sellars 2004, p.264). Indeed at work we 'are under constant surveillance, whether or not we are consciously aware of it or its effects on us, because we are social beings operating within a system of social practices' (p.265). Supervision can at the very least allow, albeit briefly, the doors to be shut, the noise to be reduced and a quiet space for satisfying professional conversation.

As outlined in Chapter 3, the quality of the supervision relationship is a significant factor in determining the effectiveness of supervision. A

review of the literature identifies the range of managerial elements in the relationship between supervisor and supervisee. The linking of supervision and managerial concerns has been a significant issue for nurses but it is contested in other professions as well. Social work has a longer tradition of supervision and in practice has always included some managerial or administrative functions.

EXTERNAL SUPERVISION: THE DEBATES

To a large extent this current climate encourages the individualist response which characterises the shift towards external supervision (Cooper 2006). External supervision is a term often used as synonymous with non line-management supervision. Points in favour of external or privatised supervision generally focus on the importance of supervisee choice and direction and the negative influence of power differentials in the supervisory relationship. Supervisee choice, especially in relation to group membership and professional identity, was reported by Davys (2005b) as a major indicator of satisfaction. Matching of supervisee and supervisor characteristics particularly in relation to ethnicity, culture, gender, age and professional and theoretical orientation are also considered to be important. It is expected that with an external supervisor, where power and authority issues have less impact, supervisees will have greater freedom to express concerns and frustrations about organisational issues.

External supervision, located as it is outside the agency, allows more intensive focus on clinical issues and personal professional development rather than organisational concerns. In addition this external supervision arrangement may improve the likelihood that supervision actually does take place. In busy agency settings supervision can often be neglected or deferred to accommodate the latest crisis unless it is made a high priority by management.

While these arguments are valid, there remains some justification for a degree of scepticism about the efficacy of external supervision arrangements. The following questions are pertinent:

- How effective is the unchecked stream of ventilation about organisational issues that can sometimes preoccupy external supervision sessions?
- To what extent can the external supervisor be an advocate for stressed and troubled workers when their mandate is ambiguous?

- Does the absence of organisational authority in the supervisor lead to a lack of real challenge?
- What do supervisors do to check out other perspectives?
- How do supervisors assess clinical practice and ensure safety?
- To whom is ultimate loyalty and confidentiality owed when a third party is paying for the supervision?

We are aware that these questions may reflect the authors' grounding in social work models of supervision which has long reflected the organisational context. Nevertheless, it is a reasonable assumption that other approaches may be influenced by traditional assumptions about context. Counselling and psychotherapy supervisory approaches are frequently based on a private practice structure which is strongly predicated on a set of assumptions about the relative autonomy of the individual practitioner. The private or semi-private (group practice) practitioner may make choices based on reputation, therapeutic or theoretical orientation, style and of course more pragmatic concerns such as cost, access, professional accreditation requirements and third party funding bodies. The private supervisor will be able to determine the length and nature of the supervision process and will largely self-monitor and evaluate his or her interventions. These conditions are likely to be replicated in the supervision arrangements.

Disadvantages of external supervision

There are a number of pitfalls in the separation of supervision from clinical accountability:

- There may be an ambiguous mandate for dealing with issues of poor performance where supervisors become aware of performance matters but have no mandate or clear contract to address these.
- Unhealthy collusion can occur where there are grievances in the practitioner relationships with line managers.
- Separation may deepen the experience of the gulf between 'management' and 'practice' and thus reduce the flow of information between the layers of the organisation.
- There is a tendency to rely on reported performance rather than 360 degree information collected through day-to-day interaction and observation of performance in teams, case consultations, etc.

- There is the potential for unhealthy triangulation of practitioner, line manager and clinical supervisor if there is not sufficient attention paid to clarity of mandate.
- The line manager may be relived of responsibility to ensure that anti-oppressive polices are satisfied, including cultural support for particular staff, addressing conflict between team members, and the monitoring of personal and practice safety issues in the workplace.
- Duty of care issues can remain unclear and yet be vitally significant when things go wrong.
- Dissonance between organisational goals and the focus and direction of supervision may remain unaddressed.

In a recent article Bradley and Hojer compare English and Swedish approaches to supervision of social workers. It is noted that in Scandinavian countries the practice of supervision provided by external consultants is 'combined with a system of internal, method-oriented supervision, from the line manager to the social workers. This latter aspect of supervision focuses on the management of cases and may be seen to be within an administrative model (Bradley and Hojer 2009, p.75). Bradley and Hojer cite Bernler and Johnsson (1985) when suggesting seven criteria that form the basis for supervision in social work (p.75). These are (1) that supervision should be a continuous activity, (2) it should assist the integration of all integrate all aspects of their work, (3) the process should encourage reflection on the use of self and feelings, (4) ideally it should be a non-linear organisational relationship between supervisor and group of practitioners, (5) supervisors should be responsible for the process of the supervision, not for the supervisee's direct work with client, (6) *all* social workers should have supervision, and finally (7) the supervisor should have expertise in social work (theoretically as well as practically), education in supervision theory and method, and cultural competence in the specific area of practice (p.75). Table 4.4 identifies a list of questions through which to consider external supervision from the perspective of the external supervisor, the manager and the supervisee.

Table 4.4 Reflections on external supervision

Reflections on external supervision
If you are an *external supervisor* what can you do to support the full professional learning of your supervisees? • Could you influence your supervisees' organisations? • How can you ensure you get good information? • How do you influence in both directions and *should you?* • What arrangements are in place for you to provide feedback to your supervisee's manager?
If you are a *manager* or *professional leader* and your team members have external supervision: • How do you negotiate the lines of accountability and feedback on supervision issues and process? • What arrangements do you have to liaise with the supervisor if you have concerns about your practitioner's work performance? • What agreements are in place if the supervisor has concerns about the practitioner and/or the work context?
If you are a *supervisee* with external supervision: • What should you do to ensure that your supervision is accountable to your manager/workplace? • What are the boundaries of confidentiality that you think important?

CONCLUSIONS

Supervision has a major role to play in safeguarding practitioners in health and social care in a process which can assist them to cope with their emotions, manage uncertainty and to continue to grow and learn professionally. The culture of the organisation will shape the manner in which supervision is valued and accepted within that organisation. Organisational culture will also filter the effects of public and legislative surveillance and ultimately determine how effective supervision can be in promoting learning and renewal of practice. In the organisational setting supervision practice is 'at the intersection of the personal and professional, where "dangerousness" may be a fear and optimism may be muted' (Beddoe 2010b) and, whether supervision is internal or external, there are inevitable difficulties of balance. Stanford's study of social workers' reflections on practice intervention supports supervision as providing a place for the rekindling of hopefulness:

> Recognition of hope and the possibility of change, alongside a commitment to care therefore need to become directives, as opposed to incidentals, of practice. Supervision is a site in which this orienting framework could be mutually explored and supported by managers and practitioners. (Stanford 2007, p.257)

To retain critically reflective practice, exploration of practitioners' emotions and their understanding of risk and uncertainty need to be given a central space in supervision (Parton 1998). Moral reasoning and a more nuanced exploration of emotional responses and concerns can strengthen supervision practice. We will explore this in more detail in Chapter 8.

Contemporary professional practice is scrutinised, audited and open to the public gaze. Most professionals do much of their work in crowded, noisy, public and stressful environments where meaningful dialogue and reflection is impossible. Supervision can at very least allow, albeit briefly, the doors to be shut, the noise to be reduced and a quiet space for satisfying professional conversation.