Centre for Excellence in Applied Research Mental Health

Establishing Clinical Supervision in Prison Health Care Settings: Phase Three

A Report for Offender Health, Department of Health

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Acknowledgements

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Aim and Scope of Document

The aim of this report is to provide the reader with a detailed account of the work commissioned by Prison Health (Department of Health), in which the School of Health and Social Care at Bournemouth University facilitated and supported the implementation and development of clinical supervision in prison health care settings across England and Wales.

Given the methodological complexity and the focus on practice development within this project, we have written this report with four distinct audiences in mind; namely, the researcher, the educator, the practitioner and the policy maker/manager/governor. This is not to suggest that the issues highlighted as being of note to a particular audience will not be relevant to another. There are overlaps in some of these areas and, indeed, given the reflective nature of the work, it must be noted that consideration of another perspective can broaden and expand one's own understanding and assist in the development of practice. The underpinning philosophy of our work dictates that we do not just provide a report for the commissioners of the project, but that we ensure it is accessible and informative for all interested parties. This report can therefore be viewed as part of the dynamic and transformatory process of supporting the development of clinical supervision in prison. Hence, we suggest that its content has significance not only as evidence for policy, but also as a resource for the continued support of clinical supervision in practice by practitioners. In addition, the methodological and philosophical issues inherent in undertaking practice development work within a secure environment are also important to consider in adding to and developing the work researchers and educators are engaged with in the prison setting.

The concept of discourse analysis is used to highlight the processes and pitfalls of implementing and supporting clinical supervision in practice. To achieve this, traditional approaches to evaluation have been replaced with a broader, more inclusive method in which all activity within the project by both the practitioners and the project team is considered valuable in contributing to a greater understanding of developing clinical supervision in practice. A wide and varied range of data has been collected through the duration of this project and has subsequently been subjected to analysis. Dominant themes and discourses that affect clinical supervision in practice are highlighted and discussed. Finally, a number of recommendations and observations are presented.

Executive Summary

In 2000, researchers from the School of Health and Social Care at Bournemouth University were commissioned to support the implementation and development of clinical supervision in prison health care settings. Work that had previously begun as a pilot study was further developed in three phases spanning seven years. Each phase was iterative and derived from the ongoing evaluation using an action research framework. In phase one, 35 health care personnel were involved in a training programme that prepared staff to facilitate clinical supervision. The findings from this initial phase indicated that there were three key themes to consider in developing, exploring and implementing clinical supervision; namely, methods and approaches to education, the barriers to implementation in prison settings and implications for practice. These issues were addressed by way of further training of prison staff in clinical supervision. This training took place in phase two of this project in which 71 prison health care staff (both nurses and health care officers) were involved. Phase three of this study, and the phase on which this report concentrates, involved the use of regional action learning groups through which prison staff were supported and supervised in developing clinical supervision in their own working environments. In total, seven action learning groups were convened across England and Wales, and included 31 prisons. More prisons were involved at various stages throughout this phase, but 31 prisons were represented regularly and consistently. Each action learning group met regularly over the course of between one year and 18 months. Readers can locate the discussion of findings from phase one in Freshwater et al. (2001a).

Findings from the evaluation of the work of these action learning groups has been separated into consideration of the use of action learning as a method to develop clinical supervision, and the actual developments made in practice as a result of involvement in this phase of the project.

The majority of action learning groups comprised health care staff; however, the inclusion of discipline officers was piloted in two of the action learning groups to evaluate the efficacy of a multidisciplinary approach to supervision. Prison officers working in a unit for prisoners with dangerous and severe personality disorder were included in one group, and prison officers with the responsibility of suicide prevention co-ordinator were included in another.

Following a discourse analysis of all data collected during and after the lives of the action learning groups, the dominant discourses prevailing in

prison in relation to clinical supervision were identified in terms of the practitioner, the educator/researcher and the policy maker/senior manager. All findings were viewed in the context of the full study; each phase in turn has informed the action plan for the subsequent phase. Consequently, the following recommendations are made:

- Practitioners in the prison setting must be empowered to change their practice and embrace their accountability through engagement with regular and ongoing clinical supervision.

- Champions of clinical supervision and reflection in prison settings should be identified and supported to raise awareness among colleagues and to ensure a component of reflection/clinical supervision is present in any induction procedures for new staff.

- Action learning as an approach to workforce development should be considered for all prison staff for a variety of development work, and should not be restricted to health care staff supporting the implementation of clinical supervision.

- Training for trainers should be continued and offered across the prison estate but in smaller geographical areas to enable ease of attendance and to provide networking opportunities for participants.

- There should be formal evaluation of the longer term outcomes of the Train the Trainers events provided as part of this project.

- There should be follow-up support made available for those who have attended the Train the Trainers training in phase three of this project.

- In implementing clinical supervision, the process must first concentrate on developing reflective practice. Staff involved must appreciate the importance of slow progression in order to promote sustainability of developments.

- Policies and standards concerning the implementation and development of clinical supervision and reflection in practice must be locally led and flexible to meet local need.

- Health care staff should be supported to work in collaboration with their discipline colleagues in developing a reflective culture, which would develop practice while simultaneously providing staff support.

- Staff should be empowered to make changes to their practice and be encouraged to do so.

- Clinical supervision and reflective practice should be afforded a higher priority within prison culture. We recommend that prison governors and senior managers should receive awareness training to ensure a good understanding of clinical supervision and reflective practice and their associated benefits.

- Staff must be provided with regular time and space to reflect on their practice and engage with clinical supervision.

- More creative modes of supervision must be considered, such as inter-prison supervision and interdisciplinary supervision, in addition to more traditional approaches.

- Multidisciplinary approaches to clinical supervision should include those working in other agencies allied to the prison service, e.g. police custody nurses.

1. Context and History of Project

Clinical supervision is identified as an area of national concern for health care practitioners across a wide range of disciplines. In 1999, a report that examined nursing in secure environments (UKCC & University of Central Lancashire, 1999) reached a number of conclusions and recommendations that were relevant to the development of clinical supervision within prison. The importance of clinical supervision for nurses working in the prison setting was identified as a major issue, but the report documented a low acceptance of it. It is suggested that the reason for this could be due to practical problems and lack of management support. As a result of the *Nursing in Secure Environments* publication (UKCC & University of Central Lancashire, 1999), Prison Health at the Department of Health, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (now the Nursing and Midwifery Council [NMC]), and Foundation of Nursing Studies co-funded what would become known as phase one of the larger phase of the study (phase three), to establish and evaluate a strategy for the effective implementation of clinical supervision within a group of prisons and to subsequently make recommendations for practice by identifying real and perceived barriers.

What follows is a brief overview of all three phases of the project with the aim of providing sufficient content for the reader to be able to evaluate and use the recommendations from the final phase and the longitudinal processes of action research for practice improvement.

1.1. Phase One

In phase one, five prisons and 35 staff were involved in a training programme that prepared them to facilitate clinical supervision in their own environments. The training was developed and evaluated through an action research approach. The qualitative findings from this phase of the work related to three main areas: the processes and approach to clinical supervision education, implications for practice and the barriers to implementation specific to the prison settings. Several categories emerged within the theme of education and included issues concerning confidence, a need for role play/case study work within any clinical supervision training, and confusion and misunderstanding about the concept of clinical supervision. In evaluating this training, participants highlighted a desire for more practical, experiential learning in the form of role play and case study examination. In terms of practice, participants indicated that individual staff needs and the establishment's perception of

need are disparate. The perceived timing of clinical supervision in relation to frequency and duration varied widely among participants, as did the ability to find time to engage in clinical supervision.

For the majority of participants, the venue for supervision was inside the prison, either in an office, a day room or staff room. Concerns were noted in relation to confidentiality and interruptions where sessions were held within the establishment. Other issues such as trust, confidentiality, the mode of supervision and the quality of the supervisor were highlighted as aspects to note when implementing supervision in prison. Participants reported that some of the barriers to implementation centred on the institutional culture prevalent within prisons, which they felt embraced feelings of suspicion and cynicism towards clinical supervision. Participants also noted poor communication, lack of motivation and apathy as other factors that could hinder the acceptance of clinical supervision. In addition to the institutional culture, operational issues pertaining to inflexible shift patterns and low levels of staffing militated against the effective implementation of supervision.

The recommendations from phase one of this project highlighted the importance of leadership within prison health care settings in supporting the implementation of clinical supervision and in overcoming some of the barriers. In addition to leadership within health care, it was recommended that prison governors and other health care managers need to be appraised of the importance of clinical supervision, and the need for appropriate training of health care staff in clinical supervision was reported. It was suggested that staff receiving training in supervision would also need to receive supervision themselves. Action learning was subsequently suggested as an appropriate approach to developing clinical supervision in prison given that, through action learning, staff could simultaneously receive supervision while developing it in their own establishments.

As a consequence of the successful completion of phase one, and Prison Health's commitment to supporting the development of clinical supervision in prisons, further funding was obtained for phases two and three of the project. (For more detailed information regarding phase one, see Freshwater et al., 2001a; 2001b; 2002.)

1.2. Phase Two

As a result of the evaluation of the pilot phase one, phase two of this project involved the development of clinical supervision training specific to prison health care staff, which was subsequently provided through

national training events. These were available to all prison health care personnel and a total of 71 staff (both nurses and health care officers) attended the training.

1.3. Phase Three

Following the training provided to prison staff in phase two, phase three was commissioned in which it was planned that staff trained in phase two would form regional action learning groups, where they would be supervised through action learning to implement clinical supervision back in their own prisons. In total, seven action learning groups were convened across England and Wales, with 31 prisons represented regularly and consistently. The evaluation of this phase is the focus of this report and so is discussed in more detail later.

1.4. Recent Policy Development

Throughout phase three of this project, major changes took place within the commissioning of prison health care services in England and Wales. One of the most radical changes to face prison health care began with a publication from Her Majesty's Chief Inspector of Prisons, Sir David Ramsbotham. Following some poor inspections of prisons, Sir Ramsbotham published a discussion paper, *Patient or Prisoner* (HMIP, 1996). In this publication, Sir Ramsbotham considered

> health care arrangements in prisons in England and Wales with a view to ensuring prisoners are given access to the same range and quality of health care services as the general public, (HMIP, 1996:i).

Following the publication of this discussion paper, Sir Ramsbotham recommended that 'it is no longer sensible to maintain a health care service for prisoners separate from the NHS' (HMIP, 1996:7). The discussion paper also stated that:

> There is an immediate need for the Home Office and the Department of Health, together with the Prison Service and the National Health Service to agree a timetable for the NHS to assume responsibility for the commissioning and provision of health care and health promotion in prisons. (HMIP, 1996:7)

Consequently, a working party was established with representation from both the NHS Executive and HM Prison Service to examine the recommendations. This working party considered the future organisation

of prison health care and ways in which to improve provision. As part of this, health care staffing was examined, as was the culture within which health care was being provided. In addressing issues of culture, the report mentioned that the health care culture was influenced by traditional attitudes with an emphasis on security and less on nursing practice and health improvement. Regarding this traditional culture, the report states:

> Newly recruited nurses often found it difficult to influence the culture that lacked clear lines of accountability to support them. These factors reduced job satisfaction and contributed to poor retention of nursing staff. (NHS Executive & HM Prison Service, 1999:11)

Following the publication of *Nursing in Secure Environments* (UKCC & University of Central Lancashire, 1999) and public concern regarding health care in prison, the Prisons Minister and the Health Minister set up a working party to look at the development of nursing in prisons in England and Wales with specific reference to health care officers. The report published by the working party (NHS Executive & HM Prison Service, 2000) provided recommendations for the training and induction of health care officers and new nurses and also the development of health care managers in prisons.

In September 2002, the Home Secretary and the Secretary of State for Health issued a joint statement to inform stakeholders that funding responsibility for prison health services would be transferred from the Home Office to the Department of Health from April 2003. This was the first step in a five-year plan whereby NHS Primary Care Trusts (PCTs) become responsible for the commissioning and provision of health care services to prisoners in their areas. The transfer of the commissioning responsibility for prison health care services from the Prison Service to the NHS has had an effect not only on the service provision for prisoners but also, anecdotally, on the staff providing these services.

2. Literature Review

Few would argue with the assertion that nursing of any kind is a complex task, whatever the setting or speciality. Nursing in secure environments has all the usual professional demands – to be patient focused, accountable, robust and evidence based. It also has particular challenges:

> Working with prisoners or patients in locked environments presents nurses with a number of dilemmas on a daily basis. They frequently have to balance issues of therapy and security while undertaking their role as a nurse often in conditions that test their professional resilience.
>
> (Storey, 2000:29)

2.1. Current Stance of the Nursing Profession and Prison Health

It has been a key assumption of the project that clinical supervision provides an excellent mechanism to both support and positively challenge nurses in their ongoing work in these settings:

> Clinical supervision is widely accepted as an essential prerequisite for high quality nursing care.
>
> (Edwards et al., 2005:405)

Particular support can be found within the regulatory professional body for nurses. The NMC published an advice sheet on clinical supervision in 2006 which contains the following extract:

> The NMC supports the principle of clinical supervision but believes that it is best developed at a local level in accordance with local needs. We do not, therefore, advocate any particular model of clinical supervision and we do not provide detailed guidance about its nature and scope. Instead, the NMC has defined a set of principles, which we believe should underpin any system of clinical supervision that is used.
>
> (NMC, 2006:1)

Practitioners and other stakeholders are encouraged to adopt the principles that the NMC sets out in relation to clinical supervision as follows:

- Clinical supervision supports practice, enabling registrants to maintain and improve standards of care;

- Clinical supervision is a practice-focused professional relationship, involving a practitioner reflecting on practice guided by a skilled supervisor;

- Registrants and managers should develop the process of clinical supervision according to local circumstances. Ground rules should be agreed so that the supervisor and the registrant approach clinical supervision openly, confidently and are aware of what is involved;

- Every registrant should have access to clinical supervision and each supervisor should supervise a realistic number of practitioners;

- Preparation for supervisors should be flexible and sensitive to local circumstances. The principles and relevance of clinical supervision should be included in pre-registration and post-registration education programmes;

- Evaluation of clinical supervision is needed to assess how it influences care and practice standards. Evaluation systems should be determined locally.

(NMC, 2006:1)

The Prison Service collaborated with the Department of Health and the Welsh Assembly Government prior to both of the above endorsements. In a document that sets out clear guidelines, definitions and practical suggestions, it begins by stating that:

> Clinical supervision has been promoted as a method of ensuring safe and accountable practice in nursing.

(Department of Health et al., 2002:1)

The document goes on to summarise several prison-specific reports, all of which place clinical supervision as a key aspect of supporting and developing health care in prisons. It particularly focuses on nursing.

2.2. The Link with Action Learning

The action learning element that formed the basis of phase three of the overall project is itself based on the premise that:

> Finding out if something works when we try it still promises us more percentage than does checking it from a book or arguing about it with somebody else.

(Revans, 1998:73)

In this way, action learning echoes the NMC stance that systems which enable practitioners to reflect on practice, and that are devised, enacted and evaluated locally, are the most likely to succeed. This theme of deliberately choosing an action learning approach to build on previous phases of the overall project will be developed more fully at a later juncture.

2.3. Broad View of the Literature

This section of the overall report is based on a broad view of the literature and uses work carried out by other authors who have conducted in-depth searches. A considerable piece of work based on the term 'clinical supervision' was written as the introduction to the phase one report. This is summarised below and is followed by an update using references from more recent literature. The other main terms used within the project are also clarified below, i.e. reflective practice and action learning. It is hoped that this section, along with the whole report, will appeal to a wide range of readers, expected to include researchers, practitioners and policy makers. This accessibility to a multiple audience is reiterated and explored later in this report.

The academic focus of this report, and indeed of the project as a whole, has been to support the development of the 'scholarly professional' working in the heat of practice rather than the 'professional scholar' working at a distance from practice. The practice of a professional is:

> Sometimes differentiated from theory, doing something as opposed to thinking about something. However the distinction is overdrawn. Action and thought…are interactive.
>
> (Polkinghorne, 2004:5)

This review of available literature therefore seeks to provide enough material to remind those working in the field of what has gone before and to identify current useful literature. It does not, however, seek to create a version of reality unrecognisable to those in practice. As Manley & McCormack commented:

> One certainty is that Practice Development is concerned directly with the world of practice and hence it is not our intention to academicize it.
>
> (Manley & McCormack, 2003:22)

This project is essentially about practice development with regard to nurses and others working in prison health care settings. Many writers

confirm the importance of clinical supervision across professions/ disciplines. It is common to see publications that refer to supervision and reflection in the 'helping professions'. See, in particular, Hawkins & Shohet (2006) who focus on supervision and Rolfe et al. (2001) who present a range of approaches to reflective practice.

2.4. Pieces of the Literature Jigsaw

This section summarises past and current literature, paying attention to the drift in terminology from 'clinical supervision' to 'reflective practice', and then goes on to explore action learning in general and more specifically as an approach to developing clinical supervision/reflective practice.

The intention is to provide supplementary jigsaw pieces of information to signpost the interested reader to material that will provide a deeper understanding of concepts used to guide the work of the project, and to support further learning and exploration. These 'pieces' are arranged as follows:

- **About clinical supervision**
  Summary of the phase one report introduction
    - o Background to the project
    - o Policy relatedness
    - o Defining clinical supervision
    - o Nursing in the prison service
    - o Clinical supervision and the prison service
    - o Summary

- **Updates from recent literature**

- **Terminology drift from clinical supervision to reflective practice**

- **About action learning**

2.4.1. Clinical supervision: summary of the phase one report introduction

The phase one evaluation report (Freshwater et al., 2001a) began with a detailed piece of writing that explained the background to the project. This included a history of clinical supervision and attention to the many definitions used. It provided an overview of the policy landscape and went on to focus on prison nursing and how clinical supervision may be applied to this particular setting. This section provides a brief summary of that introductory piece in key point format.

Background to the project

- Clinical supervision is relatively new to nursing but has a longer history in other helping professions;
- Some nursing disciplines are further ahead than others in implementing supervision;
- Approaches to supervision vary across professions and disciplines and include 'caseload review' and 'managerially led' models;
- Some approaches do not link supervision to critical reflection or innovations in practice although there is an increasing tendency towards 'process' models across professions.

Policy relatedness

- There was much attention given to clinical supervision in the mid 1990s with reports from the Department of Health and UKCC, and resulting from untoward events. These publications provide the backdrop to the project;
- The illusion of successful implementation has been reinforced by the appearance of Trust strategies and policies on clinical supervision. The reality on the ground has been, and continues to be, patchy with ongoing debate about practicalities and perceived benefits;
- The importance of clinical leadership to take the agenda forward was emphasised in the late 1990s.

Defining clinical supervision

- Various definitions exist. Some focus on support and learning, others emphasise the maintenance of professional standards;
- There is a degree of agreement that supervision is an adjunct to practice and belongs to a 'lifelong' commitment to development of the practitioner;
- Quoting directly from the phase one evaluation report, Freshwater et al. (2001a:8) emphasise that:

> Clinical supervision is not always linked to the notion of reflection in the literature; reflective practice is, however, a central tenet of clinical supervision that provides the environment within which critical reflection can take place.

Nursing in the prison service

- The prison service requires nurses with specific expertise who need support through development initiatives and clinical supervision. The skill base and professional background of staff in prison health care is varied;

- Health care is not the primary function of a prison. Prisons focus on custody and rehabilitation of offenders;

- Patients in prison have a wide range of health needs catered for through primary care and, in some places, in-patient services.

Clinical supervision and the prison service

- There has been a low uptake of clinical supervision;

- Clinical supervision and other reflective/supportive systems are not readily available;

- In 1999, a major report entitled *Nursing in Secure Environments* recommended that clinical supervision should be a mandatory requirement;

- Clinical supervision can be used to positively influence the particular culture of prison health care settings;

- Nurses in secure settings vary in their beliefs as to whether clinical supervision would be beneficial and whether it would be best provided by prison staff or local NHS colleagues.

Summary

> Clinical supervision offers a formal structure in which openness to learn from mistakes can be fostered and nurtured…
>
> (Freshwater et al., 2001a:12)

- This project seeks to establish a strategy for the effective implementation of clinical supervision;

- Good practice will be identified and disseminated using guidelines for best practice;

- Enthusiasm will be regenerated;

- A formal system to discuss/review nursing practice will enhance prison health care;

- Training needs will be identified and progressed.

Endnote

This work set the scene for what was to follow, i.e. the phase of the project that built on early pilots. This was developed through a national training initiative and culminated in the use of action learning groups as a vehicle for leadership development. This, in turn, was a support mechanism for the implementation of clinical supervision, as was so firmly recommended at the turn of the century.

2.4.2. Updates from recent literature

Since the publication of the phase one evaluation report, nurses have continued to grapple with many issues associated with supervision. There continues to be patchy implementation, and a range of literature describes, comments on, evaluates and critiques the state of the practice and theory landscape in relation to clinical supervision. In the light of ongoing disagreement and uncertainty, readers are particularly directed to a literature review conducted by Jones (2006), entitled 'Clinical Supervision: what do we know and what do we need to know'. This study made use of several relevant databases with additional information drawn from the internet, seminars and physical library searches.

Jones notes that:

> Clinical supervision in nursing is over a decade old in the UK and yet emerging nursing literature suggests that many ideas remain unfamiliar to nursing practice.
>
> (Jones, 2006:577)

Despite the apparent lack of a cohesive approach across the nursing profession, Jones reviews 'what is known and what we need to know', taking an optimistic stance through the exploratory nature of his study and a belief that 'it is important to revisit and consider some complexities of clinical supervision in order to identify a way forward' (Jones, 2006:578).

This optimism seems to be shared by other authors who address some of the complexities alluded to by Jones. For example, Jubb Shanley & Stevenson (2006:586) 'make some suggestions for more complex versions that may be suitable as the profession develops'. Begat & Severinsson (2006:615) go further, concluding that 'the purpose of work becomes clear when nurses reflect on themselves as professional and as authentic human beings'.

Johansson et al. (2006:650), using a focus group and content analysis approach, uncover an emphasis on the 'value of caring in nursing supervision' that seems to concur with the high ideals and hopes expressed by many authors. Hawkins & Shohet (2006), in their revised third edition of *Supervision in the Helping Professions*, summarise the ongoing and renewed optimism noting in their recent work, written 17 years after the first edition, that:

> This includes a greater emphasis on learning and building on the positives in order to flourish in our work. The title of the conclusion has changed from 'The Wounded Helper' to 'Keeping

> our Hearts and Minds Open'…woundedness and learning are
> two inextricable strands of effectively enabling others.
>
> (Hawkins & Shohet, 2006:x)

In light of all the optimism, however, '…resistance shown by nurses…remains perplexing' (Jones, 2006:577). This resistance may be related to one particular update since the phase one report that merits attention, i.e. the ongoing drift in terminology from 'clinical supervision' towards 'reflection', 'reflective practice' and 'critical reflection'. This evolution in terminology is explored in the next section of this literature review and more fully in the main body of the report. It is noted that when prison health care staff began to get a better understanding of supervision, they felt empowered through the action learning group process to embrace new terminology.

Prison staff felt that they had permission to change terminology. This demonstrates the importance of owning a change in order to make change sustainable and successful. By tracking the changes in dominant discourses, we attempt to establish and link with the discourse analysis that is the underpinning methodology of the whole report.

2.4.3. Terminology drift from clinical supervision to reflective practice

In the beginning were the words…and the words were 'clinical supervision'. This sub-section considers the terminology drift from clinical supervision to reflective practice.

Annette Gilmore conducted a review of evaluative literature on clinical supervision for the UKCC in 1999 and noted that:

> Clinical supervision is proposed as a way of 'harnessing' reflective practice, but reflective practice need not always be a part of the process.
>
> (Gilmore, 1999:23)

She further summarises the work of authors who were concerned that 'some practitioners may not be able to cope with…intense scrutiny of themselves and their work', adding:

> Furthermore if the supervisee is inexperienced clinically then reflection may be an inappropriate and frustrating method. A more directive teaching programme may be more effective.
>
> (Gilmore, 1999:23)

Alongside this concern expressed through professional literature, there was another, possibly more powerful, drive for change in terminology

emerging in the practice field. The term 'clinical supervision' was contentious. Many nurses focused on the word 'supervision' and associated this with the more traditional use of the word where to supervise means to 'superintend' or 'oversee' (Oxford Dictionary and Thesaurus, 1997). Jones recently articulated this concern by citing other authors:

> Walsh et al. (2003) proposed that the term itself 'clinical supervision' is problematic in that it implies a hierarchical relationship.
>
> (Jones, 2006:578)

In prison health care, Freshwater et al. (2002) used a direct quote from an interviewee in the work that supported the initiation and commitment to the current project. Their respondent said:

> I mean, even my Senior Officer came in the other day and said 'clinical supervision: is it watching someone do a procedure?'…
> I think that's quite common around prisons – that it's being monitored, supervised in their actual working practice and not really…I mean, I think the term is wrong. I think it's misleading: it's really reflective practice. They don't understand that.
>
> (Freshwater et al., 2002:17)

Formal and informal education has gone some way to alleviating concerns about this misconception, and nursing as a profession is gradually arriving at a deeper and more collective understanding of the link with critical reflection:

> We all reflect on our practice to some extent, but how often do we employ those reflections to learn from our actions, to challenge existing theory and, most importantly, to make a real difference to our practice?
>
> (Rolfe et al., 2001:xi)

It has been argued that:

> While it is impossible that we all share exactly the same meaning, it is important for the sake of communication and the development of Clinical Supervision that nearly all of us agree nearly all the time on what Clinical Supervision means. Alternatively, we need to engage in a process locally where a shared meaning of Clinical Supervision is developed and acknowledged.
>
> (Jubb Shanley & Stevenson, 2006:592)

As will be seen later in this report, the action learning group approach facilitated the creative harnessing of emerging thoughts based on real life experience in prison health care settings and concurred with recent literature that suggests:

> It might…be the case that only one definition or approach is unhelpful to nursing since, like nursing practice, clinical supervision encompasses various ideas in different ways.
>
> (Jones, 2006:579)

In light of these tolerated differences, it is perhaps unsurprising that the terminology has drifted, especially given the previous point made about resistance based on the false assumption (and/or practice) of hierarchy in the supervisory relationship.

> Nurses should…be aware that there may be different but equally valuable perspectives on supervision and not allow this to become yet another barrier to its implementation.
>
> (Lyth, 2000:722)

There is much deliberation about the potential misuse of any form of hierarchical approach to clinical supervision. Cutcliffe & Hyrkas (2006) conclude that:

> The importance of having a clinical supervisory relationship that remains separate from administrative/managerial supervision and one where confidentiality is assured was highlighted... Furthermore, the attitudes were not restricted to one professional or disciplinary group. The effective support system of clinical supervision should therefore not be diluted by awkward and unnecessary amalgamations with administrative/ managerial supervision.
>
> (Cutcliffe & Hyrkas, 2006:617)

Paradoxically, one study concluded that clinical supervision offers great benefits for nurse managers offering '…positive long-term effects on their leadership and communication skills…' (Hyrkas et al., 2005:209). This hints at a wide definition of what can be construed as clinical. The need for health care staff who have reached managerial positions where their direct clinical work is minimal appears to be an emerging theme across professions. For example, Hyrkas & Sirola-Karvinen (2006) attempt to explain terminology by clarifying:

> ...the difference between the concepts in order to avoid confusion among supervision, clinical supervision and administrative supervision…
>
> (Hyrkas & Sirola-Karvinen, 2006:602)

They use the latter term as a descriptive label for the form of supervision needed by nurses at higher levels in their career.

Whatever the state of this debate, it remains the case that many nurses do not actively engage in clinical supervision (although many do claim to engage in reflecting on and in their practice):

> There continues to be debate about the practicalities of implementing the Clinical Supervision process which meets the needs of all parties concerned (including professional bodies, practitioners, managers and consumers).
>
> (Freshwater et al., 2001a:7)

The overall project was designed to address these practicalities. Emergent learning and findings are fully reported within the main body of this report.

2.4.4 About action learning

This section gives an overview of action learning by offering definitions, a summary of origin, background thinking and core philosophy. It also considers recent use of the approach in secure settings. Action learning has been used with prison staff to support the development of practice following provision of mental health awareness training (Musselwhite et al., 2005).

A search of standard nursing, psychological and educational databases using the term 'action learning' elicited a multitude of examples of how action learning is used to help work-based groups to share learning, to learn together and from each other and to move practice forwards. There are many theoretical frameworks in the family of reflective approaches that seek to utilise and validate the learners' experience, both in the workplace and the classroom. Such approaches include 'experiential learning' (Kolb, 1984), 'action inquiry' (Torbert, 2004) and 'participative inquiry' (Reason & Bradbury, 2001). The recent emergence of the term 'whole person learning' (Taylor, 2007) explicitly endorses a radical approach to learning that fully embraces the whole of the person in the learning process and endorses the notion of 'peer' whereby learner and teacher are equals.

Fundamentally, action learning is an approach to learning at work that stresses the importance of 'doing' in the learning process. For those

readers wanting a more thorough explanation of the principles and practice of action learning and a deeper look at its origin and development, we suggest Pedler (1997).

The term 'action learning' itself was introduced and theory relating to it developed by Reg Revans following his work in the British coal industry, and the term was first used in print in 1945. In a review of his own work over decades, Revans returns to the equation:

$$L = P + Q$$

He explains that L means learning, P refers to programmed or taught knowledge and Q to questioning insight. Action learning thus builds on theoretical learning by posing questions based on practical insight drawn from working in practice. Action learning certainly does not reject traditional approaches; it simply proposes that they are not enough.

> Action learning…deals with the resolution of problems (and the acceptance of opportunities) about which no single course of action is to be justified by any code of programmed knowledge, so that different managers, all reasonable, experienced and sober, might set out by treating them in markedly different ways.
>
> (Revans, 1998:6)

In the USA, Lewin and colleagues 'are often hailed as the early pioneers of…participative learning approaches' (Taylor, 2007:28) during the 1940s, while Knowles et al. (1998) cite the earlier work of Lindeman (1926), saying:

> The resource of highest value in adult education is the learners' experience…experience is the adult learners' living textbook.
>
> (Knowles et al., 1998:37)

Whatever the root in history, action learning is one of many approaches that attempt to use the 'living textbook' in a participatory approach to learning based in and on experience:

> Action learning offers many advantages to the busy practitioner, notably its immediate relevance to the challenges and demands of real life…It is also immensely flexible, and attractive to adult learners because it respects their independence and experience.
>
> (Morris, 1997:49)

Morris here makes special mention of the role of the learner as an independent, active and willing participant with the motivation to engage. This accurately picks up the spirit of Revans' life work in this area.

This focus on day-to-day reality in practice settings, where no one position or discipline can claim the 'higher ground' of knowing, is particularly important in prison health settings. Here, nurses, doctors and allied health colleagues are in constant interaction with discipline staff (in the custodial sense of the word). As will be revealed later in the report, the action learning approach enabled very productive relationships to develop that were not entirely foreseen at the outset of the project when the focus was clearly on nurses.

> The allocation to each participant of a real-life exercise that is ill-structured and obscure from the outset (and for which there can be no preconceived line of attack) must encourage in each of them an ability to seek for, and to identify, those fresh questions likely to open up promising avenues of inquiry.
>
> (Revans, 1998:13)

It is from this base that Revans emphasises the difference between action learning and the 'learning by doing' that we can all claim to have been doing for years. Critics and sceptics thus suggest that there is nothing new in action learning. Revans counters this natural criticism by saying that:

> It is recognised ignorance, not programmed knowledge, that is the key to action learning: men start to learn from and with each other only when they discover that no-one knows the answer but all are obliged to find it.
>
> (Revans, 1997:5)

Overall we can say that:

> Providing opportunities for group members to discuss the implications of what they were learning and inviting them to think ahead to how they might apply it to their own circumstances…is familiar to many of us now…
>
> (Taylor, 2007:30)

Action learning groups stress the collaborative nature of learning by creating a spirit of support in which students can test out ideas (Bourner et al., 2000). This approach helps to redress the balance between the programme of the course of study and the questions raised by students during their own learning.

> This experiential approach to learning puts participants and their own process central to the learning they achieve.
>
> (Taylor, 2007:32)

This philosophy of explicitly using the participants' experience in the action learning groups was thought by project leaders and learning group facilitators in this study to provide a excellent 'fit' with the process model of clinical supervision they were attempting to encourage. The basic principle of the action learning groups was to ensure that learning took place alongside practice. The practical application of this principle, applied to prison health care settings, is explored more fully later in this report. The use of action learning, support for champions and a consistent and prolonged project plan has reaped rewards in areas that some thought to be among the most resistant, and in a culture that has at times been undeservedly criticised for its out-dated practices.

3. Methodology

According to Williamson & Prosser (2002:587), 'action research as a tradition has developed since the 1940s as a tool for producing change in organisations with workers' involvement'. It is this potential to encourage and manage change within organisations that underpinned our decision to use an action research approach in this work. Sandars & Waterman (2005) note that action research has several definitions which are particular to the context within which it is used. However, they provide a more generic understanding of action research and report two defining features of the approach: first, it is a cyclical process including a change intervention, and second, there is a partnership between the researcher and the subjects. In this project, these relationships can be seen on two levels: between the facilitator and the action learning group members and between the research team and the action learning group members.

Sandars & Waterman (2005:295) suggest that:

> Action research is characterised by a process in which there is an initial analysis including critical reflection, fact finding and conceptualisation about the problem. This is followed by planning and delivery of an intervention, which in turn is followed by more fact finding or evaluation. The whole cycle of activities is repeated so that there is both improved action and greater understanding of the problem.

According to Corbett et al. (2007:82), action research not only links action with research, but also 'assumes an educational mission as part of the problem solving process'. In addition to adopting an educational focus, action research also encompasses researcher and participant reflection to progress and manage changes in practice.

In supporting the development and implementation of clinical supervision within HM Prison Service in England and Wales, action research cycles were evident on two levels. First, the action learning groups adopted a cyclical approach to developing clinical supervision, and second, the project team worked within a cyclical framework in determining the progress and direction of the project. As can be seen in Figure 1, reflection underpins this whole process.

Figure 1. Layers of Action

Level One

The Project Team
- Project co-ordinators
- Action learning group facilitators
- Key stakeholders

Action Research Cycle

Findings

Specifying Learning

REFLECTION

Action Planning

Evaluating

Action Taking

Level Two

Practitioners/Action Learning Group Members
- Health care officers
- Nurses
- Managers
- Discipline officers
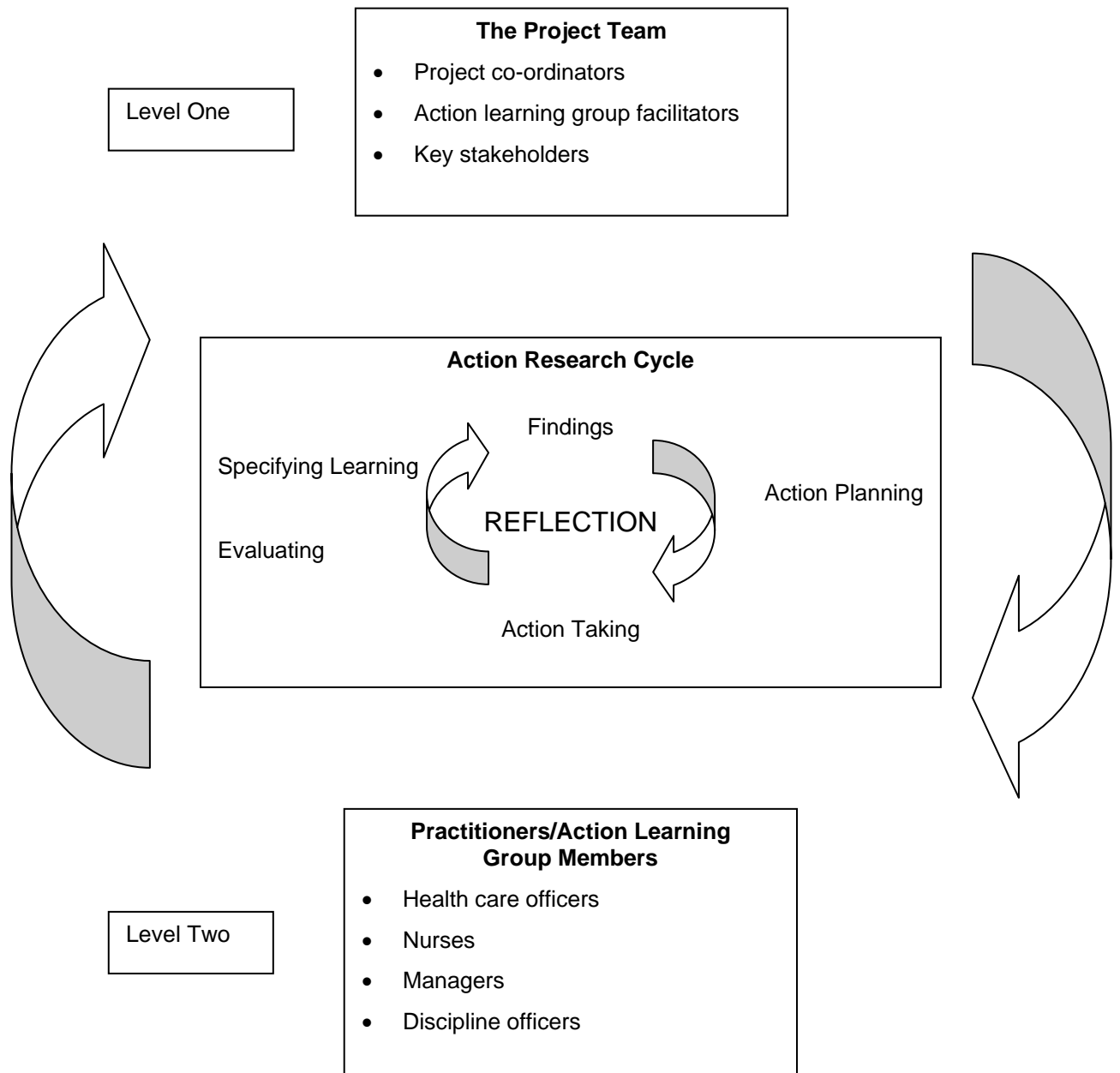
3.1. Action Learning and Action Research: The Relationship

Action learning is an approach where the method itself makes a difference to practice. Action learning and action research are inextricably linked; the interface can be viewed as essentially that of reflection, which is a fundamental assumption of both.

3.2. Participants and Sampling

Originally, prison health care staff who trained as clinical supervisors in the second phase of the project were to be organised into regional action learning groups where they would be supervised through action learning in developing and implementing clinical supervision back in their own prisons. Unfortunately, this proved difficult given the time lapse between phases two and three. During this period, some staff who had trained as supervisors in phase two left the service, transferred to different establishments or faced such resistance back in practice that they gave up trying. Following much investigation, it became clear that a new strategy to assemble regional action learning groups would need to be adopted. It was decided that a questionnaire to elicit the state of clinical supervision across the Prison Service coupled with an invitation for expressions of interest in becoming involved in the project would be the most efficient way of setting up these groups.

Given the changes that were underway in terms of the commissioning arrangements for health care services in prisons and the new partnerships that were being built with PCTs, many of the responses to the questionnaire identified that the provision of clinical supervision in some health care settings was being adequately addressed by the PCTs and that those particular establishments did not therefore need to be involved in this project. However, 60 prisons responded to our letter of invitation and questionnaire; a 43% response rate. In considering these replies, it was decided that, in addition to concentrating on areas where clinical supervision was not in place, it would be useful to identify those areas where it was in place and being used successfully so that good practice could be shared. Following analysis of the questionnaires and expressions of interest, three regional action learning groups were established based on Prison Service regions, although not all regions were represented by a prison:

- Group One: South West; Thames Valley; Hampshire & Isle of Wight; Kent; Surrey & Sussex; London
- Group Two: North West; West Midlands; Wales
- Group Three: North East; Yorkshire & Humberside; East Midlands

A review of these groups took place soon after their inception following feedback from the members and facilitators. It became evident from the group attendance rates that the geographical regions were too big to enable regular attendance and travel to the groups. Over the subsequent months, a number of strategies were adopted to engage with prison health care staff in developing and implementing clinical supervision through action learning. These are detailed in the evaluation section of

this report as it was felt that the way in which the groups were finally established and the processes they encountered were part of the overall evaluation of their efficacy.

In addition to the changes made in organising the original action learning groups, demand for involvement in the groups and a clear need for smaller geographical areas meant further funding was needed to reorganise the groups into more manageable areas. Following discussion with the Safer Custody Group at the Home Office, it was decided that one of these groups should contain suicide prevention co-ordinators (SPCs). SPCs are discipline officers working in the main prison with a responsibility for co-ordinating the Assessment Care in Custody Teamwork (ACCT) processes within their prisons. Given the nature of their role, Safer Custody felt that these officers would benefit greatly from the supportive element of clinical supervision. Ultimately, it was considered that these officers would then be able to develop and support supervision among the ACCT assessors working in their own prisons. Safer Custody identified the West Midlands as an appropriate region within which to pilot this approach. SPCs in all prisons in the West Midlands were contacted by the project team and invited to join the project. One of the additional action learning groups was therefore held in the West Midlands region. Another was held in Wales, two in the North West and one in the North East. In establishing the groups in these regions, all prisons were contacted by letter and invited to join. Further discussions with interested prisons were held via telephone.

In addition to having SPCs in the West Midlands action learning group, discipline officers also emerged from a prison in the North East region as having a need for clinical supervision. At HMP Low Newton, a unit for prisoners with dangerous and severe personality disorder (DSPD) was being created and links with the health care department were a natural outcome. Discussion with the head of health care and the management of the DSPD unit did indeed highlight a strong need for clinical supervision for both health care and DSPD unit staff. Therefore, the North East action learning group comprised both health care and discipline staff.

Table 1 details the areas and prisons within the action learning groups once the project was established.

Table 1: Action Learning Group Composition

Action Learning Group	Prisons
Wales	Cardiff, Usk, Gloucester
Midlands	Nottingham, Everthorpe
West Midlands*	Werrington, Featherstone, Stafford, Drake Hall, Blakenhurst, Shrewsbury, Brinsford, Long Lartin, Brockhill
London/South East	Belmarsh, Wormwood Scrubs, Brixton, Wandsworth, Feltham, Maidstone, Dover, High Down, Blantyre House, Rochester
North West 1	Liverpool, Risley, Styal,
North West 2	Preston, Garth
North East**	Low Newton

* Action learning group including suicide prevention co-ordinators
** Action learning group including discipline officers working in DSPD unit

It is noted that not all regions are represented in the table above. This is due to operational constraints on some prisons in specific regions and, in some instances, a reported lack of need for support in implementing clinical supervision. In addition, in some areas, some prisons were represented at the beginning of the action learning group but subsequently did not attend consistently or regularly. These prisons are not mentioned.

3.3. Data Collection

The action research approach to developing practice requires an ongoing awareness of and reflection on various sources of data which subsequently inform the direction and evaluation of work as it progresses. This approach allows participants and researchers to introduce new strategies and interventions through which practice can be transformed and changes sustained. In keeping with this approach to our work, data were collected continuously and from a variety of sources throughout the duration of phase three. This not only informed the work of the project team and action learning groups, but also provided a full and thorough evaluation of the project.

Data were collected from:

- Regular group notes written by the facilitators in conjunction with group members, which were sent to the project co-ordinator following each action learning group meeting highlighting key group processes and outcomes;

- A final group report, written by the group facilitator at the end of the life of the group for the project team, which served as an overall evaluation of the group from the facilitator's perspective;
- Written reflections from the group facilitators at the end of the life of the action learning groups outlining their own personal thoughts and feelings about the action learning group experience;
- Transcriptions from focus group interviews held with action learning group members, undertaken by a research assistant, at the midpoint of the life of the group (see Appendix 1 for interview guide);
- Transcripts from taped interviews with individual action learning group members held at the end of the project (see Appendix 2 for interview guide);
- Notes taken from telephone interviews at the end of the project;
- Email correspondence between project team and participants;
- Reflections and notes made by the project co-ordinator at the Reflective Practice in Prison conference, held in September 2006 at Prison Service College, Newbold Revel, Rugby;
- Participant evaluations and facilitator reflections from three national training events for prison staff held during 2006/07;
- A project diary kept by the project facilitator;
- Regular updates provided by the project team for Prison Health at the Department of Health;
- Minutes from project team meetings and away day event;
- Additional outputs from the project; namely, conference presentations and publications.

3.4. Ethical Considerations

In keeping with traditional approaches to research, the ethical principles of beneficence, anonymity and confidentiality were considered throughout. Participants in this project gave their consent to be involved through the use of clinical supervision contracts and by virtue of their voluntary attendance at action learning group meetings.

3.4.1. Prising open practice

In earlier phases of this project and in other prison-related practice development work, we encountered suspicion, cynicism and a reluctance to open up (Freshwater et al., 2001b; 2002; 2006). Given the closed nature of the prison setting, this is unsurprising. However, in this project, its very essence in promoting reflection and supporting the development of clinical supervision necessitated staff to overcome any suspicion and cynicism in order to open up and examine their practice, be it in the health care or discipline environments. We suggest that the inclusion of researchers with both prison nursing experience and experience of researching in prison assisted with accessing this closed system.

It is recognised in the literature that action research requires a close collaborative working relationship between researcher and participant (see Williamson & Prosser, 2002). Although this close relationship is efficacious in research and practice development terms, consideration needs to be given to the nature of the work being undertaken. Supporting staff to examine and challenge their practice throughout the duration of the project was not problematic or ethically challenging. The challenge was encountered as the project came to an end. Given the nature of the environment within which the participants were practising, removing the support and supervision provided by the action learning groups was ethically problematic. The potential problems facing participants beyond the action learning groups was considered by both group facilitators and project co-ordinators, and action to address these issues was taken through discussion within action learning groups.

3.5. Data Analysis

Discourse analysis as a method of analysis can be seen in a wide range of health care literature. Examples include dementia care (Adams, 1998), nursing diagnosis (Powers, 2002), community mental health (Cowan, 2003), wound care (Hallett et al., 2000), ward rounds (Fox, 1993) and nurse education (Kotecha, 2002; McKenna & Wellard, 2005). Cheek (2004:1145) states that 'discourse analysis is an approach rather than a method' and suggests that discourse analysis is underpinned by the researcher's own philosophy. In considering the underlying postmodern philosophy and experience in prison health practice development work of the researchers involved in this study, the use of discourse analysis seemed the most appropriate approach to working with the data.

The style of discourse analysis we chose to undertake in this project has as its aim the 'analysis and deconstruction of dominant common sense views (discourses) of how the world/everyday life is' (Ballinger & Payne, 2000:568). The world/everyday life in the context of this project is that of the participants – the world of the prison.

Cheek (2004:1144) asserts that discourse analysis is 'concerned with the way in which texts themselves have been constructed in terms of their social and historical "situatedness"'. She continues that:

> Texts not only represent and reflect a certain version of reality, they also play a part in the very construction and maintenance of that reality itself.

She is clear to point out that texts are both constitutive of and constructed by their context. In this project, the 'texts' that were subjected to analysis came from a variety of sources as noted previously. Through analysis of these texts, the dominant discourses prevailing within the prison context in relation to the implementation, support and development of clinical supervision are revealed. Not only are they made explicit, but they are constructed through the reality of those working in and linked with the setting. Given the origin of the texts, it is not only the voices of the participants and research team that are heard; texts that were constructed from wider activities undertaken, such as the Reflective Practice conference, Train the Trainers events, papers presented at conferences and publications, were also analysed. We believe that this approach allowed for a broader consideration of the effect of external influences on the dominant clinical supervision discourses that prevail in the prison setting, both in health care and in discipline settings.

4. Findings

Given the complexity of this project, careful consideration has been given to the presentation of the findings from both the process of implementing clinical supervision in the prison setting in terms of practice, and the process of implementing clinical supervision through the use of action learning as an approach to development. As has been mentioned previously, it is important that the findings from this project are accessible and relevant to policy makers, researchers, educators and practitioners alike to effect changes in practice that are applicable and, more importantly, sustainable. Therefore, the findings from this work are presented with all audiences in mind and we have highlighted the key issues which we feel are important for each audience to consider. In addition, the findings are presented in two sections: the action learning groups and documentary data. The dominant discourses that prevail, their impact on practice and our recommendations for further work are then presented later in this report.

4.1. Action Learning Groups

For each action learning group, a variety of data was analysed: an interim focus group interview, individual participant interviews at the end of the action learning group life, and monthly/bi-monthly reports from the facilitator concerning processes and outcomes. Given the different approaches taken by individual facilitators in managing these groups, each group was considered separately and reported as such. They were examined in the following areas:

- Action learning as an approach to developing practice;
- 'Real' developments in practice, achieved as a result of the work of the action learning group.

4.1.1. The Midlands (February 2005– March 2006)

This group comprised health care managers and front line nurses, and met monthly at an external venue felt to be central to the region covered by the action learning group. The facilitation of this group was shared between two experienced clinical supervisors/facilitators, with each taking the group for six months. Both had some experience of prison health care staff as they were involved as trainers in phase two of this project. There were occasions when group meetings were cancelled and rearranged due to inclement weather, holidays, lack of confirmed attendance and sickness. It became clear early on in the life of this group that attendance was an issue for many. After the first meeting, some members who had travelled a considerable distance deemed the travelling to be prohibitive to their continued involvement and withdrew. At the beginning of the

group, five prison health care staff appeared to be committed. During the subsequent few months this dropped to three and finally to two.

The project team considered suspending this group and redirecting the resources towards setting up another group. However, considering the input and effort given by the group members and facilitator, this was deemed to be unnecessary in that developments in practice as a result of the group (however small) were important to support. The meeting schedule remained fixed at monthly meetings, with the facilitator committed to attending however many participants could come. It was felt that this consistent demonstration of commitment by both the facilitator and project team would provide information about how to engage prison staff in this type of work.

Regular reports provided by the facilitator of this group were compiled in sections outlining the themes discussed at the meeting and the action points for the group with an indication of each member's agreed personal actions. In addition, the facilitator provided members' responses to the questions: 'what did you gain from today's session?' and 'state one thing you intend to do or change to your practice of supervision over the next month'. This provided the project team with information from both the facilitator and group perspectives.

Action learning
In terms of the group processes, it is clear from the feedback that this group initially spent a great deal of time identifying the barriers they faced in setting up clinical supervision in practice and subsequently, through facilitation and supervision, discussing and considering strategies for overcoming them.

The underlying movement in the group processes suggests a transition from identifying problems and sharing frustration to seeking support from one another and sharing possible solutions. Indeed, later in the life of the group, it became clear that the facilitator took the opportunity to expose the members to the supervisory experience by developing their own clinical supervision skills as both supervisor and supervisee in providing space for the discussion of their frustration and problems in implementing supervision.

In evaluating the use of action learning as an approach to developing practice, members from this group considered it to be a valuable method. The action learning group as a space within which to gain support and develop practice was well utilised by all who attended. Members specifically noted the support they received from one another in facing

problems in practice and, indeed, the way in which they valued the opportunity to network with their peers in other establishments. Attending the action learning group meetings was noted by one participant as having 'given me the confidence to get clinical supervision up and running' (P1).

However, the poor attendance in this group was noted as an important consideration to the efficacy of action learning in this context. The members felt that attendance by staff from more than two prisons would be more useful in terms of providing opportunities to network and share experiences. This was qualified with the suggestion that the geographical catchment area of the group needed to be smaller to encourage participation and ultimately improve the opportunity for inter-prison collaboration. One member noted that, although action learning as an approach to developing supervision was useful, 'smaller groups i.e. area catchment would be beneficial to try and build links between more local establishments, to develop smaller networks' (P2).

Indeed, this group suggested that inter-prison clinical supervision could be a possibility in the future, but that it would be easier to establish if more prisons had participated in the action learning group.

Practice developments

Information gathered from this group demonstrates a great deal of developments in practice as a result of engagement with action learning. The barriers to the implementation of clinical supervision were identified very quickly and were seen as both operational and strategic. Examples of the barriers discussed include:

- Blame culture;
- Staff attitudes;
- Lack of training;
- Clarity of terminology;
- Low staffing levels;
- High sickness rates;
- Time;
- Inappropriate venue.

This group identified some key issues that they felt could overcome some of the barriers to implementation, notably: perseverance, encouraging a more supportive team environment, appropriate induction and using a trial and error approach to implementation.

The facilitator of this group identified that the impact of the recent PCT transfer of commissioning arrangements within prison health care

settings appeared to have had an impact on the group members' feelings of insecurity. This, in turn, produced another barrier to implementation. Interestingly, however, during the initial stages of this phase of the project, many of the prisons approached about being involved in the action learning groups suggested that they did not need assistance because the PCT was already adequately meeting their clinical supervision needs.

In examining the reports from this group, the issue of organisational structure also featured as a barrier to implementation although it was not highlighted explicitly. In discussion of the action points from the meetings, there appeared to be a strong sense of the need to obtain agreement for actions from managers and governors before developments could be realised. From a project perspective, the need to obtain affirmation from managerial levels highlights broader issues associated with the organisational culture.

One of the most significant developments to have emerged in practice as a direct result of involvement in action learning was the implementation of clinical supervision awareness training sessions in one of the prisons as an attempt to deal with resistance to supervision. In another establishment, it was decided that a reflective practice group would be useful in terms of providing a forum through which staff could reflect on their practice. It was felt that by calling it reflective practice, rather than clinical supervision, staff would be more likely to engage with it. However, it became clear that the lack of protected time for this group to meet hampered its development in practice.

Through a final self-evaluation of this action learning group, members reported a more positive approach to clinical supervision. Consequently, it appears that staff back in practice are now being encouraged to seek supervision for themselves and, indeed, more senior staff in one prison have been referred for clinical supervisor training. Members noted that clinical supervision now takes place in one of these prisons and that awareness sessions exist for all new staff.

4.1.2. London/South East (March 2005–September 2006)

This group paved the way towards a more flexible way of engaging prisons in action learning. Initially, prisons in the South East and London were invited to participate in this action learning group, on the basis of their response to the scoping exercise mentioned earlier. Although there had been much enthusiasm for the work, attendance at the first couple of meetings was very poor. It was decided that to engage more fully with interested staff, awareness raising sessions and visits to individual prisons could be useful in dispelling myths and that explaining the

purpose and scope of the project could be a way forward. Over the following six months, many of the prisons in the region were visited by two facilitators; one with many years of prison health care experience, the other with experience in clinical supervision and reflective practice. At these meetings, discussion focussed on the current state of clinical supervision in the prison and barriers to implementing reflection and supervision. Common barriers to implementation included: suspicion, apathy, time, resources and lack of understanding. The opportunity was taken during these meetings to begin to support staff in considering possible solutions and different approaches to supervision. The possibility of creating local partnerships for supervision was discussed, as were more creative ways of looking at promoting reflection and reflective practice before attempting to introduce clinical supervision.

As a consequence of these visits and the detection of an obvious need for education, some further work with the London prisons was undertaken by way of short training sessions, provided by one of the group facilitators (see Awareness Raising Session on attached CD). Following the outreach work, both facilitators provided a reflective narrative on the experience. As one facilitator noted, 'this is a quiet, evolutionary approach which is likely to pay long term dividends, preferable to a high energy but short lived implementation'.

Once awareness training had been provided, key staff were invited to attend a meeting at the Department of Health to discuss further involvement and development of clinical supervision as part of the project. This meeting was well attended and provided an opportunity for those staff who had spent time with the facilitators during their prison visits to clarify issues and begin to consider the implementation of clinical supervision in their prisons and the benefits of participating more fully in the action learning group. Major issues concerning managers and practitioners were highlighted at this meeting and included lack of training opportunities, and concerns and misunderstanding regarding official auditing and inspection policies with regard to clinical supervision.

Subsequently, this group became established and met every other month over the next 12 months. Key members remained committed and consistently attended meetings, bringing with them examples of good practice, documentation and ideas to share. Although some of the other action learning groups had constructed their own contracts and ground rules, this group remained flexible and open to new members. As information about the work being undertaken by this group spread, staff from other prisons showed interest and joined; some for the duration, others for one or two meetings.

Action learning

At both the interim and final stages of evaluation, members of this group highlighted the benefits of action learning as a method for developing reflective practice and clinical supervision in prison health care settings. The way in which action learning fosters a sense of owning change was, for some, an important issue in developing supervision and reflective practice. For others, the space provided by the action learning group to expose, recognise and share good practice was seen as important. Overall, participants noted the way in which the action learning group provided support and continued motivation for individuals to develop practice.

During the focus group held half way through the project, one member from this group noted:

> *I have got to the point where I feel that this is a day for us and I'll move quite a lot you know to come because that's how valuable it is, personally and as part of the group.* (P3)

The opportunity to network with staff from other prisons was also seen to be a beneficial outcome of involvement in the group.

According to the group facilitator, the way in which the group evolved is important to consider because it was distinctly different from the more traditional approach to both action learning and group supervision. Given that the processes of the group were influenced by members receiving supervision through an action learning approach, we suggest it was an action learning–supervision hybrid. Interestingly, the fact that the group was flexible, had no written contract and was left to evolve at its own pace with minimal pressure from the facilitator led us to consider the nature of action learning with prison health care staff and to examine what approaches to use within this culture. The group was thereby supported to continue in this fashion rather than be aligned with other action learning groups in the project.

Practice developments

In keeping with the experiences of other action learning groups, this group spent time examining the barriers to implementation. One of the main issues the group felt they needed to address was the terminology. The term 'clinical supervision' was felt to have negative connotations within the prison setting and, as such, the group preferred to speak about reflective practice, given that they felt reflective practice was at the heart of clinical supervision and would be more inclusive for all staff working with prisoners.

In addition to addressing the terminology, members felt that creativity in developing and supporting reflective practice would be key to its successful implementation. Therefore, in one prison, one member examined all the opportunities available to them in which they could utilise their supervisory skills in encouraging staff to reflect constructively on their practice. The rationale was that, to achieve the aim of structured, regular and formal clinical supervision, staff would need to be comfortable with reflection and challenge. An example of this was given by one manager who examined the possibility of using the Significant Event Analysis form as a framework for developing reflective practice. The sharing of documentation within the group was exceptional, with policies, procedures, guidelines and forms from all prisons shared openly. To ascertain the level of need and understanding of clinical supervision in one prison, the group member representing that prison spent time engaged in developing and administering a questionnaire to all health care staff at the prison. This questionnaire was shared with the group and provided a useful way of conducting a needs analysis.

Other developments in practice reported by members of this group indicate changes in local culture where reflection on and in practice is supported and encouraged with a view to developing formal supervision in due course. In other prisons represented in this group, clinical supervision had been started, with one prison now using a group supervision approach, while in another, individual supervision is now offered. Awareness raising was identified as a need in many of the prisons in this group, which subsequently led to sessions being provided by members. Reports from one prison in the group highlighted the way in which reflection had begun to seep into everyday practice. Developments at this prison included the introduction and development of a regular team meeting, now called a 'group development meeting', where the emphasis is on reflection and support. The manager at this prison noted how she felt that the action learning group experience gave her permission to change and develop practice in a more pragmatic way than she would have done previously.

When considering the barriers to implementation of clinical supervision and reflection in prison health care settings, members in this group and others highlighted the importance of senior management support. When considering the most appropriate way of securing this support, often required from governing governors to be truly useful, the group made links between clinical supervision and clinical governance. It was felt that, to provide senior managers with a framework within which clinical supervision could be placed in developing practice, raising standards and meeting targets, clinical governance would prove to be ideal. One of the

members devised the diagram in order to assist in explaining the position of clinical supervision within the clinical governance framework. This model can be viewed on the CD attached to this report (see Clinical Governance Relationship).

Perhaps one of the most useful and successful products to be developed by this group was the Reflective Practice Toolbox. The toolbox was conceived when it became clear that many of the issues faced in these prisons were similar and were felt to be estate-wide. The toolbox consists of useful documents and ideas generated by the group which they felt would be useful for all health care staff working in prison trying to implement and support clinical supervision and reflective practice. The toolbox is currently in press and due for publication through the NHS/Department of Health website. However, it can be viewed on the CD attached to this report (see Tool Box).

4.1.3. Wales (January 2006– November 2006)

This group met for a whole day, every other month, away from prison establishments and initially comprised six staff from three prisons. Over time, attendance at this group appeared to be consistently from three staff from three prisons: two health care managers and one senior nurse. The facilitator of this group was a very experienced clinical supervisor/facilitator with no experience of prison health care. At the first meeting, the facilitator and group members agreed ground rules for subsequent meetings, including confidentiality about the content of the group meetings. Therefore, no reports were provided for the project team regarding the group's progress and, as such, no detail can be provided here as to the growth and development of the group. The lack of on-going information was not felt to be an issue, though, because it provided the project with a group where confidentiality had been assured and gave a different perspective on undertaking research using action learning.

Information that allowed the project team to evaluate the efficacy of action learning to develop clinical supervision in practice and to discover any changes in practice was provided at the end of the life of the group in the form of reflections by the facilitator. In addition, a focus group was conducted after six months as an interim evaluation (see Appendix 1) and one group member was interviewed by a member of the project team (see Appendix 2) after the group had finished.

Action learning

The interim evaluation of this group highlighted the thoughts of the group as to the usefulness and efficacy of action learning as a method to support the implementation of clinical supervision. Members noted that membership of the group and attendance at meetings helped improve

motivation to make changes in practice. Members reported that participation in the group built their confidence in implementing supervision and was an enjoyable experience in terms of being given time out to reflect on their own practice. The fact that the action learning group was held away from the prison environment was also seen as important:

> *You need to get away from it. At the moment I've got my phone with me, and I'm expecting a call any time now to say… whatever, has happened. But by actually being physically away from the place, it gives me a chance, by the time I get here to relax and then do the part that we are here to do. Otherwise if I was in there, all I'd be thinking now is that I've got to go back in about 20 minutes time and go and do the drugs on B wing.* (P4)

Once members engaged in clinical supervision through action learning, the value of both experiential learning and clinical supervision was recognised and, for some members, this was transformatory:

> *Some of the nurses, myself included, traditionally trained, you get on with the job, you leave it at the door and you don't reflect too much, you don't think too much, you get on with it, and this clinical supervision – we haven't got time for that. We've work to do, shifts to cover, what a load of rubbish. But I will say there has been a definite change, and I think a lot of the change has…very useful this has been. Members of this group are often role models for staff at the prison and they say 'well, if they think it's a good idea, they don't think its silly', they think its good to spend time reflecting on things and speaking with somebody… so it's been a change, and I tell you what, I'm not the person who would have thought it, because I'm the one who thought 'oh it's a load of old rubbish' so I can't believe how I have warmed to it all and actually need it now.* (P5)

Through reflecting on the experience of the action learning group, the facilitator noted the commitment shown by the final three members and attributed it to the major organisational change occurring in their prisons with the introduction of the PCT, the complementary skills and levels of the members and, indeed, the size of the action learning group. The small size of this group appeared to foster an atmosphere of trust through which discussion of difficulties in practice was not constrained. The facilitator also felt that the group responded to her commitment to the group and admiration of their work.

Practice developments

Midway through the life of the action learning group, members were asked about the developments that had occurred in their practice as a result of being part of the group. No specific changes in practice were reported in terms of formal implementation of clinical supervision. However, members noted that they and some of their staff had taken part in one of the national training events (Train the Trainers), and that they had begun to develop a clinical supervision tool for use back in practice.

At the end of the action learning group meetings, one member was interviewed (see Appendix 2 for interview guide) to ascertain if any changes in practice had occurred as a result of engaging with action learning. This respondent reported that regular clinical supervision was now in place in her establishment. In addition, she noted that there was more of a culture of reflection beginning to develop in practice, with reflection on practice not restricted to formal sessions.

As a consequence of the action learning group experience and the enthusiasm generated by the facilitator, the group members and facilitator decided to develop a paper for future publication in the nursing press.

4.1.4. West Midlands (February 2006–December 2006)

This group met every other month over a period of 12 months with an experienced clinical supervisor/facilitator who had minimal experience of prison work. This group met at a venue away from any prison establishments, central to all workplaces. Although this project was principally for health care staff, interest from the Safer Custody Group at the Home Office in relation to including suicide prevention co-ordinators subsequently saw this group become a pilot action learning group, comprising both health care staff and discipline staff. Attendance at this group was fairly consistent and entry, once established, was controlled by the group. The approach adopted in this group to developing clinical supervision can be viewed as a clinical supervision–action learning group hybrid.

Action learning

The initial meeting of this group was spent considering the concept of clinical supervision and its relationship to the work practices of both health care and discipline staff. The overriding feedback from this first session suggests that it was used to clarify the purpose of the group and to provide an opportunity for the group to get to know one another, which was achieved through discussion of experiences concerning clinical supervision. From the facilitator's reflections on this initial meeting and the interview data provided at the end of the year of meetings, it is clear

that, although the health care staff had an understanding of the purpose of the group and nature of clinical supervision, the two discipline officers had none. Indeed, one of them seemed unclear about why he was attending. However, at the end of the first meeting, health care and discipline staff both reported feeling enthused and engaged. One of the SPCs stated:

> *I remember turning up on the morning, I was first there, and I spoke to* [name]*, I was watching the other staff come to the venue, recognising one or two and that it was mainly health care staff. Luckily there was an ally on my side, another discipline officer from* [prison] *and we were more or less glancing across the table just nodding our heads and thinking 'what are they talking about here – I haven't got a clue'. I understood the fundamentals of what they were coming out with, and on reflection…good word, on reflection, I thought, we actually do this but not in a formalised way. We tend to do it on the side, as and when the door opens…so we sat and listened to these people about another area, where there was a group set up that crossed over from the medical side onto the discipline side as well. And I sat there straight away thinking it was a brilliant idea.* (P5)

The second and subsequent meetings were facilitated by a different facilitator from the initial meeting, but this did not seem to be an issue. A contract was agreed with this group, which appeared to enable an atmosphere of trust and confidentiality to flourish.

As mentioned earlier, the feedback and reflections from this group indicate that a clinical supervision–action learning group hybrid approach was successfully adopted to support and develop clinical supervision back in the workplace. Group members were thereby exposed to clinical supervision in various modes, e.g. group, individual and peer, while being provided with the theory to better understand both clinical supervision and reflective practice. This, in turn, provided members with the experience of being supervised and of being a supervisee, and gave them the theory to underpin any developments back in their own establishments. One participant commented that:

> *I found it probably the most useful method of learning simply because if you are talking about action…action being involved, then I think to actually do the physical side of a process you retain the knowledge that you have learned a lot easier. I think that paper exercises, reading or looking at slides, overviews and*

things like that, fine, but it's sometimes forgotten where to be physically involved in the process. It can identify how you feel about it, and your anxiety, but it also equips you to teach other people and take it forward. (P6)

One of the major issues that arose from this group was the initial isolation felt by the discipline staff. However, this soon transformed into appreciation of the importance of multidisciplinary working. The inclusion of non-health care staff in a group dominated by health care staff not only provided an opportunity for those staff working in the same prison to forge closer working relationships, but enabled a better general understanding of the roles of health care and discipline staff from both perspectives. We suggest that action learning as a concept not only assists with the development of practice but also with the development of multidisciplinary working.

Involvement in action learning and clinical supervision not only served to support the development of supervision back in practice and improved multidisciplinary working, but also provided a safe space for members to reflect and consider their working practices. Over the life of this group, reflections and evaluative work suggest that group members experienced higher levels of self-awareness and, indeed, excitement and enthusiasm for clinical supervision.

Practice developments

The pilot nature of this group enabled the project team to consider the nature and efficacy of clinical supervision for prison staff other than those from health care and to examine developments in the practice of both health care and discipline staff.

One of the most striking developments in practice reported by one member of this group was the expectation that the group would continue to meet after the allocated period of facilitation within this project. In fact, reports suggest that meetings have indeed taken place. However, it is also clear that a substantial degree of support is required from individual governors for the work to continue, particularly with discipline staff. The action learning group experience enabled the discipline officers to articulate and enthuse about the benefits of supervision not just for individual staff but for the establishment as a whole. An understanding of the importance of linking clinical supervision to managerial and establishment targets is clearly understood as the most efficient way of gaining support from governors for introducing clinical supervision. It is important to note that the motivation and enthusiasm to continue with the work appears to be driven by the discipline staff members.

Developments in health care settings as a consequence of involvement in this action learning group appear to be centred on raising the awareness of colleagues of clinical supervision through the provision of training sessions and general discussion and enthusiasm. Although the initial aim of this project was to support the development and implementation of clinical supervision in health care settings, it is clear that, in some instances, the very act of spending time on action learning, and on assessing and considering the barriers to effective supervision in health care, resulted in consideration of how to overcome them. This, in turn, led to this group concentrating on actions designed to raise awareness. Alongside engaging in clinical supervision, and in gaining experience of being supervised and in supervision, it appears that the hybrid approach (supervision–action learning) met the needs of practitioners both in the action learning group and back in the prisons.

4.1.5. North East (January 2006–January 2007)

This group met every other month for one day over a period of 12 months, away from the prison environment and with a facilitator/clinical supervisor who had a prison nursing background and good understanding of the prison setting. When invited to participate in this group, one prison in particular demonstrated a keen interest for both health care and discipline officers to join. Other prisons in the area showed little interest in joining this group, and following consultation with the funders of the project, it was decided that this group could provide a second pilot approach in which health care staff worked alongside discipline officers in developing clinical supervision.

In contrast to the West Midlands action learning group, where members (both health care and discipline) originated from different prisons, the North East action learning group comprised staff from one prison. At this prison, a new initiative was developing, the Primrose Project, which had the focus of caring for prisoners with dangerous and severe personality disorder (DSPD). Given the nature of this prisoner group, officers were recruited specifically to work on this unit and it is from this staff group that the prison officer members of the action learning group originated. These officers and their managers were initially contacted about this project as a result of health care management at the prison informing the project team that this initiative was in progress and that they felt the officers would benefit from involvement in clinical supervision.

In total, four members of staff from this prison consistently attended the action learning group meetings: three discipline staff and one mental health nurse.

Action learning

The first meeting of this group was held in the training department of the prison. It quickly became apparent that the environment would not be conducive to clinical supervision or action learning for a number of reasons. The close proximity of a training room to the prison could potentially lead to members feeling unable to switch off or, indeed, to feel a conflict between being at work and attending the group. In addition, using training facilities for this type of work does not provide staff with a feeling of being valued, something that is important when supporting them to implement an initiative which is fraught with barriers and negativity. Indeed, one participant commented that:

> *Using an outside venue was helpful and an important part of the process. It feels essential to do this to enable peer supervision and to make it more open and less 'rank' orientated.* (P7)

The first meeting of this group proved to be more of an exploratory meeting in which the purpose of the action learning group could be clarified. Members were therefore able to discover the relevance of the group to their own practice and decide whether their involvement would be useful to both them and the prison. It became clear at this meeting that staff felt the action learning group experience would need to involve some theory and/or teaching to ensure all members had a similar understanding from which to work. Therefore, as happened in the West Midlands group, an action learning–clinical supervision hybrid approach was adopted.

One of the key issues of note from the action learning group facilitator reflections is that this group was concerned and preoccupied for quite some time with the barriers to implementing clinical supervision. Although none of the members was forced to attend the group, negativity appeared to predominate for much of the early meetings. This negativity was directed at the operational implementation of clinical supervision, and the possible non-acceptance of clinical supervision in a prison discipline culture. The barriers highlighted by the group in terms of developing clinical supervision in practice included: time and resources, the blame culture, suspicion, caution from senior managers and poor understanding of clinical supervision and reflective practice by staff.

One of the major barriers discussed was the terminology and the importance of renaming it to make it more understandable and relevant to officers and nurses. To that end, the term 'practice facilitation' was discussed as being more useful. Much of the initial work in the action learning group was based around education about the basics of clinical

supervision and reflective practice to alleviate the need to refer to supervision as 'clinical'. This education helped ensure a good understanding of the principles of reflection and supervision which would then enable an appreciation of its value and importance.

Having a contract was an important issue at the beginning of this group in providing members with the confidence and reassurance that matters discussed would be confidential to the group. In addition, it was important for the group to have control over who attended the meetings. This control and commitment to the group appeared to assist in the development of the members' confidence in discussing and challenging their practice.

In an attempt to ensure that all group members had a common understanding of clinical supervision, time was spent providing theory which was then related to their practice. The facilitator noted that the inclusion of theory into the action learning group meetings provided members with some recognisable element in what they perceived as 'training'. Later in the life of the group, when common understanding had been achieved, members were facilitated to experience clinical supervision in different forms for themselves. It was this exposure to the experience that was reported to have been one of the most valuable aspects of the action learning experience.

Practice developments

Given the multidisciplinary nature of the action learning group, it was felt that it would be useful to consider the development of a common policy for clinical supervision that could be used across the Primrose Project and health care. Even though this was felt to be appropriate by the action learning group members, it was deemed that this course of action needed to be sanctioned by the governor. Indeed, the involvement of the discipline officers, although agreed by line management, also needed to be sanctioned. A proposal to develop policy was considered inappropriate by the governor; however, they were amenable to officer involvement in developing reflective practice and clinical supervision as part of the Primrose Project.

Given that the action learning group comprised the majority of the staff working on the Primrose Project and one member of health care staff, the group still felt it would be appropriate for them to develop reflective practice and supervision together, with supervision being offered by the health care member to the discipline staff, and vice versa. As a result of this approach, a peer group supervision process was initiated back in the prison, in between action learning group meetings.

At the end of the facilitated period for this group, they suggested that the work would be continued in practice. In discussing the aim of developing clinical supervision for others back in the workplace, this group acknowledged the importance of starting small and of encouraging others and showing that supervision is useful. One of the overriding comments from the interviews held with two of the action learning group members concerned the impact the meetings had on the individuals, rather than their specific practice. Both respondents noted how much more self-aware and reflective they had become in themselves. Changes in the work environment were described by one member as follows:

> *You can see peer reflection happening in and out of meetings* [back in the prison]. *Where once a challenge could have been taken personally, now it leads to reflection.* (P8)

4.1.6. North West 1 (October 2005– March 2007)

This group was initially set up to encompass a cluster of prisons in the North West. Given the large number of prisons in this region, two action learning groups were funded. The group named North West 1 commenced with 10 members and ended after 16 months with a core of four staff from three prisons. Given the poor attendance at this group after the first meeting, meetings were held every two months, with the facilitator offering extra support by way of individual visits to prisons unable to attend the action learning group for whatever reason. Much of the work undertaken by the facilitator in the early days of this group concerned the provision of awareness-raising sessions. The core members of this group, however, continued to meet when possible but changed their aim of developing clinical supervision in practice to supporting and developing reflective practice. It is through this group that it is felt a huge shift took place in practice in relation to health care staff embracing and developing reflective practice on a regular basis. When considering the changes to practice evident as a result of involvement in this action learning group, the success is owed to the quiet champions who tirelessly strived to change the culture in their prisons from resistance to reflection.

Action learning

This group felt that action learning was an excellent way to support the development of supervision in practice. Of most importance to this group was the experiential learning that took place which they were then able to transfer into practice. The group also found action learning to be useful in terms of generating ideas, reflecting and testing out solutions in a safe environment, while simultaneously learning from each other. As one participant noted:

> *The action learning group encouraged me to really reflect and see my own solutions. It also enabled me to see some progress when I could not see it at first.* (P9)

Another participant commented that:

> *I think what the ALG gave me the chance to do was to try something out and then talk about what happened when you did try it and any problems you encountered…And I suppose you sort of reflected within that group at that moment in time, and then you come up with either like an action point or you would come up with a decision but you would always come away with an action that you were going to do, or take to the next one. So it always moved forward because you would have together to come up with some sort of action to take the project forward. But obviously it was safe. That's the main thing as well, it was safe.* (P10)

Practice developments

In terms of practical outcomes from this group in changing practice, there have been significant changes. As has been mentioned, this group chose not to implement clinical supervision but to develop a culture of reflective practice. As a result of the action learning group, pre-existing meetings in one prison were formalised and documentation introduced. In another prison, the daily team meetings were transformed into a more reflective space in which staff could discuss their practice. In the third prison, a questionnaire was distributed to all staff to elicit understanding and the need for more reflective practice. Regular meetings have since been held which are underpinned by reflection.

In general, there was a sense from this group that it is important to step back from the use of clinical supervision and begin by supporting a reflective approach to practice. The group reported that, through action learning group meetings, there had been recognition that there are many opportunities throughout the prison day in which to take advantage of the chance to reflect on and challenge practice. The need for creativity was recognised and embraced by this group in developing practice:

> *I have instigated regular meetings where issues are raised, reflection happens and outcomes are recorded. We do not call this supervision but this will gradually be possible as staff get used to reflecting and feeling less threatened.* (P9)

One of the challenges as a consequence of this realisation is how to document the reflection. The documentation of clinical supervision and reflection for the purposes of audit, inspection and professional development pervaded almost all action learning group discussions at some point, and this group was no exception.

The members of this action learning group also identified the importance of managerial acceptance and support in developing reflective practice and ultimately clinical supervision. This was identified by one member as vital given the current changes to health care commissioning and the increasing involvement of PCTs within prison health care settings. One member in particular spoke about the problems they had encountered due to the increased involvement of their local PCT:

> *I've just come into a bit of conflict where some of the red tape of the organisation is hindering me…so for the last three months there's been no reflective, not formal, reflective sessions. All of that is on hold until the Trust gives me a proper green light really.* (P9)

In evaluating the experience of implementing and supporting the introduction and development of a reflective culture within one of these prisons, a member of the action learning group noted that there was a tendency for champions and leaders to spend more time evangelising about clinical supervision and reflection rather than just getting on with it. In this member's experience, it was her own enthusiasm and continual persistence in extolling the virtues of reflective practice and clinical supervision that enabled it to flourish:

> *That's my tenaciousness I suppose, and that in itself…I think people that perhaps, especially those that weren't interested, they probably went through a period where they thought 'will she shut up', you know 'she's boring the pants off me', to 'I'll listen to her if that gets her off my back', to sort of becoming interested…I think I had to be patient sometimes…you get these little breakthroughs.* (P10)

She continues by suggesting that 'the reason I think it worked here is because I have made it a priority…you need somebody committed on the ground floor and you need the manager to drive it' (P10). This member perceived the success in her prison to be due to perseverance, role modelling, good leadership and managerial support in demonstrating the practical benefits of reflection rather than spending time talking about it. She suggests that by 'just doing it', the benefits can be demonstrated

instantly which she feels is more effective than 'talking about doing'. For this to happen, this participant notes the importance of flexible, locally led policies and guidelines alongside managerial support and leadership.

4.1.7. North West 2 (October 2005– March 2007)

Similar to the North West 1 group, this action learning group began well, but dwindling attendance caused the project team to reconsider their approach. As with the North West 2 Group, and to some extent the London/South East group, the facilitator began a series of visits to individual establishments. In the case of the North West 2 group, these visits resulted in support for individuals on a local level with two prisons consistently involved in the project. The staff involved from these two prisons maintained contact with each other and managed to meet on occasions to discuss their progress. In addition to support from the facilitator, the prison nursing advisor from the Royal College of Nursing also made a visit, which served to highlight the project to a wider audience via the Prison Nurses Forum at the Royal College of Nursing. Given the individual approach taken with this group, further funding was made available to progress work. Therefore, work with these prisons continued over an 18 month period.

Action learning

Given the way in which work with this group evolved to a more individual, flexible, 'virtual' action learning group, it is interesting to note how this affected the implementation of clinical supervision in practice when compared with other, more traditional action learning groups in the project. Staff from two prisons managed to meet and engage with the project and, indeed, with each other which enabled the sharing of practice and experience. In evaluating the efficacy of action learning as an approach to developing supervision, those staff who had been involved in the project highlighted that having facilitated time to consider and develop clinical supervision in their establishments was invaluable as it provided the motivation to continue when difficulties arose. In addition, those involved noted the importance of knowing that there were similar problems elsewhere and that they were not unique to one prison. This was seen as very helpful in terms of gaining support for developing practice. The staff involved in this group really valued the opportunity to work with staff from other prisons and also to have time out for themselves to reflect on their own practice.

Practice developments

At one of the prisons involved in this group, strong links have now been made with health visitor colleagues outside the prison setting who have agreed to become supervisors for staff in health care. In addition to the introduction of external supervisors, documentation has also been

introduced in line with PCT procedures. Given the external supervision that is now on offer in this prison, four nurses have attended clinical supervisor training so that they may team up with their health visitor colleagues to facilitate further clinical supervision sessions.

Participants from the second prison to take part in this group have been instrumental in the development of a reflective tool for use by prison staff. This was the result of identifying barriers to the implementation of clinical supervision through discussion with other members of the group. This reflective tool was subsequently shared with other action learning group members taking part in this project and now features as a resource in the Clinical Supervision Toolbox, currently in press.

In reflecting on the practice developments that have occurred in this group, the facilitator's reflection on this work highlights the importance of very clear, visible local leadership, both internally and externally, as being vital in the quest to support and implement reflective practice and clinical supervision in prison health care settings.

4.2. Documentary Data

Regarding the concept of textual evidence in research, Cheek (2004:1144) states that 'pictures, interview transcripts, poems, procedures, field notes; in fact texts can be a representation of an aspect of reality'. Miller & Alvarado (2005:349) suggest that 'documents are produced in and reflect specific social and historical circumstances'. We suggest that the use of a variety of textual data collected throughout the course of this project allowed us to examine and identify the wider discourses prevalent within the prison culture which promote, support and inhibit the development of reflective practice and clinical supervision within this setting. To facilitate this broader understanding and to elicit these dominant discourses, further data were collected throughout the course of the project in the form of textual evidence, including:

- The project diary, maintained by the project co-ordinator;
- Minutes from project team meetings and away day;
- Formal updates for Prison Health at the Department of Health;
- Training and development materials developed as part of the project for use in clinical areas;
- Training event evaluations and reflections;
- Reflections and evaluation of the Reflective Practice conference;
- Conference presentations external to the Prison Service – RCN etc.;
- External publications.

The findings from consideration of textual data are presented in terms of the audiences for which they were produced, e.g. the project diary was written for the project team so that the process and challenges of this work were identified and acted upon accordingly; the national training events were devised for practitioners to enable them to return to their prisons and train colleagues; updates were provided for the funders of the project so that they could be kept informed and directly contribute to the project's development; and external publications were predominantly for those outside prison health care to enable fellow practitioners and educators to more fully understand the world of the prison worker rather than rely on outdated representations and stereotypes.

In presenting the textual data in this way, the dominant discourses that prevail in and around the development of supervision in prison settings are representative of the thoughts of the project team, key stakeholders and the prison staff participants, thus providing the project with a footing in both practice and research.

4.2.1. Practitioners and educators

The documentary data considered here consists of training materials developed by the project team (see Appendix 5) and the additional materials published by participants and the research team in the form of conference presentations and journal articles/book chapters.

Train the Trainers Events
(Two held in London in 2006/07 and one in York, 2007)
One of the most commonly mentioned barriers to implementing clinical supervision was highlighted by the action learning groups as being a lack of understanding/education. The Train the Trainers events were therefore designed by the project team to provide key prison staff with the teaching materials and learning theory necessary to enable them to return to their prisons and train their colleagues in clinical supervision and reflective practice (see Appendix 5 for details of the training). The course was presented to staff over two days; day one focussed on the underpinning theory of reflective practice and clinical supervision, and day two provided participants with the opportunity to reflect on their own teaching/learning styles while being given the theoretical foundations of presentation skills and approaches to adult learning so that they could return to their prisons able to disseminate the training materials appropriately. All events were well evaluated and the second and third events developed as a result of the previous evaluation.

One of the dominant discourses prevalent throughout the Train the Trainers events centred on the barriers to implementation. Therefore, much of the work undertaken with the participants included identification

of issues and, more importantly, discussion of solutions and strategies to overcome them. In addition, there was much consideration given to the notion of 'permission', both in terms of changing practice back in their prisons and in terms of being certified as able to train others. Other issues highlighted included the need for senior managers and governors to engage in clinical supervision training so that they could gain a better understanding and hence enthusiasm to support the implementation of clinical supervision and reflective practice. In terms of the training, many of the participants felt that two days was too short a timeframe for such a huge amount of information. Many felt that more experiential learning would have been useful and that gaining experience of being supervised during the course would have helped.

Contact with a health care manager who facilitated staff attendance at a Train the Trainers event revealed that developments in practice as a result of the course have been significant. Regular supervision is now in place for the staff at the prison. The training course attendee now spends two days per month exclusively addressing the clinical supervision needs of the staff group.

Reflective Practice Toolbox

The reflective practice toolbox is a publication written by practitioners from the London/South East action learning group as a result of realising that the problems and issues facing prison staff in supporting and implementing reflective practice and clinical supervision in prison are common to many prison settings. This group felt that it would be useful for those new to clinical supervision in prison settings to have a resource to address some of the issues faced by all staff implementing clinical supervision and reflective practice, and to provide ideas and advice. Following encouragement from their facilitator and the project lead, the toolbox was constructed and published as a resource for the whole service. One of the dominant issues to emerge from the toolbox was the need for flexibility in supporting and implementing clinical supervision and reflective practice in prison. Rigid adherence to policy and protocol, often imported from outside the prison setting, results in an inability to adapt to meet the needs of practitioners and officers in prison. The toolbox thereby provides permission for practitioners to take clinical supervision and reflective practice and use them as they see fit within their own establishments.

Reflective Practice Conference, held September 2006

This conference was held in response to the repeated discussions that prevailed throughout the action learning groups regarding the need for support and understanding from senior managers, governors, policy

makers and prison inspectors. This added to the concerns about the lack of understanding among prison staff of the importance of reflective practice and clinical supervision. A conference therefore provided a platform for key speakers from various departments and organisations to attend, and the opportunity for workshop activity and reflection on practice was an appropriate way to address some of the issues raised in the action learning groups. The conference programme can be found in Appendix 6.

In total, 36 delegates from across England and Wales attended this event. It was well evaluated by all who attended and, according to many participants, not only provided an informative day away from practice and the opportunity to network, but also provided the space for participants to reflect on their own practice, something which they identified was valuable. The main issues discussed at this conference were: the auditing of clinical supervision by audit and inspection teams in terms of what was expected and how that expectation could be met; use of terminology; defining clinical supervision in terms of what it is and what it is not; discussion of different approaches to implementation, all of which had an underpinning philosophy of perseverance; and the need for more support from policy makers and managers.

Walsh L (2005)

This book chapter, published in *Transforming Nursing Through Reflective Practice* (Johns & Freshwater 2005), examines the potential for practice development through the use of reflective practice and the implementation of clinical supervision. The benefits of reflective practice in the prison health care setting are discussed and some of the findings from phase one of the clinical supervision project are highlighted.

Walsh L & Freshwater D (2006)

This paper, published in *Nursing Times*, provides practitioners with an overview of using action learning as an approach to developing practice. The work in this project is reported on, along with other work involving prison staff in which action learning played a key part in practice development (Musselwhite et al., 2005). The dominant themes in this publication concern the importance of considering the nature of training and the learning environment in the prison health care setting. Action learning is suggested as a highly effective approach to developing practice within the prison setting.

Freshwater D, Walsh E & Esterhuizen P (2006)

This book chapter was published in the second edition of a well-respected clinical supervision text in which case studies are used to

highlight the relevance and application of clinical supervision in everyday practice. In the chapter relating to the clinical supervision project, this work is given as a practical example of how action learning groups can be used to support the implementation and development of clinical supervision.

This section of the chapter shows how useful action learning can be because reflective practice is an intrinsic part of the work of action learning groups. An analysis of the Strengths, Weaknesses, Opportunities and Threats (SWOT analysis) of action learning as a concept was presented and can be seen in Table 2:

Table 2: A SWOT Analysis of Action Learning, taken from Freshwater et al. (2006:86)

Strengths	Weaknesses
• Useful for initiating and sustaining changes in practice • Challenges taken-for-granted ideas • Facilitates and develops reflection in and on practice • Promotes collaborative working	• Time consuming • Resource intensive • Requires strong facilitation • Requires consistent attendance • Requires commitment from members and employers
Opportunities	**Threats**
• Improved staff morale • Improved ability to reflect on practice • Improved team working • Opportunity to embed theory into practice • Improvements in practice	• Inherent learning culture of prison • Time constraints • Poor facilitation • Poor understanding of action learning by group members • Lack of commitment by employers and members

Conference presentations by project team

During the course of this project, the project team presented their work at a variety of conferences, both nationally and internationally. A selection of these presentations can be found on the CD accompanying this report.

National

• RCN International Research Conference, Exeter, 2002: 'Clinical Supervision';

• RCN International Research Conference, York, 2006: 'Researching Health Care in Prisons: Methodological Conflicts and Dilemmas';

• HMP/DH Sharing Good Practice Conference, York, 2006: 'Clinical Supervision';

• RCN Prison Nurses Forum Annual Conference, London, 2006: 'Clinical Supervision'.

International

- Seventh International Reflecting on Reflective Practice Conference, Amsterdam, 2002: 'Clinical Supervision in Prison Health Care';
- International Association of Forensic Mental Health Annual Conference, Melbourne, Australia, 2005: 'Clinical Supervision in Prison Health Care';
- International Qualitative Health Research Conference, Brisbane, Australia, 2006: 'Clinical Supervision in Prison Health Care'.

The papers presented at these conferences had the project at their heart but focussed on different aspects of the work, depending on the theme of the conference. For example, research conference presentations addressed the research element of the work, both in terms of the challenges of undertaking research in the prison setting and developing practice within the prison culture. At some conferences, the aim was to disseminate and celebrate some of the good practice encountered throughout the project; at others the challenges of nursing in prison were highlighted; or the aim was to stimulate debate and reflection on implementing clinical supervision in any health care setting. Notably, a presentation at one of the conferences resulted in some constructive dialogue with police custody nurses which, in turn, illustrated some useful opportunities for cross-speciality working in terms of clinical supervision.

4.2.2. Project team

There were two main sources of data that were considered for inclusion in this evaluation: the project diary and the minutes from the project team meetings and away days.

Project diary

The project diary proved invaluable for documenting the developments and progress of the work, and was important because a record of positive achievement can provide much needed motivation for perseverance when challenges arise. The diary illustrates the journey taken throughout this project. What is clear is the way in which the early stages of this work demanded a great deal of 'ambassador' work both on the part of the facilitators and the project co-ordinator. Given that there had been a great deal of interest in clinical supervision informally from the practice area, it was surprising to the project team that large scale advertising of the project and individual contact were needed with many establishments to engage them with the project.

It took approximately seven months for the first action learning groups to begin work. It felt as though there was reluctance by staff and managers to commit to the meetings. Some level of tension was noted in those prisons with PCT involvement as opposed to those yet to engage fully

with their PCT. Interestingly, some prisons felt that PCT involvement meant that they had no use for working with the action learning groups because the PCT provided training and support for supervision. Alternatively, others who were not fully engaged with their PCT were more than willing to work with us.

One of the major discourses to emerge from the project diary was the way in which some of the action learning groups evolved. Flexibility became a clear way forward for many of the groups in terms of attendance, frequency of meetings and group membership. Support for the facilitators to manage their groups creatively was given throughout by the project team because it was seen as important from the project perspective to adopt varying approaches to managing the groups.

Team meeting minutes

The minutes of project team meetings proved invaluable in documenting the development of the team's thinking. This development had an impact on the overall project as team decisions affected the direction of the project. One of the major discussions that took place within the team meetings was the impact of the terminology on the action learning group members. Action learning group members were referring to reflective practice as clinical supervision. It was suggested that members appeared more comfortable in referring to reflective practice, especially in those groups where discipline staff were members. We concluded that groups were changing the terminology so as to manage the discomfort caused by reference to clinical supervision. Alternatively, however, this change in terminology could have been the result of misunderstanding or, indeed, a need to take a step back to ensure that staff understood the fundamentals of reflection in order to engage with supervision.

Attendance was highlighted within the project team meetings as being an issue. It was decided fairly early on in the project that action learning group meetings should continue as scheduled in one area to provide consistency and structure. This approach to the evolution of the groups provided the project team with varying approaches to facilitating action learning, which has enabled contrasts and recommendations to be proposed.

The minutes also document discussion among the team concerning the need for high levels of communication to sustain groups. In maintaining the momentum of the groups, it became clear that regular contact and reminders from the project co-ordinator were vital in ensuring ongoing engagement with the project. Over time, some groups became more cohesive and required less contact with project team members external

to their group but, for some groups, this contact appeared vital for addressing their fragility.

4.2.3. Policy makers/ managers/ governors

The periodic updates written by the project team to keep the Department of Health appraised of the direction of the project were considered relevant to policy makers/governors/managers as they held important information about the challenges of implementing and supporting clinical supervision in the prison setting. It was clear from the evaluation of the action learning groups that, while an individual's education, understanding and motivation are important in the successful implementation of clinical supervision and reflective practice, the key to continued success is thought to be excellent leadership and support from a managerial level in terms of resources and enthusiasm.

In addition, understanding was needed from governors and managers that the implementation of clinical supervision and reflective practice requires a change in culture, which is inevitably very slow. Acceptance and appreciation of this slow pace, alongside commitment, role modelling and enthusiasm, appear to be key tenets in the success of its implementation. This is especially important if we consider the way in which staff were reluctant to engage with the project and were often unable to attend action learning group meetings due to operational constraints back at their establishments. While we accept that staff sickness and operational issues need to be acknowledged, we question the extent to which managers and governors value the contribution that reflection and clinical supervision can make to their workforce.

Table 3: Findings: Key Issues

Audience	Key Issues
Policy Makers/ Inspectors/Auditors	• Need for support and empowerment of nurses • Organisational commitment vital to implementing clinical supervision • Sustainability depends on priority afforded to clinical supervision by the organisation • Leadership and role modelling are important • Action learning is an effective approach for fostering multidisciplinary working • Appreciate importance of slow progress • Flexibility to implementation
Educators/Researchers	• Action learning is a useful method for developing practice and changing culture • Terminology is important to consider • Type of training venue is important • Begin with reflection rather than clinical supervision • Need to consider prison culture when selecting methodologies and facilitating groups • Geographical positioning is important
Practitioners	• Understand accountability and empowerment • Understand importance of creativity • Flexibility to implementation is key • Value of multidisciplinary groups • Links with clinical governance to support development and implementation • Start with awareness raising and develop reflective practice • 'Just do it' and persevere • Value practice and importance of taking time to reflect

5. Discussion

The purpose of this section is to outline the key issues that emerged from this project, with specific reference to the experiences of the project team and participants during phase three of the work. We have chosen to discuss these issues in terms of the use of action learning as an approach to developing clinical supervision and reflection in prison, and in terms of the actual developments that occurred in practice as a result of involvement with this project.

5.1. Action Learning

5.1.1. The physical environment

The physical environment has been shown to be important for effective action learning (McGill & Brockbank, 2004). The actual location of the action learning group meetings is known to be important to prison staff for a variety of reasons. A setting away from the prison environment not only enables staff to relax and feel comfortable (both physically and mentally) but also prevents external interruptions, helps remove any barriers to full engagement caused by rank and hierarchy, and perhaps most importantly, demonstrates commitment and valuing of staff by the organisation by virtue of the time given and funding provided.

5.1.2. The psychological environment

The action learning group developing clinical supervision and reflective practice needs to provide its members with a safe environment within which practice can be shared and challenges addressed. The physical environment plays a part in helping to provide a relaxed atmosphere; however, it is also important that group members feel safe in discussing their own practice and in challenging one another. The value of good facilitation cannot be overestimated in this regard (Haddock, 1997). The importance of having a safe place to explore oneself in action learning is highlighted by Bourner & Frost (1996) and Heidari & Galvin (2003). In providing this safe environment, the facilitator plays an important role, most notably at the beginning of the life of the group. In this project, some facilitators had experience of prison work, others did not; but what is important is the recognition by the facilitator that group safety should be considered, especially if one takes into account the culture of the prison environment within which the group members work.

The psychological environment provided within the action learning group setting not only supported staff to examine their own practice in a safe place but, in some senses, provided staff with a feeling of ownership in terms of any changes made in practice. The support afforded by the facilitator and the shared sense of ownership among the action learning

group members served to motivate and enthuse members while increasing their own self-awareness. In turn, this situation empowered members to change practice and introduce new initiatives. By virtue of having action learning group membership within a project funded by Prison Health, members appeared to be in some way 'given permission' to instigate change.

5.1.3. Group composition

The composition of the action learning groups in this project was predominantly drawn from the health care setting. Two of the groups, however, included discipline officers; those working with prisoners with DSPD and others working within a safer custody remit. In both of the groups with discipline staff members, the opportunity to work across disciplines was welcomed by all members. In those groups where all members were from a health care background, the opportunity to work with staff from other prisons was welcomed. The benefit of action learning to encourage a better understanding and knowledge of colleagues is well documented in the literature (Bourner & Frost, 1996). One of the key issues to note in this context is the way in which action learning supports both networking between prisons and multidisciplinary working between officers and health care staff. Indeed, even within solely health care action learning groups, basic grade nurses working with health care managers, for example, proved popular in supporting a better understanding of other perspectives.

5.1.4. The hybrid model of action learning

The action learning groups in this project were designed to provide supervision for the members while enabling them to develop clinical supervision back in practice. To achieve this, it is clear that the action learning groups morphed into hybrid action learning/supervision groups. The ability to use the group time to expose members to supervision so as to support them in developing supervision back in their prisons proved to be very successful. The experiential element of the action learning group meetings in this project was, we suggest, the key to their success.

5.2. Practice Developments

5.2.1. Changing culture

What is most notable and indeed unexpected in terms of actual practice developments is the way in which the use of action learning to develop clinical supervision has resulted in the beginnings of a culture change, rather than purely formal clinical supervision, whereby reflective practice and reflection are becoming more commonplace. By engaging in clinical supervision through action learning, participants were able to experience supervision and focus on the barriers to its implementation in practice. Consideration of these barriers led, in many instances, to a realisation that without effective reflection clinical supervision would be impossible.

Strategic plans for clinical supervision were therefore discussed but, operationally, opportunities for developing reflection in prison were more commonplace and were generally seen as more useful in preparing the way for formalised clinical supervision.

5.2.2. Terminology

One of the most commonly highlighted barriers to the implementation of clinical supervision was the terminology. The 'clinical' element of the term was irrelevant for prison officers working in a discipline setting and therefore excluded them. The 'supervision' element was a barrier given the more common meaning of the term, especially when considered within a prison setting. To this end, once the issue was identified, action learning groups quickly began to consider new and alternative descriptions such as 'practice facilitation'. Indeed, what has become apparent over time is the increased use of the term 'reflective practice' rather than clinical supervision. However, in some action learning groups, this switching of the terms led to some confusion as they were seen to mean the same thing. This was identified and clarity provided.

5.2.3. Governance and management

The importance of managerial support was reported to be paramount when trying to establish systems of supervision within the prison setting. It was also noted that, in the quest to obtain support for clinical supervision, action learning group members seized opportunities to link it to other formal systems of quality measurement, targets and, in health care, the clinical governance framework. Spouse (2001:15) notes that

> Successful professional development only takes place in cultures that value education as an essential and continuous process…with clinical governance, learning and continuous development become part of the fabric of organisations.

The links between clinical supervision, clinical governance and professional development are clear. Although clinical supervision is not mandatory, and neither do we believe it should be, by linking it to well-known targets and quality assurance strategies, managerial support is more readily available.

5.2.4. Pragmatic creativity

One of the most striking developments within this project concerns the way in which action learning group members took opportunities to include and encourage reflection on practice in the everyday activities of staff. From both discipline and health care perspectives, being creative with opportunities to reflect and encouraging colleagues to reflect on their practice were seen as important to recognise. Some of the most successful developments in practice centred on action learning group members recognising opportunities to engage with staff in reflecting on

practice. In addition, the realisation through support and action learning group meetings that clinical supervision should be flexible to meet the needs of the practitioners engaging with it, gave members permission to be as creative as they wanted in their quest to introduce supervision and reflection.

The advice provided by the NMC (2006) notes the importance of flexibility in supervision. The acceptance that some reflection/supervision is better than none enabled action learning group members to concentrate on their successes in beginning to change the culture of their workplaces rather than concentrating on their failure to implement supervision as it would be in an ideal world. In addition, the importance of perseverance in introducing supervision and reflection, and tolerance of negativity from some staff, were also viewed as crucial for successful implementation. From this project we can see that developing reflection and supervision in the prison setting is more effective if staff who are enthusiastic continue without the support of their colleagues rather than spending time trying to convert them. In many ways, this project has highlighted the efficacy of starting small, persevering and remaining committed, however many people are involved.

6. Conclusions and Recommendations

The recent Prison Health Partnership Survey (McLeod, 2007) highlights staff morale as one of the top challenges for improving health care for prisoners, in addition to standards compliance, clinical governance and cultural change. Given the aims and purpose of clinical supervision and reflective practice, and the benefits of action learning as an approach to practice development, we suggest that these approaches have huge potential to address these challenges, given what we have witnessed throughout this project in terms of improved motivation, maintaining and improving standards, and promoting changes in culture.

The recommendations that follow have been written after thorough consideration of not just the findings of the project but also the process through which the project team engaged in working with both practitioners and policy makers. Given the action research approach underpinning this work, we believe that the 'process' is just as important to consider as the 'outcomes'. As such, we have made our recommendations according to the audience for which we feel they are most suited and who are most likely to be able to use them effectively. It must be reiterated that although we have separated our recommendations they are not applicable solely to the audience we have suggested and request that the reader considers all recommendations because they may relate to their own sphere of responsibility.

When considering the recommendations we felt were important, it became obvious that there was a key message for each audience regarding implementing and supporting clinical supervision and reflective practice in prison. We have therefore noted that message in bold.

6.1. For the Practitioner

Value the contribution that clinical supervision can make in developing and supporting practice

From the work done during this project, there appeared to be some reluctance among health care staff to engage in reflective practice and clinical supervision. This is not particular to prisons and the reasons provided by practitioners for this reluctance have been reported earlier in this report. However, underpinning the operational and strategic barriers, we suggest that there are deeper professional issues that need to be addressed in this setting.

Throughout this project, action learning group members were reluctant to implement changes in practice without reassurance from their managers and governors. In addition, staff have requested certification of involvement in the project, both for attending training and action learning group meetings. It was as though there was a reluctance to take responsibility for instigating and supporting change without some kind of permission. We suggest that this is the product of an oppressive organisational culture where permission is perceived as necessary, be it through policies, protocols, missives from managers or published standards and targets. In addition, there was a great deal of anxiety in the action learning groups about the documentation of clinical supervision to provide proof for those inspecting practice and to meet organisational expectations. Conversely, where action learning group members had the unreserved support of their managers to develop supervision and felt empowered and enthusiastic, the practice was changed.

> **Recommendation: Practitioners in prison settings need to be empowered to change their practice and embrace their accountability through engagement with regular and ongoing clinical supervision.**

In implementing reflective practice and clinical supervision in the prison setting, it is clear that role modelling and strong leadership are vital in successfully engaging staff. The importance of ensuring that all staff are aware of the benefits of reflection and clinical supervision cannot be overstated.

> **Recommendation: Champions of clinical supervision and reflection in prison settings should be identified and supported to raise awareness among colleagues and to ensure a component of reflection/clinical supervision is present in any induction procedures for new staff.**

6.2. For the Educator/Researcher

> **Action learning is a highly effective approach to support the development of practice in prison**

This work has confirmed the effectiveness of action learning as a way for practice in prison to be developed and supported. Action learning appears to have been well received because there is tangible activity and visible development. However, it is important that the right venue, geographical location and facilitator are selected to ensure physical comfort, psychological safety and attendance.

Recommendation: Action learning as an approach to workforce development should be considered for all prison staff for a variety of development work, and should not be restricted to health care staff supporting the implementation of clinical supervision.

It has been demonstrated in this project that poor understanding of the concepts of clinical supervision and reflective practice are barriers to its effective implementation. Training that not only informs but builds capacity for further developments in practice is therefore necessary.

Recommendation: Training for trainers should be continued and offered across the prison estate but in smaller geographical areas to enable ease of attendance and to provide networking opportunities for participants.

Recommendation: There should be formal evaluation of the longer term outcomes of the Train the Trainers events provided as part of this project.

Recommendation: There should be follow-up support made available for those who have attended the Train the Trainers training in phase three of this project.

In developing and supporting clinical supervision and reflective practice in prison, it must be acknowledged that there needs to be flexibility. Prison staff have traditionally been accepting of direction; indeed, the way in which practice is developed within such organisations is historically rooted in a positivist paradigm. However, the successful development of reflection and clinical supervision in practice requires staff to take ownership of any change and develop the situation to meet their own needs.

Recommendation: In implementing clinical supervision, the process must first concentrate on developing reflective practice. Staff involved must appreciate the importance of slow progression in order to promote sustainability of developments.

Recommendation: Policies and standards concerning the implementation and development of clinical supervision and reflection in practice must be locally led and flexible to meet local need.

6.3. For the Policy Makers/Senior Managers

A well-supported and highly motivated workforce is central to the delivery of high quality care

At the outset, this project aimed to implement and support clinical supervision in prison health care settings. However, when staff from areas outside prison health care became involved in this work, the value placed on multidisciplinary working was evident in the success of the integration and enthusiasm generated. Where discipline staff worked alongside health care staff in developing clinical supervision, it became clear that the benefits of reflection and supervision must not be the preserve of health care alone. The prison workforce as a whole would benefit from the introduction of a more reflective culture and regular support through clinical supervision.

> **Recommendation: Health care staff should be supported to work in collaboration with their discipline colleagues in developing a reflective culture, which would develop practice while simultaneously providing staff support.**

The barriers to clinical supervision have been noted throughout this work, but it has been shown that with a creative, pragmatic approach in a supportive environment a change in culture to being more reflective can be achieved. However, this will only be realised in areas where staff are empowered and supported by their managers.

> **Recommendation: Staff should be empowered to make changes to their practice and be encouraged to do so.**

The benefits of clinical supervision and reflective practice appear to be poorly understood by senior managers in the prison setting and are therefore afforded low priority. Without high levels of commitment and support by senior managers, the implementation of clinical supervision and reflective practice into the prison setting will be unsustainable. Prison governors and senior managers need to appreciate and understand the importance of clinical supervision and reflective practice for good quality offender care.

> **Recommendation: Clinical supervision and reflective practice should be afforded a higher priority within prison culture. We recommend that prison governors and senior managers should receive awareness training to ensure a good understanding of clinical supervision and reflective practice and their associated benefits.**

One of the essential requirements of formal clinical supervision is the need for protected time and space in which to engage in supervision, either internally or externally to the prison.

> **Recommendation: Staff must be provided with regular time and space to reflect on their practice and engage with clinical supervision.**

> **Recommendation: More creative modes of supervision must be considered, such as inter-prison and interdisciplinary supervision, in addition to more traditional approaches.**

Given the current plans to streamline public services that provide care for offenders and to create a more efficient service for all, there are many reasons why reflective practice and clinical supervision would be beneficial to all those caring for offenders.

> **Recommendation: Multidisciplinary approaches to clinical supervision should include those working in other agencies allied to the prison service, e.g. police custody nurses.**

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Appendix 1: Interim Evaluation

Focus Group Interview Schedule

Guiding Questions

What have you managed to change or implement as a result of action learning group involvement?

What have been/do you think are the barriers to implementing clinical supervision?

How can these barriers be overcome?

How have you found action learning as an approach to implementing clinical supervision?

Appendix 2: Final Evaluation

Individual Participant Interviews

Guiding Questions

How did you find action learning as a method to develop knowledge and skills of clinical supervision/reflection?

What changes have taken place as a result of your involvement in the project, both for you personally and your colleagues?

Did you attend any of the events associated with this project i.e. the reflective practice conference and the Train the Trainers events? If you did, were they useful to you?

Appendix 3: Example Clinical Supervision Contract

As both supervisees and supervisors, we agree to the following:

- To work together to facilitate in-depth reflection on issues affecting practice, so developing both personally and professionally
- To meet for (insert agreed times/dates)
- To protect the time and space for clinical supervision by keeping to agreed meetings and time boundaries
- We will work to each supervisee's agenda, within a chosen framework of reflection
- We will all be open to feedback about how we handle the supervision sessions
- Each supervisee will keep any notes used during the session
- To be non-judgmental

As supervisees we agree to:

- Prepare for the clinical supervision sessions
- Take responsibility for making effective use of time, including punctuality, and any actions we may take individually as a result of clinical supervision
- Be open to accepting support and challenge, and be willing to learn

As supervisors we agree to:

- Keep all information shared in clinical supervision confidential, unless any unsafe, unethical, illegal practice or practice affecting prison security is highlighted. In the event any of the above are disclosed, we will attempt to support the supervisee to deal appropriately with the issue directly, themselves. If we remain concerned, we will reveal the information to the appropriate authority but only after informing them of our intention to do so
- Offer supervisees guidance, support and supportive challenge to enable in-depth reflection on issues affecting practice
- Use our own professional development to support and develop our own abilities as supervisors, without breaking confidentiality

Anything else?

- We will use a peer supervision model of clinical supervision in which all group members attending the group will be given time and space to bring their issues for discussion. Time constraints will deem it necessary to discuss, at the start of the session, the duration of each members input (in their role as a supervisee) at the meeting

- The introduction of new or temporary members to the group will be discussed by the group and agreed before admission
- During these sessions, operational rank will be irrelevant and all group members will be respected as individuals

Frequency of meetings: (insert)

Venue: (insert)

Duration of supervisory relationship: (insert)

Signed

Date

Appendix 4: Reflective Practice Tool

Developed by the NW2 Clinical Supervision Action Learning Group, October 2005

One – Describe the event

_____

Two – How did you feel after the event?

Three – Outstanding questions, e.g. Is it safe?

Where can you find answers or support?

_____

Four – What would you do if it happens again?

Five - Other issues, e.g.

Are there health & safety implications?

_____

Appendix 5: Train the Trainers

Quoted from flyer sent out to all prison establishments:

Training is provided free for prison staff over two days in order to support participants to provide training and facilitation for their colleagues in clinical supervision and reflective practice.

This training will provide participants with the information needed to develop a learning environment suitable for clinical supervision and reflective practice; the skills needed to deliver clinical supervisor training and skills in group facilitation. It is based on the principles of experiential learning and aims to support participants in developing clinical supervision and reflective practice in their own establishments.

Day one of the training will incorporate modules concerning:

- Introduction to reflective practice and clinical supervision
- Clinical supervision and reflective practice: theories and models
- Clinical supervision and professional practice
- On being a supervisee
- On being a supervisor
- Group supervision

In essence, day two is spent reflecting on day one through the use of experiential learning. It is envisaged that participants will be returning to their prisons to train colleagues and develop reflective practice, therefore, the following issues will also be incorporated into the training:

- Experiential learning
- Learning styles
- Presentation skills
- Managing change

Appendix 6: Reflective Practice
Conference, Prison Service College

09.00-09.30	Registration/coffee	
09.30-09.40	Introduction/housekeeping	Liz Walsh Project co-ordinator
09.40-10.00	The development of clinical supervision in prison	Richard Bradshaw, Head of Prison Health
10.00-10.20	Supporting reflective practice and practice development	Theresa Shaw Chief Executive, Foundation of Nursing Studies
10.20-10.40	Health care inspection and clinical supervision	Elizabeth Tysoe Health of Health Inspection, HM Inspectorate
10.40-11.00	Questions/forum discussion	Liz Walsh: facilitator Richard Bradshaw Elizabeth Tysoe Theresa Shaw
11.00-11.15	Coffee	
11.15-12.15	Workshop I Clinical supervision toolbox Work-based learning through reflection/ reflective practice	Steve Dilworth (ALG facilitator) Philip Esterhuizen (ALG facilitator)
12.15-12.45	Developing clinical supervision in practice	Professor Veronica Bishop
12.45-13.30	Lunch	
13.30-14.00	Clinical supervision at HMP Liverpool	Debbie Carroll Nurse Manager, HMP Liverpool
14.00-14.30	Reflective practice and the NMC	Joe Nichols Professional Officer, Nursing and Midwifery Council
14.30-15.30	Workshop II Clinical supervision toolbox Work-based learning through reflection/ reflective practice	Steve Dilworth Philip Esterhuizen
15.30-16.00	Close of conference/reflections on the day	Professor Dawn Freshwater

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