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Enablers and barriers to effective clinical supervision in the workplace: a rapid evidence review

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ABSTRACT

Objectives We aimed to review the international literature to understand the enablers of and barriers to effective clinical supervision in the workplace and identify the benefits of effective clinical supervision.
Design A rapid evidence review.
Data sources Five databases (CINAHL, OVID Embase, OVID Medline, OVID PsycInfo and ProQuest) were searched to ensure inclusion and breadth of healthcare professionals.
Eligibility criteria Studies identifying enablers and barriers to effective clinical supervision across healthcare professionals in a Western context between 1 January 2009 and 12 March 2019.
Data extraction and synthesis An extraction framework with a detailed inclusion/exclusion criteria to ensure rigour was used to extract data. Data were analysed using a thematic qualitative synthesis. These themes were used to answer the research objectives.
Results The search identified 15 922 papers, reduced to 809 papers following the removal of duplicates and papers outside the inclusion criteria, with 135 papers being included in the full review. Enablers identified included regular supervision, occurs within protected time, in a private space and delivered flexibly. Additional enablers included supervisees being offered a choice of supervisor; supervision based on mutual trust and a positive relationship; a cultural understanding between supervisor and supervisee; a shared understanding of the purpose of supervision, based on individual needs, focused on enhancing knowledge and skills; training and feedback being provided for supervisors; and use of a mixed supervisor model, delivered by several supervisors, or by those trained to manage the overlapping (and potentially conflicting) needs of the individual and the service. Barriers included a lack of time, space and trust. A lack of shared understanding to the purpose of the supervision, and a lack of ongoing support and engagement from leadership and organisations were also found to be barriers to effective clinical supervision.
Conclusions This review identified several enablers of and barriers to effective clinical supervision and the subsequent benefits of effective clinical supervision in a healthcare setting.

Strengths and limitations of this study

► This paper was based on evidence identified in the international literature using a rapid review, which involves a systematic search and rigorous analysis.
► Papers were limited to Western only and the last 10 years for pragmatic reasons.
► Although in many areas there was a vast amount of information, which provides strength to the findings, a rapid review necessarily pays less attention to study design and sample sizes.
► Much of the data were heterogeneous in nature, and this also hindered our ability to relate the findings to specific professions and settings.
► The findings drawn from the overall themes were evident across much of the literature.

INTRODUCTION

Understanding what makes clinical supervision effective and learning more about the barriers to and challenges of effective supervision are important concerns for the health and social care workforce. Most organisations provide some provision, but many lack an understanding about why it is important, who should be involved, what the possible benefits are and how it could be improved.

Supervision is at the core of practice for all health and social care professionals, where there should be a sense of shared responsibility for the effectiveness and safety of practice.[1] It is important to understand this complex process to ensure best practice for all participants involved (practitioner, service delivery manager, clinical supervisor, peers, clients and other service users, the profession itself).

Supervision has been described as an event that involves an ongoing professional relationship, between two and more staff members with different levels of knowledge or expertise, to support professional development and to enhance knowledge and skills.[2] Definitions of supervision emphasise the promotion of professional development in addition to ensuring patient safety. For example, Nancarrow *et al*[2] focus on the progression of clinical practice through professional guidance and support and refer

to Proctor's[3] three functions of supervision—managerial/administrative, educational and supportive. All three functions should be overlapping and flexible.[2]

It has been suggested that there are many forms of supervision: internal managerial, internal reflective, external professional and external personal.[1 4] At one end of this continuum, managerial supervision takes place inside the organisation and is mostly focused on task and process. At the other end, personal supervision is worker focused and centres mainly on the narrative brought into the supervision space by the worker.[1] This last type of supervision (personal) has been highly valued by workers to air their feelings; providing a safe place to connect and self-reflect. Personal supervision allowed a more intensive focus on clinical issues and personal professional development rather than organisational concerns.[4] Two types of supervision tend to coexist when the line manager is also the clinical supervisor—a focus on practitioner learning and development, and another focused on service delivery, risk management and underperformance. Kilminster and Jolly[5] argued for clarity on dealing with underperformance in addition to identifying what helps and hinders effective clinical supervision. Managing this split highlights the need for supervisor training.

In this review, we used the following definition of supervision as it encompassed both personal development and service development in the context of a relationship extending over time:

> This relationship is evaluative, extends over time and has the simultaneous purposes of enhancing the professional functioning of the more junior person and monitoring the quality of the professional services. (Bernard and Goodyear, p8)[6]

While it is evident that supervision is important, we must now understand exactly what aspects of supervision we should be focusing on, and it is hoped that best practice can be sought from looking across such a range of different healthcare professionals. Any critical differences that impacted on supervision across health professions were also noted.

Identifying the focus of supervision
The aim of this rapid review was: 1) to syntheses the evidence of international literature on the enablers of, and barriers to effective clinical supervision in the workplace; 2) to identify the benefits of effective clinical supervision in the workplace.

METHODS
A Rapid Evidence Assessment (REA) was used in this study. A REA is similar to a systematic review in that they both use rigorous methods of appraising and synthesising evidence from published studies.[7] However, restrictions on the data retrieved are placed on the search at the data collection phase.

Search strategy
The research protocol was developed with advice from a data analyst at Newcastle University. As a result, we refined our initial search strategy and targeted the most appropriate databases. The following databases were used to ensure a breadth of health and social care professions were included: CINAHL, (Allied and Health Professionals literature), OVID Embase, OVID Medline (Medical literature), OVID PsycInfo, (Psychological literature) and ProQuest (Social Science literature). See the Search strategy section for a breakdown of search terms used.

A systematic search (see online supplemental material 1 for search strategy) of each database was carried out in line with our search strategy. As is typical of rapid reviews, limits were placed on the search to ensure the research could be done in a timely manner. For example, only including papers from the last 10 years ensured we were able to capture the most relevant documents for current supervision practice in a shorter space of time. Search terms were developed to include a comprehensive list of healthcare professionals, supervision types and forms of effectiveness. Restrictions were placed on the databases in line with our search strategy.

Procedure for screening of data, data extraction and ensuring quality assurance
All citations were downloaded to EndNote (reference management database) and duplication was removed (n=2683). Authors independently reviewed the same 500 titles and abstracts to make sure that the same papers were being included/excluded. Any discrepancies were discussed and the inclusion/exclusion criteria were refined as needed (see box 1). All 13 239 titles and abstracts were screened by two researchers (CR and AK).

Box 1   Revised inclusion/exclusion criteria

Inclusion criteria for papers
1. Papers that include clinical supervision and/or peer support in the workplace.
2. Papers that include a regulated healthcare profession.
3. Papers published within the last 10 years (1 January 2009–12 March 2019).
4. Papers that include primary research and systematic reviews.
5. Papers which are quantitative, qualitative or mixed methods.
6. Papers written in English.
7. Papers reporting on a Western culture setting.

Exclusion criteria for papers
1. Focus not on formal and structured clinical/peer supervision (by this we mean that the supervision was not a 'one off' event but must have some ongoing relationship, as detailed in the very definition of supervision).
2. Not in healthcare context.
3. University setting.
4. Not evidence based (eg, opinion pieces, letters or weak evidence).
5. Paper not written in English/outside review period.
6. Supervision of children/animals/patients.
7. Non-Western culture setting.

A pilot data extraction exercise was conducted to ensure quality assurance. This exercise involved all four reviewers independently reading full papers and was repeated with a further 10 papers to check consistency of inclusion/exclusion and data extraction. The data extraction framework was revised following this initial review of papers. The clear inclusion/exclusion criteria and detailed data extraction form were used to ensure rigour. The data extraction form has been added as online supplemental material 2. Regular meetings were held between all four reviewers to ensure quality was maintained and to discuss uncertainties or queries that arose from the papers, and it was during this phase that the definition of clinical supervision was identified .

Synthesis of papers

Once the data were entered onto the data extraction database (see online supplemental material 2 for the data extraction form), the data were analysed using a qualitative thematic synthesis,[8] which is a useful approach when aiming to pull out common elements across the heterogeneous literature. These themes were used to answer the research aims.

Patient and public involvement

Patients or the public were not involved in the design, or conduct, or reporting, or dissemination plans of our research.

Findings

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

Paper demographics
Setting

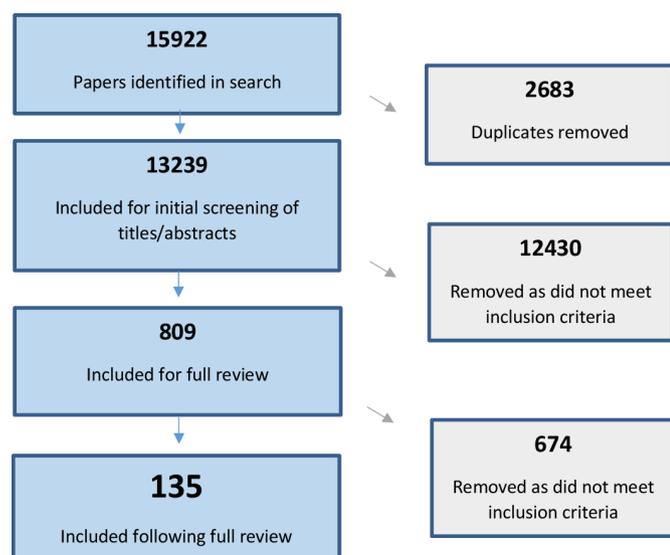A range of countries were represented within the included papers, with the majority being from Australia (38), the UK (31), the USA (24), New Zealand (11) and Canada (7). The findings were further diversified by the broad set of health and social care professions included in the review. The majority of papers included doctors, nurses, psychologists and social workers. Examples of other allied health professionals included were music therapists, physiotherapists, occupational therapists, speech and language therapists, podiatrists and dietitians.

Research designs

Papers included in the review were a mix of qualitative papers (53) using interview or focus group data and quantitative papers (50) using surveys and questionnaires. Several papers used a mixed-methods approach (15) and literature reviews (15), case study (1), action research (1), unidentified (1).

Type of supervision

Of the included papers, a large majority focused on clinical supervision (110), with a minority focusing on peer supervision (22) or both (3). These included both individual and group supervision sessions. Within the literature, there were several types of clinical supervision and peer supervision discussed. However, there was not always a clear distinction between different types of supervision, and terms were often used interchangeably such as peer supervision and peer mentoring. The working definition we used was clinical supervision, which was conducted either in a one-to-one or small group situation by a senior staff member or by a more experienced staff member at the same level. Clinical supervision included: action planning; reflection on clinical situations; role development and training; indirect and direct supervision; and included supervision from both internal and external organisations.

The research questions were answered using evidence from this literature review.

What are the enablers to effective clinical supervision?
An open, supportive and safe environment

There was considerable evidence to highlight that having an open and safe environment where supervisees feel comfortable and trust their supervisor is an integral part of supervision.[4 9–34] Having the time to discuss personal issues based on the needs of the individual was identified as an important focus for supervision.[30 32 35–37] There was also evidence of the value of time spent reflecting on practice, including ethical issues[14 15 18 28 38 39] and of receiving feedback.[15 30 32 39–42]

Establishing a supervisory relationship based on trust

Being able to develop a positive relationship with a supervisor that was based on trust was seen as key by a wide range of professions.[2 4 10 11 28 39 42–46] Supervisors who were deemed experts in their own profession were also more likely to be viewed as credible and trustworthy, and supervisees felt they were better placed to support them.[11 12 32 46–48] Trust was also underpinned by having the opportunity to be able to explore each other's belief and

Figure 1 Flow chart of papers included in full review.

Flow chart content:
- 15922 — Papers identified in search
- → 2683 — Duplicates removed
- 13239 — Included for initial screening of titles/abstracts
- → 12430 — Removed as did not meet inclusion criteria
- 809 — Included for full review
- → 674 — Removed as did not meet inclusion criteria
- 135 — Included following full review

value systems in a neutral space, away from organisational hierarchies and the workplace and where emotions could be managed in an open and reflective way[10 49] and when the supervisee respected the supervisor personally and professionally and both parties could self-disclose experiences.[32 50]

Regular supervision with timely feedback

Many studies reported on the importance of receiving regular and constructive feedback during supervision[2 14 15 32 40 44 51–54] and having the time to reflect on practice.[14 15 18 28 42 51 55] Supervision was valued for the sharing of tacit knowledge, for providing real-time feedback[41] and when it provided confirmation that staff had done the right thing.[15]

The majority of the literature reviewed did not specify supervision frequency. There was scant evidence on how often clinical supervision should take place.[56] However, Dilworth et al[57] reported that supervision should take place on a monthly basis to ensure sufficient support. Furthermore, McMahon and Errity[27] reported that supervision that was less than fortnightly was insufficient and healthcare workers who spent at least 60 min in supervision perceived their supervision to be more effective.[58]

Supervisory relationships develop over time and are complex,[59] therefore supervision should not be a one-off activity, instead, it needs to be sustained over time and from early on in a career.[60] However, the importance of providing unplanned discussion time to support emerging needs and ensure staff well-being was also identified.[61]

Training for supervisors

Supervisors need to have training in cultural awareness to enable them to be culturally competent. This was seen as an asset leading to improvements in communication, reflection and problem-solving.[4 10 62] Supervisors also need to be trained on listening skills[30 32 63] and helping supervisees to problem solve.[64] Findings showed that it was important that the supervisor was able to not only provide feedback, but also receive it themselves.[2 15 30 32 41 42]

What are the benefits of effective clinical supervision?
Job satisfaction and staff retention

Several studies reported that effective supervision was found to have a positive impact on: staff retention,[61 65–67] job satisfaction,[13 68 69] staff well-being[63 70–72] and perceptions of being valued.[73] Wilson et al[32] found that feedback from supervisors facilitated learning and encouraged staff development. Continual Professional Development (CPD) and training for supervisors themselves were also found to increase retention.[74] Regular supervision was found to increase staff retention.[61] McMahon and Errity[27] reported that greater supervision frequency, with regular progress reviews, was significantly related to positive outcomes.

Reduced stress and anxiety

Several studies found that supervision reduced stress and anxiety.[15 22 44 47 70–72 75–78] Evidence suggested that the reduction in stress and anxiety came about as supervision provided a medium for sharing skills, knowledge and resources, in a supportive environment.[15 44 47] A reduction in stress for supervisors was also found, following the provision of training and CPD support for supervisors.[74] Studies reported that supervision helped participants to manage their feelings,[44 76] also improving understanding of the importance of well-being and learning to help reflect on practice.[72]

Better working environment

Research highlighted that effective supervision and a supportive working environment can improve the uptake of workplace policies as supervisees understand the importance and reason for the policies.[79] Better teamwork, relationships and more support in the workplace can also help with professional development.[61] A study by Davis and Burke[16] reported that supervision with nurse managers improved communication among staff and facilitated reflection, sharing ideas and problem-solving.

Increased quality of care delivery

Several studies made links with the provision of effective supervision and an increase in quality of care.[16 23 71 72 76 80–82] A study carried out by da Silva Pinheiro and de Carvalho[76] reported group supervision with nurses had helped them to manage their feelings, which they linked to an increase in quality of care for their patients. Claridge et al[81] looked at whether direct supervision with resident doctors increased patient outcomes. Results showed that with direct supervision, there was a greater uptake of compliance with managerial protocols, and as a result patient outcomes were improved.[81]

What are the barriers to effective clinical supervision?
Lack of time and heavy workloads

One of the main barriers identified for effective supervision was a lack of time and heavy workloads.[2 17 21 25 35 41 48 57 73 83–98] Many studies reported that supervisors were unable to find time for supervision due to busy work environments, which ultimately restricted supervisor flexibility and quality when they did find the time.[53 82 99] Other studies reported a lack of opportunity and time for reflection within supervision, which left staff feeling that they had to 'figure things out' for themselves without adequate support.[32 84]

Many noted that supervision was not a priority, for both supervisor and supervisee.[2 27 60 71 72 94 100] As a result, supervision was sometimes perceived to be a bonus,[11] feeling that they were expected to not 'dwell' on stressful workplace issues. There was often an expectation that supervisors had the time to develop relationships and would take the time to complete the necessary paperwork prior to and following supervision, which could be time-consuming.[80]

A lack of adequate resources could lead to an overstretched workforce not being able to support each other effectively, and a decline in clinical supervision due to pressures on staff time.[18] Kenny and Allenby[60] discussed a

lack of monetary incentives for supervision, affecting how supervision was perceived and whether it was provided or attended. Supervisees only wanted to attend supervision when it was within work time and when there was protected time for it.[60]

Lack of staffing, shift working

The type of clinical environment could facilitate or hinder clinical supervision.[56] Key factors were organisation location, shift work patterns and work-environmental factors (quantitative demands, tempo, cognitive demands, influence at work and social support). Jelinek *et al*[51] discussed that there was a reduction in supervision levels during unsociable shift patterns. Supervision was dependent on service demands and was often not seen as a priority if there was insufficient staff numbers in busy environments. Differences seemed to not only reflect culture (regardless of policy asserting its importance) but also ease of access to supervision. For example, there was a lack of supervision outside day shifts or in rural communities with fewer staff despite the potential for increased need due to professional isolation.[2 33 60 101]

Lack of management/organisational support

Organisational culture and attitude toward supervisory practice were found to be important, needing managerial support and buy-in.[60 101] If management do not recognise the importance of supervision, it is unlikely it will become embedded into the organisational culture, and a lack of commitment from organisations and managers can act as a barrier to providing the time and resources required for effective supervision.[2 27 31 37 73 93 101 102] In busy agency settings, supervision can often be neglected or deferred, to accommodate the latest crisis, unless it is made a priority by management.[1] A study exploring which nurses decided to participate in clinical supervision found that support from empowering and fair leadership was crucial, affecting the adoption and uptake of clinical supervision, both positively and negatively.[103]

Lack of supervisor training and support

Several studies reported that a lack of training for supervisors was a barrier and resulted in ineffective supervision.[32 38 64 76 91 92 104–107] Supervision was varied and individual when no direction about how to approach it was available.[56] Studies also reported a lack of quality in supervision when supervisors were unfamiliar with professional guidelines (ie, standards set by regulators), their role and responsibilities as a supervisor, ethical standards set in place by employers and inadequate educational preparation.[11]

Lack of supervisor competence and skills was identified in a number of studies highlighting barriers to effective clinical supervision, such as: being intolerant, blameful and inflexible,[2] being unable to deal with unmotivated supervisees[76 87] and manage differing personality types,[108] the lack of ability to share feelings,[49] inability to give appropriate feedback[51] and an inability to understand personal issues.[35]

Lack of understanding and support when dealing with underperformance

Supervision should facilitate learning opportunities when needed.[109] However, supervisors do not always have the time and opportunity to upskill staff or work with those who are underperforming.[110] Kilbertus *et al*[111] also found that some supervisors reported not feeling able or comfortable in recognising and managing a failing trainee. Issues arose when either the supervisor or supervisees were unaware of the supervisee's lack of knowledge and skills.[4 33 47]

A lack of support from employers was noted by supervisors when raising concerns about staff,[51] not always being told where to signpost supervisees to if there were any concerns or needs outside of their remit (eg, mental health support). Supervisors themselves may also need to seek support.[60] Supervisors also feared that if they gave supervisees negative feedback, that in turn they would receive negative teaching evaluations, and this would impact on their own future promotion and career.[41] There was also evidence that clinical supervision was delegated to the most junior consultants, with the least experience to deal with complex underperforming trainees.[110] Kilbertus *et al*[111] highlighted that a lack of continuity of feedback meant that it was easy for struggling residents to fall through the net.

Dealing with supervision from another discipline or from an external organisation

External supervisors (who work in a different organisation to their supervisee) and interprofessional supervision (supervisors from a different profession) may require additional training and guidance.[1 4 60] Interprofessional supervision can sometimes lead to misunderstanding due to differences in roles, responsibilities and levels of training. There may also be an absence of shared theory, language, differences in professional decision-making processes and codes of conduct.[112] In addition, an oversight of ethical practice could be weaker with an interprofessional model.[113] It may also disadvantage supervisors with regard to the professional role, not being able to raise all issues, and causes disempowerment due to differences in professional status[1] and places a burden of responsibility on the supervisor to have a good working knowledge of the context of practice of other professions.

Beddoe[1] states that an external supervisor will hold less information about the practitioner compared with an internal supervisor, who will likely identify managerial concerns more effectively. Having an external supervisor, however, increased the likelihood that supervision took place.[9 114 115] Yet it was the supervisee who mainly set the agenda with regard to issues to be discussed, and therefore underperformance was more likely to remain concealed. This type of supervision highlights the

weakness of self-assessment, which is a particular concern for those who are underperforming.[116]

Lack of relationship and trust

Supervisees need to feel that they can trust their supervisor,[52] yet sadly, this was sometimes lacking.[16 17 61 84 117 118] Unhelpful and untrusting relationships led participants to distrust their supervisor's advice, or be self-critical.[39 52] Palmer-Olsen *et al*[44] found that supervisors who did not establish a secure supervisory alliance were less effective in helping their supervisees learn to implement a specific therapy. A lack of supervisor commitment, or when supervision was reduced to a 'tick box' exercise, or too bureaucratic, it was found to be less effective.[2 61 85] It was also noted that sometimes people did not 'fit' with their supervisor.[32 39]

Lack of understanding about what supervision was and its purpose

Several studies reported a lack of a common understanding about the role and purpose of supervision.[2 60 97 100 119] On such occasions, supervisees reported anxiety and sometimes perceived that supervision equated to surveillance.[11 32 44 60 73 120] Negative associations with the term 'clinical supervision' also led to a lack of engagement.[11 37]

DISCUSSION

This rapid systematic review aimed to identify the enablers of and barriers to effective clinical supervision and identified the benefits of supervision for supervisees and supervisors within the workplace.

When in place and done well, clinical supervision has many benefits for the organisation, professional development and patient services, and each of these three levels makes an important contribution to ensure benefit is achieved. This review has highlighted evidence which indicates what needs to be in place to ensure clinical supervision is effective. Evidence from the literature review indicates that the organisation plays a key role in ensuring supervision takes place,[60 95 102] that it is valued and expected,[73 95] that supervisors are trained[29 37 68 79 91 99 104 121] and time is protected.[22 25 79 92 99 122] Supervision needs to be provided in a neutral, open, supportive environment to facilitate discussion and reflection on clinical practice, career development and any personal issues that may arise in the workplace.[4 9 10 13–16 18 20 21 23–26 29 30 32–34 44 117 123–125]

Having a relationship based on trust with the supervisor was also found to be key.[2 4 10 11 28 32 39 42–46] There was also evidence on the benefit of reflecting on practice[18 28] and on receiving feedback.[30 40 41] Having regular but flexible supervision that fitted around all stakeholders' needs was also highlighted as important. Clinical supervision provides the chance to facilitate learning opportunities when needed[98] and to upskill staff who were underperforming.[110]

There was much evidence about the positive benefits of clinical supervision, in that those who received support through clinical supervision were better able to cope with the demands of the job[23 75] and were less likely to leave.[69 126] Effective supervision increased resilience[78] and job satisfaction.[68 69 127] There was also evidence to suggest that supervision helped with reducing stress and anxiety.[63] Supervision was also seen to drive up the quality of care and has a positive effect on the working environment.[16 23 71 77 80–82 87]

A number of barriers were highlighted within the literature that should be taken into consideration when exploring how to implement effective supervision practice. These included a lack of time and heavy workload,[2 16 17 21 35 41 48 54 57 64 73 83–85 87–96 98] a lack of resources,[18 37 60] unsupportive management and colleagues,[2 27 31 73 93 102 128] a lack of supervisor training,[11 17 32 38 64 76 91 92 105–107 124] and a lack of trusting relationships and ongoing support.[16 17 45 61 75 84 117 118] Supervisees were also sometimes unaware of the purpose of the supervision practice,[2 60 64 100 119] impacting on engagement.[2] A recent study has highlighted the need for supervision to include patient care, concluding that the usual model of meeting for a supervisory discussion away from patient care was not found to be effective.[129] Although this is an interesting and important finding, our findings would suggest that the overall supervisory experience is not as simplistic as this. There is a need to take into account all of the factors and levels presented in this paper, there being no single answer leading to effective supervision.

There were no critical differences identified across the range of healthcare professionals in terms of ensuring effective supervision is in place, with similar themes being apparent across all. Naturally, professions such as psychologists and social workers will face different challenges and have different needs from their supervisory relationship; however, this is part of the supervisory process and identification of those needs is what will make it an effective experience for the supervisee.

It is clear from the evidence that support from management is needed to enable effective implementation, including cost and training for staff. However, this review has highlighted that supervision is subject to different interpretations by managers, who tend to focus more on service delivery rather than on staff development, and agreeing on the shared purpose of supervision is important to reduce ambiguity.[1 10] Beddoe[1] argued that managerial supervision creates a shift from being practitioner focused to a monitoring agenda. Problems seem to arise when the focus was perceived to be monitoring performance, rather than on the provision of support.[1 9 10 39 42 115] Pack[72] highlights that line managers need to focus on protecting the employing organisation and their patients/clients from risk,[96] whereas external supervisors can focus more on the personal development. This split may offer a solution that avoids the inevitable tension experienced by a manager who is also the clinical supervisor. The issue of managing underperformance alongside personal development further highlights this tension and indicates again that having two different

supervisors might offer a solution; like experienced by junior doctors in the UK, who have an educational supervisor (who oversees educational development) and a clinical supervisor (who oversees clinical practice). A split role, when feasible, might be the preferred solution and when this is not an option then supervisors need training to support them to manage these challenges. The model of practice which is best is a source of continued debate. However, what is clear is that there is no 'one size fits all' for clinical supervision and all stakeholders need to consider how to make their supervision as effective as it can be and involve discussion to agree on the shared purpose of clinical supervision.

Limitations

This paper was based on evidence identified in the international literature using a rapid review, which involves a systematic search and rigorous analysis. Although in many places there was a vast amount of information, which provides strength to the findings, a rapid review necessarily pays less attention to study design and sample sizes. An additional limitation of this rapid review was that the study focused on publications in English, studies set in Western only settings and publications within the past 10 years only. Much of the data were heterogeneous in nature, and this also hindered our ability to relate the findings to specific professions and settings. However, the findings drawn from the overall themes were evident across much of the literature.

CONCLUSIONS

This review has identified the following enablers of and barriers to effective clinical supervision with regard to the organisation, the supervisor and supervisee.

Enablers included having a set place and a regular time slot for supervision to ensure it takes place. It is more likely to occur when a private space is made available and when protected time is available. Also, there needs to be some flexibility to enable staff working irregular hours such as night shift to access clinical supervision. Barriers to supervision happening were apparent when these issues of place and time were not in place.

Another key enabler identified was when the supervisory relationship was based on a positive relationship and on mutual trust. Ideally, supervisees should be offered a choice of supervisor and there should be some cultural understanding between them. When this is not the case, when the relationship lacks trust, this becomes a barrier, as does having to accept a supervisor not well matched to the supervisee and when cultural understanding is missing.

For clinical supervision to be effective, there needs to be a shared understanding of its purpose. Ideally, this is based on the individual needs of the supervisee and the focus is on enhancing knowledge and skills to support professional development and improve the service. Barriers occur when there is no agreed purpose and no agreement or conflicting views on the focus of clinical supervision.

This review identified that a range of types of supervision can be effective: one-to-one, group, internal, external and distance supervision can all offer a range of benefits. Going forward, having different types of supervision, with different people who offer different perspectives, should be considered and may overcome some of the barriers in place when only one, poorly matched, supervisor is available. Clearly, having different supervisors also overcomes the problem of having a line manager who is both the clinical supervisor and service manager and who may need to manage the needs of the service with the potentially conflicting needs to the individual. Lastly, providing training to supervisors is helpful to ensure they are supported and developed in this role and indeed also benefit from feedback themselves, without such training barriers to effective supervision may occur.

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