# The Perceived Experience of Supervision within the PACE Trial.

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**Full Report**

**October 2007**


# Acknowledgements

We would like to thank the PACE Trial Management Group, in particular Professors Peter White, Michael Sharpe and Trudie Chalder, principal investigators and Julie DeCesare, trial manager, for giving us the support to carry out this ancillary study. We would especially like to thank all the therapists who gave up their time to complete the questionnaire.

Special thanks to Dr Mary Burgess and Ms Jessica Bavinton, the 2 other therapy leads within the trial, who assisted with the development of the questionnaire.

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## Rationale

This study was set within the UK inter-professional multi-centre randomised controlled PACE trial of manual based therapy (White et al 2007). The aim of supervision within "the trial" was to maintain specificity, sustain retention, manage quality control and assurance, monitor competence in delivering therapy and enhance professional development.

The rationale for the ancillary study was that the approach to supervision within the trial appeared to be different from the previous experience of supervision for many of the therapists (Clouder & Sellars 2004, Sellars 2004, Sweeney et al 2001). A review of the literature on supervision and reflective practice highlighted that there are many models, methods, approaches and factors that influence the effectiveness of supervision (Edwards et al 2005, van Ooijen 2000).

## Background Literature

Clinical supervision has been defined as;

> *"A structured, formalised approach (for which time is set aside) for discussing professional practice with a colleague or peer that encourages reflection on, and evaluation of, clinical decision-making and outcomes"* (DoH 2003).

Lyth (2000, p. 728) had previously proposed the following expanded definition of clinical supervision,

> *"Clinical supervision is a support mechanism for practising professionals within which they can share clinical, organisational, developmental and emotional experiences with another professional in a secure, confidential environment in order to enhance knowledge and skills. This process will lead to an increased awareness of other concepts including accountability and reflective practice".*

In current clinical practice, supervision has broadened its remit of being a means of ensuring competence to practice and quality monitoring to greater

emphasis being placed on continuing professional development (Clouder & Sellers 2004, Falender & Shafranske 2007). Continuing professional development (CPD), reflective practice and clinical supervision are now embedded in many policy documents (CSP 2000, DoH 2000, 2003, 2004). The definitions in box A highlight the importance placed on reflective practice, CPD and competence.

**Box A: Allied health professions (AHP) project continuing professional development & competence core definitions**

Source: Allied health professions project: Demonstrating competence through continuing professional development [CPD]. Final report. August 2003. London: DoH

**Continuing professional development (CPD)**

A wide range of learning activities through which professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice.

**Competence**

The complex synthesis of knowledge, skills, values, behaviours and attributes that enable individual professionals to work safely, effectively and legally within their particular scope of practice that has at its core concepts of professionalism, autonomy, self-regulation, awareness of the limits of personal practice and the practice of the profession to which individuals belong, and within which structured, career-long learning and development to meet identified learning needs forms an integral part.

**Reflective practice**

The structured process of reviewing an episode of practice to describe, analyse, evaluate and inform professional learning in such a way that new learning is identified, modifies previous perceptions, assumptions and understanding, and informs subsequent practice.

**Outcomes-based approach**

An approach to providing evidence of CPD that seeks to attest to on-going competence that focuses on individuals' learning achievements, their application of learning to practice and the benefits of this, rather than simply input (e.g. the amount of time devoted to learning activities or the amount of credit accrued through undertaking formal learning programmes).

It is important to recognise the part clinical supervision plays in fulfilling the two agendas of professional development and professional regulation (Clouder & Sellars 2004). In the trial, supervision was used to monitor ongoing competence, an element of professional regulation, and enhance professional development through reflection, sharing good practice, group supervision and peer support.

The relationship between supervisee and supervisor has been suggested as key to effective supervision with the supervisor finding regular time, and demonstrating a commitment to the supervisee's professional development by providing feedback in a constructive, unthreatening and supportive environment (Barnett 2007, Edwards et al 2005).

The use of supervision within the trial was different from traditional clinical supervision (Clouder & Sellars 2004) in that it was predominately off site and long arm and used a mixture of modes; telephone one to one supervision; one to one face to face supervision; group supervision; competency review of audio/ video tapes of supervisee sessions for adherence to therapy and peer support. Group supervision has been shown to enhance communication, planning and delivery of services through professional support, reflection and learning (Alleyne & Jumaa 2007, Wimpenny et al 2006, Hyrkäs & Appleqvist-Schmidlechner 2003), and support training (Lindren et al 2005, Mason 1999).

Additionally, supervision in the trial was structured by an agenda, aimed to summarise previous session content, review any learning, help supervisees apply a specific therapy and to develop their assessment, conceptualisation and treatment skills and therefore used a cognitive therapy supervision framework (David & Freeman 2006, McBride 2007, Sloan et al 2000).

The therapy supervision in the trial was also being used in-conjunction with on-site managerial clinical supervision through professional groups/ services in the 6 study centres. This could be defined as joint or co-supervision "*…supervision provided by two or more workers who work equally and collaboratively to encourage the strengths and capabilities of the supervisee. The goal of co-supervision is to provide a learning environment within the context of an ongoing relationship"* (Coulton & Krimmer 2005, pg. 154).

**Study Framework**

A systematic review of the literature was conducted using standard literature search techniques from 1995 to 2005 and subsequently 2006-2007. Online computer searches of relevant databases were completed, using the key words; supervision, supervisor, supervisee, peer support, group supervision, clinical supervision, supervision models, reflective practice, and clinical reasoning. The computer searches were supplemented by known books and other resources on supervision models and practice. 78 articles were critically reviewed.

The articles reviewed were predominately in the field of general and mental health nursing, although psychology, psychiatry, medicine, physiotherapy and occupational therapy were represented in the literature. Many of the studies reviewed were qualitative using a mixture of methodological approaches.

**Aim of the study**

The aim of this study was to explore the experience of supervision by the therapists within the trial and to consider whether;

a). the experience of supervision differed between the therapies and

b). previous experience of supervision was similar or different to that within the trial.

**Supplementary Questions:**

- How was supervision perceived within the trial by therapists?
- How were models/ methods of supervision perceived by therapists?
- What were the perceived advantages and disadvantages of the different methods?
- Were there any perceived barriers to use of reflection within the supervision process?
- Did supervision within the trial relate to the therapists on-site service/ management supervision (joint/ co-supervision)?
- Was supervision perceived differently within therapies and/ or professional groups?

**Proposed Implications of the Study**

As the aim of the study was to identify the perceived experience of supervision within the trial and whether this differed from previous practice and experience, the study could offer insights into the model (s) of supervision favoured by therapists and use of training and supervision within research studies.

- It may identify the need for additional training in the use and application of supervision for therapy leads and/ or therapists.
- It may offer guidance for researchers carrying similar inter-professional multi-centre studies in the future.
- It may offer insight into preferred methods of supervision in relation to level of experience and/ or expertise in a specific field.

**Research Design & Method**

A number of research designs and frameworks were considered for this small exploratory study to gain an insight into the experience of supervision within the trial (Fossey et al 2002, Reynolds 2003, Bowling & Ebrahim 2005). Qualitative research aims to gain understanding from the subject's point of view, to give meaning to actions and experiences (Denzin & Lincoln 2003a). There are two main paradigms in qualitative research; interpretative and critical (Denzin & Lincoln 2003a, Fossey et al 2002). These paradigms place emphasis on seeking understanding of the meanings of human actions and experiences. One approach within interpretative research is phenomenology where researchers are interested on how people experience the world (Fossey et al 2002). Recently a form of analysis derived from interpretative research and phenomenology has been used to explore experiences and meaning within chronic illness and mental health (Reynolds 2003, Koivisto et al 2002, Knight & Moloney 2005). Qualitative data is commonly collected through in-depth interviews, observation, group interviews or focus groups (Fossey et al 2005). The use of in-depth narrative interviews and/ or focus groups would enable an exploration of subjective meaning of the experience of supervision within the trial.

It is common in qualitative research for the researcher to work closely with the participants, and have an understanding of their role in the process i.e. reflecting on own values, beliefs and personal experience that may affect the research (reflexivity) (Bowling 2002, Denzin & Lincoln 2003a, 2003b). The researcher is therefore likely to have an impact on the people they are studying. In order to reduce this possible influence and limit any potential barriers in gaining information from therapists in the trial a self report questionnaire utilizing survey methodology was chosen rather than qualitative semi structured interviews and focus groups, as the method of data collection (Bowling & Ebrahim 2005). The questionnaire collected both open (qualitative) and closed (quantitative) data.

**Development of the Questionnaire**

The questionnaire was developed using the reviewed literature on supervision in practice and the 1st author's and other therapy leads' experience of supervision within the trial (see appendix 1). It was piloted prior to use on colleagues within the university research centre for clarity and ease of use. Spence and colleagues (2001) in a review of the evidence in relation to supervision suggested lists of factors regarded as qualities of "good" and "non-preferred or disliked" supervision. These lists were used to formulate a likert scale as part of the questionnaire in section 3 (Bowling & Ebrahim 2005). To further reduce any bias in collecting and analysing the data and to maintain confidentiality the questionnaire was distributed, collated and analysed by a research assistant independent of the trial (GA).

**Sample**

18 therapists (6 therapists per therapy approach) employed within the trial across 6 centres in 3 UK cities; comprising of a potential 6 Occupational therapists (OT), 6 Physiotherapists/ Exercise physiologists (EP), and 6 Cognitive behaviour therapists/ Psychologists (PSY).

**Procedure**

All therapists in the trial (N=18) were sent a letter of invitation, information sheet, consent form (with separate sealed envelope for return) and a

questionnaire by post (see appendices 1-4). A stamp addressed envelope was enclosed for ease of return. After 4 weeks a follow-up letter (see appendix 5) and further copy of the questionnaire was sent to 9 therapists.

**Analysis**

Descriptive, content and thematic analysis was conducted (Fossey et al 2005, Bowling & Ebrahim 2005). Where appropriate frequencies and percentage of response were recorded. More detailed statistical analysis would be inappropriate due to the mainly qualitative nature of the data and size of the study.

**Ethical considerations**

Written informed consent was required from therapists to take part in the study. Each person was required to complete an anonymous self report questionnaire. The professional group of the therapist was recorded. The 1st author (DLC) was aware of the implications of reflexivity and was aware of the potential bias of being both researcher and therapy lead in the trial (Denzin & Lincoln 2003a). Each participant was assured of the confidentiality of the data they provided within the questionnaire. To further reduce any potential influence or bias in collecting and analysing the data and to maintain confidentiality, the questionnaire was distributed, collated and analysed by a research assistant (GA) independent of the trial. A notice of substantial amendment to the original trial ethics application was submitted for consideration by the West Midlands Multi-centre Research Ethics Committee (MREC) and approval was granted. The study would need the support of all therapists involved in the trial to give a fair reflection of the use and experience of supervision within the trial. However, each therapist would have the right not to participate in the study.

**Findings**

The purpose of the study was to explore the previous and current experience of supervision by the therapists within the trial and to highlight any similarities and differences. Fourteen out of a possible 18 therapists responded, a response rate of 78%.

**Section 1: Prior Experience of Supervision**

All respondents (N=14) had previous experience of one-to-one and face-to-face supervision as supervisees, and half of them (7) also as supervisors. While all occupational therapists (OT, n=5) had previous experience as supervisors, none of the psychologists/ cognitive behaviour therapists (PSY, n=4) who responded to the questionnaire had been supervisors themselves. Amongst the physiotherapists/exercise physiologists (EP, n=5), 2 had previous experience as supervisors and 3 had none.

All OT respondents had previous experience of peer support meetings and on-site supervision; only one reported not having previous experience of reflective practice and goal/target setting. No OT respondents had previous experience of group meetings, off-site supervision, telephone supervision, video conference supervision, or competence rating.

All EP respondents had previous experience of goal/target setting, while only one of them reported not having previous experience of group meetings, sharing good practice and reflective practice. Two had previous experience of competency rating and one reported having previous experience of telephone supervision and off-site supervision.

All PSY respondents had previous experience of group meetings, off-site supervision, reflective practice, and goal/target setting; only one reported not having previous experience of peer support meetings and on-site supervision. Three (75%) had previous experience of competency rating and another reported having previous experience of joint and telephone supervision.

As a whole, all 14 respondents had previous experience of one to one, face to face supervision, 13 of goal/target setting; 12 of reflective practice; 11 of on site supervision; 11 of peer support meetings; 9 of sharing good practice through in-house seminars; 8 of group meetings; 6 of joint supervision; 5 of off site supervision; 5 of competency rating; 2 of telephone supervision and none of video conference calls. The table 1 below summarises the responses regarding previous supervision experience.

**Table 1: Previous supervision experience: form, frequency and qualification stage (N=14)**

| | Yes | No | D | W | 2W | M | 2M | 3M | 4M | 6M | Y | N | I | E |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| One to one; face to face | 14 | -- | -- | 7 | 1 | 7 | 3 | -- | -- | -- | - | 8 | 9 | 5 |
| Group meetings | 8 | 6 | -- | 2 | -- | 6 | 1 | -- | -- | -- | - | 6 | 5 | 2 |
| Peer support meetings | 11 | 3 | -- | 1 | -- | 7 | -- | 2 | -- | -- | - | 6 | 6 | 3 |
| Sharing good practice | 9 | 5 | -- | 1 | -- | 7 | -- | 1 | -- | -- | - | 6 | 7 | 3 |
| Off-site supervision | 5 | 9 | -- | 1 | -- | 2 | -- | -- | -- | 1 | - | 4 | 1 | -- |
| On-site supervision | 11 | 3 | -- | 5 | 1 | 8 | 1 | -- | -- | -- | - | 8 | 8 | 4 |
| Joint supervision | 6 | 8 | -- | -- | -- | 3 | 2 | -- | -- | 1 | - | 2 | 5 | 2 |
| Telephone supervision | 2 | 12 | -- | -- | -- | 1 | -- | -- | -- | -- | - | -- | 1 | -- |
| Video Conference | -- | 14 | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| Competence rating | 5 | 9 | -- | 1 | -- | -- | -- | 1 | 1 | 1 | 1 | 3 | 1 | 1 |
| Reflective practice | 12 | 2 | 1 | 6 | -- | 4 | -- | -- | -- | -- | 1 | 5 | 5 | 6 |
| Goal/target setting | 13 | 1 | -- | 3 | -- | 3 | -- | 1 | -- | 4 | 3 | 7 | 7 | 5 |
| As supervisee | 14 | -- | 1 | 5 | 1 | 6 | -- | 1 | -- | 1 | -- | 8 | 10 | 11 |
| As supervisor | 7 | 7 | -- | 3 | 1 | 5 | -- | -- | -- | -- | -- | 1 | 7 | 4 |

**KEY: Frequency,** D= Daily; W=Weekly; 2W=Fortnightly; M=Monthly; 2M=2Monthly; 3M=3Monthly; 4M=4Monthly; 6M=6Monthy; Y=Yearly. **Stage of Qualification,** N=Newly Qualified/Novice; I=Intermediate (1-4 years experience); E=Expert (more than 5 years experience).

While some respondents chose to describe the frequency of supervision sessions in terms of weeks, or months or years, others combined weekly, monthly and six-monthly terms. This was often directly linked to specific actions, spheres and types of supervision. Similar contextual caveats are

observed in respondents' own descriptions of previous supervision experiences which are also clearly linked to individual circumstances and expectations.

**Previous experience of supervision style/approach/model in respondents' own words**

Open ended questions were introduced in the questionnaire, in order to encourage respondents to use their own words to describe their particular experiences. These open ended questions were used to gather information related to both their previous experiences of supervision and their supervision experiences within the trial. Table 2 shows the responses of their experience prior to the trial.

**Table 2: Previous experience of supervision style/approach/model**

| ↓ **Descriptors that respondents used** | **OT (N=5)** | **P/EP (N=5)** | **PSY (N=4)** | **Total (N=14)** |
|---|---|---|---|---|
| Face to face, one to one | **2** | **3** | **2** | **7** |
| Reflective Practice | **--** | **1** | **2** | **3** |
| Systematic | **--** | **--** | **2** | **2** |
| CBT | **--** | **--** | **2** | **2** |
| Case presentation and informal discussion | **--** | **1** | **1** | **2** |
| Monitoring, supporting and CPD assurance | **1** | **--** | **--** | **1** |
| Mutual problem solving | **--** | **1** | **--** | **1** |
| Group supervision | **--** | **--** | **1** | **1** |
| Managerial, educative and supportive | **1** | **--** | **--** | **1** |
| Flexible | **--** | **--** | **1** | **1** |
| Formal appraisal | **--** | **1** | **--** | **1** |
| Collaborative | **--** | **--** | **1** | **1** |
| Internet | **--** | **1** | **--** | **1** |

**KEY: OT=**Occupational Therapist; **P/EP=**Physiotherapist/Exercise physiologist; **PSY=**Psychologist. CBT= Cognitive Behaviour Therapy; CPD= Continuing Professional Development.

The descriptor of supervision approach, style or model most often used by respondents was 'face to face and one to one'. 7 respondents (50%) used this descriptor, and it is noticeable that such a response was evenly distributed within the 3 disciplines. The remaining descriptors used by respondents were mainly individual and singular, except for 'reflective practice', 'systematic' and 'CBT' (which were used by half of the PSY respondents in each case).

The predominance of singular responses did not necessarily mean that the previous experiences of supervisees were completely unrelated to each other,

but it rather suggested that respondents' use of their own terms allowed them to describe supervision styles and approaches according to their own perceptions. 'Mutual problem solving', 'collaborative' and 'group supervision' might, for instance, refer to the same supervision style and approach, but the fact that respondents choose to use one term rather than the other allows us to identify subtle but important distinctions. 'Group supervision' may be seen for instance as a basic distinction between individual or collective supervision, while collaborative supervision might stress the collaboration between participants (within group supervision), and 'mutual problem solving' seems to point out more specifically an aspect of collaboration within supervision. These 3 responses could have been grouped together, but this may have prevented us from seeing relevant differences.

**Audio recorded sessions**

Of the 14 respondents, only 4 of them (all the PSY respondents) had previous experience of their sessions being audio-taped. 3 reported that the tapes had been reviewed by a supervisor and that they were given verbal feedback (one of them had also received written feedback), while only 1 of them had the tapes reviewed by peers.

**Supervision used for professional development**

Only one respondent (physiotherapist) reported that no previous supervision experience had been perceived as professional development. The other responses are summarised in Table 3.

Most respondents used different descriptors to express their perception of how supervision was used for professional development in the past. The 2 descriptors that were used more than once were broad and used by respondents from the same discipline: 'identifying areas of professional development' (2 OT) and 'enhancing skills and techniques' (2 PSY).

**Table 3: Previous supervision used for professional development**

| ↓ Use of supervision for professional development | OT (N=5) | P/EP (N=4) | PSY (N=4) | Total (N=13) |
|---|---|---|---|---|
| To identify areas of professional development and set up a development plan. | **2** | -- | -- | **2** |
| To enhance skills and techniques | -- | -- | **2** | **2** |
| Using PDP to set new goals and objectives for personal and team development | **1** | -- | -- | **1** |
| To set new goals and objectives to educate and achieve | -- | **1** | -- | -- |
| To explore and reflect on skills | **1** | -- | -- | **1** |
| To explore and reflect on what works and what does not (efficacy) | -- | -- | **1** | **1** |
| To learn new skills from experts | -- | **1** | -- | **1** |
| To learn to use therapy techniques | -- | -- | **1** | **1** |
| To reflect on interpersonal components of therapy | -- | -- | **1** | **1** |
| To discuss risk issues | -- | -- | **1** | **1** |
| To discuss how to decide on approach to clients | -- | -- | **1** | **1** |
| To discuss the links between theory and practice | -- | -- | **1** | **1** |
| To inform practice | -- | -- | **1** | **1** |
| To improve practice and service delivery | -- | **1** | -- | **1** |
| To become a researcher and develop as a therapist | -- | **1** | -- | **1** |
| As a 'moaning session' | **1** | -- | -- | **1** |

**KEY: OT=**Occupational Therapist; **P/EP=**Physiotherapist/Exercise physiologist; P**SY=**Psychologist. **PDP**=Personal Development Plans.

### Supervision used for professional regulation

4 respondents (2 P/EP, 1 PSY, 1 OT) reported having no previous experience of perceiving supervision as professional regulation. The other responses are summarised below in Table 4.

Of the identified descriptors none was used more than once, so the responses were individual. It was observed that the use of the same term - whether a verb (e.g. 'ensure') or a noun (e.g. 'standards') by different respondents entails distinctive meanings linked to the respondents' priorities and expectations. It is notable for example that while an OT respondent specified the need to ensure an adherence to standards and operational policies, a PSY respondent stressed therapy standard as part of their professional qualification, and an EP respondent highlighted the need to ensure that evidence based practice is developed in line with standards.

**Table 4: Previous supervision used for professional regulation**

| ↓ Use of supervision for professional regulation | OT (N=4) | P/EP (N=3) | PSY (N=3) | Total (N=10) |
|---|---|---|---|---|
| To ensure adherence to standards and operational policies | **1** | -- | -- | **1** |
| To check therapy standard and as part of qualification assessment | -- | -- | **1** | **1** |
| To ensure evidence based practice is developed in line with standards | -- | **1** | -- | **1** |
| To review clinical cases and ensure practice is competent | **1** | -- | -- | **1** |
| To ensure general objectives are met | -- | **1** | -- | **1** |
| To identify clinical/professional practice to regulate HPC Certificate | **1** | -- | -- | **1** |
| To ensure service and departmental adherence | -- | **1** | -- | **1** |
| *To learn to manage working difficulties regarding team work and case/workload | -- | -- | **1** | **1** |
| *To monitor record keeping, ensuring fit with COT guidelines | **1** | -- | -- | **1** |
| *Supportive supervision, while clinical responsibility assumed by supervisor during training | -- | -- | **1** | **1** |

**KEY: OT=**Occupational Therapist; **P/EP=**Physiotherapist/Exercise physiologist; **PSY=**Psychologist. **COT=** Professional body (College of OT); **HPC=** Regulatory body (Health Professions Council). * These specifications refer more to process and practice than to professional regulation.

Clearly these responses could also be grouped together as they all refer to professional standards, but their distinctions are relevant to highlight different approaches and priorities between the different disciplines. On the other hand, as it is highlighted in a footnote on the table, several responses in this section seem to be more related to process and practice rather than to professional regulation.

**Previous use of reflective practice**

Only one respondent (P/EP) reported not having previous experience of reflective practice. The other responses are summarised below in Table 5.

The terms to describe previous use of reflective practice were also mainly individual, except for the use of reflection on clinical practice, which was evenly distributed within EP and PSY (50%), in diaries (2PSY), in log books (1OT, 1PSY), and in supervision discussions (1OT, 1PSY). As suggested earlier, the use of respondents own words allowed us to identify which

aspects of a particular type of supervision they individually related to their experience.

**Table 5: Previous use of reflective practice**

| ↓ **Use of reflective practice** | **OT (N=5)** | **P/EP (N=4)** | **PSY (N=4)** | **Total (N=13)** |
|---|---|---|---|---|
| Reflection on clinical practice* | **1** | **2** | **2** | **5** |
| In written work/diaries* | **--** | **--** | **2** | **2** |
| In log books* | **1** | **--** | **1** | **2** |
| In supervision discussions* | **1** | **--** | **1** | **2** |
| In supervision to explore other ideas and training needs* | **1** | **--** | **--** | **1** |
| Reflection on patients sessions† | **--** | **--** | **1** | **--** |
| Reflection on own skills† | **--** | **1** | **--** | **1** |
| Reflection on role with patients and colleagues† | **--** | **--** | **1** | **1** |
| By supervisor‡ | **--** | **--** | **1** | **1** |
| For myself, not in supervision (only verbal)‡ | **1** | **--** | **--** | **1** |
| In peer supervision groups‡ | **--** | **--** | **1** | **1** |
| In service training‡ | **--** | **1** | **--** | **1** |
| As a crucial component of counselling in psychological practice‡ | **--** | **--** | **1** | **1** |
| As basic clinical training ∟ | **--** | **--** | **1** | **1** |
| After courses of particular events which facilitated new learning ∟ | **1** | **--** | **--** | **1** |
| To identify key issues/learning points ∟ | **1** | **--** | **--** | **1** |
| To evaluate learning experience ∟ | **--** | **1** | **--** | **1** |
| To problem solve difficult scenarios ∟ | **--** | **1** | **--** | **1** |

**KEY: OT=**Occupational Therapist; **P/EP=**Physiotherapist/Exercise physiologist; **PSY=**Psychologist. *Process and learning, combined; **†** Pure reflection on skills; **‡** Regulatory process; ∟ Learning.

The fact that all OT respondents (n=5) had been supervisors in the past, while none of the PSY respondents (n=4) had such an experience suggested a significant difference in the experience of these two groups. This was also reflected, for example, in the responses related to the stage of qualification at which respondents had specific types of supervision. It was notable for instance that all OT respondents had stated all three stages of qualification (i.e. Novice, Intermediate and Expert) in Table 1, while none of the PSY respondents stated the Intermediate nor the Expert stage.[1] Of the EP respondents, two stated only Intermediate stage, one stated Intermediate and Expert stages, one Novice and Expert stages, and one all of these stages.

[1] Three PSY respondents only stated Novice as a stage of qualification, while one of them left this section of the questionnaire blank.

This also reflected the fact that 2 EP respondents had been supervisors in the past, as they stated the Expert stage.

Apart from providing information about the stages of qualification at which respondents had specific styles of supervision in the past, this may also be relevant in relation to the fact that those who had been supervisors themselves may consider their supervisor's roles with more hindsight when filling-in section 3 of the questionnaire.

**Summary of Prior Experience of Supervision**

There are some examples of disciplinary unanimity in the responses to specific questions. On site supervision and peer support meetings seem to be for example, common practice amongst OT practitioners while they did not seem to have group meetings, off-site supervision, telephone supervision, video conference supervision, and/ or competence rating. In contrast, all PSY respondents had previous experience of group meetings, off-site supervision, reflective practice, and goal/target setting, 3 of competency rating, while only one of them reported having previous experience of joint supervision and telephone supervision. Finally, all EP respondents had previous experience of goal/target setting, 2 of competency rating, while only one of them reported having previous experience of telephone supervision and off-site supervision. In general, the most common styles of previous supervision experience amongst all respondents were:

- one to one, face to face supervision (14);
- goal/target setting (13);
- reflective practice (12);
- on site supervision (11);
- peer support meetings (11); and
- sharing good practice through in-house seminars (9).

When it came to respondents using their own words to describe specific styles of supervision, the descriptor of supervision approach most often used by respondents was '*face to face and one to one'*. 7 respondents (50%) used this

descriptor, and it was noticeable that such a response was evenly distributed within the 3 disciplines. The remaining descriptors used by respondents were mainly individual choice, which did not necessarily mean that the previous experiences of supervisees were completely unrelated to each other, but it rather suggested that respondents' use of their own terms allowed them to describe supervision styles and approaches according to their own perceptions and to stress their own priorities.

**Section 2: Experience of Supervision within the Trial**

In this section the respondents' replies regarding their supervision experiences within the trial were reviewed. Table 6 indicates which supervision styles were liked and disliked according to disciplinary distinctions. The respondents' views on supervision agenda are shown in Table 7, the advantages and disadvantages of trial supervision in Table 8 and Table 9 respectfully, and finally the perceived barriers to supervision within the trial in Table 10.

All respondents (N=14) confirmed liking group supervision and competency rating (see table 6). Only 1 OT respondent disliked self evaluation; only 1 PSY respondent disliked observation; while only 1 EP respondent disliked one to one, face to face meetings, on site supervision, review of tape sessions by supervisor, and verbal feedback by supervisor. It was notable that this EP is the respondent that most often (5 times) marked disliking supervision styles. On the other hand there are 3 respondents who did not mark disliking any styles (1OT, 1EP, 1PSY).

It was also notable that group supervision and competence rating, which were liked by all respondents, had only been experienced by 8 and 5 respondents before the trial (see table 1 & table 6). None of the OT respondents had experienced group meetings or competence rating before; 4 EP respondents had experienced group meetings before and 2 had experienced competency rating; all PSY respondents had experienced group meetings before, and 3 had experienced competency rating (1 PSY left the previous experience of competency rating blank).

**Table 6: Liked & disliked aspects of Supervision within the trial with disciplinary distinction.**
**All respondents completed this table (N=14), OT=5; P/EP=5; PSY=4**

| | Like | | | Dislike | | | Would like more of | | | Would like less of | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | OT | EP | PSY | OT | EP | PSY | OT | EP | PSY | OT | EP | PSY |
| One to one, face to face meetings | 5 | 4 | 4 | -- | 1 | -- | 2 | 2 | -- | -- | 2 | -- |
| Group meetings | 5 | 5 | 4 | -- | -- | -- | -- | 3 | -- | -- | -- | -- |
| Peer support meetings | 5 | 4 | 4 | -- | -- | -- | -- | 5 | -- | -- | -- | -- |
| Sharing good practice through in-house seminars | 4 | 3 | 3 | -- | -- | -- | -- | 4 | 3 | -- | -- | -- |
| Off site supervision | 4 | 3 | 2 | 1 | 1 | 2 | 1 | 2 | -- | 1 | 2 | -- |
| On site supervision | 4 | 3 | 4 | -- | 1 | -- | 2 | 3 | 1 | -- | 1 | -- |
| Joint supervision | 2 | 2 | -- | -- | 2 | -- | 2 | 1 | -- | -- | 1 | -- |
| Review of taped sessions By supervisor | 5 | 4 | 4 | -- | 1 | -- | 1 | 3 | -- | -- | 1 | 1 |
| Review of taped sessions By peers | 5 | 5 | 3 | -- | -- | -- | -- | 4 | 1 | 1 | -- | -- |
| Telephone supervision | 5 | 3 | 1 | -- | 2 | 2 | 1 | -- | -- | -- | 3 | -- |
| Reflection | 4 | 4 | 4 | 1 | 1 | -- | 2 | -- | 1 | -- | 2 | -- |
| Information giving | 4 | 4 | 4 | -- | -- | -- | 1 | 1 | -- | -- | -- | -- |
| Self evaluation | 4 | 5 | 4 | 1 | -- | -- | 1 | 2 | -- | -- | 1 | -- |
| Verbal feedback | 4 | 4 | 4 | -- | 1** | -- | 1 | 3 | -- | -- | -- | -- |
| Learning logs | 2 | 4 | 3 | 3 | 1 | -- | 1 | 1 | -- | -- | -- | -- |
| Role play | 4 | 2 | 3 | 1 | 2 | 1 | 2 | 1 | -- | -- | 3 | -- |
| Written feedback | 5 | 5 | 3 | -- | -- | -- | 1 | 3 | -- | -- | -- | -- |
| Observation | 3 | 4 | 3 | -- | -- | 1 | 1 | 1 | -- | -- | 1 | -- |
| Competency rating | 5 | 5 | 4 | -- | -- | -- | 2 | -- | -- | -- | 1 | -- |

**KEY: OT=**Occupational Therapist; **EP=**Physiotherapist/Exercise physiologist; **PS=**Psychologist. **One EP respondent specified liking peers' verbal feedback and disliking supervisor's verbal feedback.

5 respondents had previous experience of off-site supervision; 4 were psychologists (PSY), and one was a physiotherapist/exercise physiologist (EP). Their perception of off-site supervision within the trial was divided, 3 EP respondents liked it but were divided on whether they would like more or less of it, while 2 PSY respondents liked it and 2 did not. In general, 9 out of the 14 respondents reported that they liked off-site supervision; while 4 reported not to like it (one respondent left this blank). 3 respondents would like less off-site supervision and 3 would like more.

This question about respondents preferences for more or less activities in the trial introduced further complexity, as their liking and disliking some activities did not necessarily correspond with their expectations for more or less of them. For example, 1 OT respondent liked reviews of taped sessions by peers

but would like less of them, 1 EP respondent who liked face to face meetings would like less of them, 1 PSY respondent liked review of tapes by supervisor but would like less of it. On the other hand, 1 OT respondent disliked learning logs but stressed their usefulness. It was also observed that several respondents specified that they would like more of some activities having left blank replies when asked if they liked them or not. Blank responses were explained with comments like 'not experienced' (1 OT blank response to 'observation'), 'not applicable' (1 PSY blank response to 'joint supervision') or 'not sure what this is' (1 EP blank response to 'information giving'). Finally, the most often blank response was to 'joint supervision' (OT=3; EP=1; PSY=4).

**Setting up agenda for supervision**

Only 2 respondents (1EP, 1 PSY) reported not setting up the agenda for supervision. As observed in the table 7, respondents' views on setting up an agenda varied, and they referred to a range of issues, from the purpose of a supervision agenda, to its usefulness and the ways in which the agenda is set. It is clear that respondents gave high priority in general to ensuring main concerns and key points were discussed and also to ensure an efficient use of supervision time. It was observed that other roles and tasks were also considered here by respondents.

**Table7: Uses of supervision agenda (N=12)**

| ↓ **Use of supervision agenda** | **OT** | **P/EP** | **PSY** | **Total** |
|---|---|---|---|---|
| To ensure own main concerns/issues are discussed | **4** | **--** | **1** | **5** |
| To ensure best use of supervision time | **1** | **3** | **--** | **4** |
| To put down key points both supervisor and supervisee want to discuss | **1** | **1** | **1** | **3** |
| To prioritise | **1** | **2** | **--** | **3** |
| For group/peer supervision | **--** | **1** | **--** | **1** |
| To enable a mix of clinical and logistical topics | **--** | **1** | **--** | **1** |
| To document issues discussed in supervision session | **1** | **--** | **--** | **1** |
| Agenda is set in advance | **3** | **1** | **--** | **4** |
| Agenda is set at start of session | **--** | **1** | **--** | **1** |
| Supervisor sets agenda of issues | **--** | **--** | **1** | **1** |
| Supervisor works through the agenda after prioritising | **--** | **--** | **1** | **1** |

**KEY: OT=**Occupational Therapist; **P/EP=**Physiotherapist/Exercise physiologist; **PSY=**Psychologist

**Advantages of Trial Supervision**

Table 8 shows that group and peer support supervision were the most popular styles amongst OT and EP respondents. The regularity of supervision sessions was highlighted by 4 respondents' across the 3 disciplines, as well as the helpfulness of audio-recording feedback. The remainder of the responses shown in table 8 are generally individual, which again highlights the individual priorities and subtle differences of each respondent.

**Table 8: Advantages of trial supervision (N=14)**

| ↓ Advantages of trial supervision | **OT** | **P/EP** | **PSY** | **Total** |
|---|---|---|---|---|
| Useful to have group/peer support supervision | **3** | **2** | **--** | **5** |
| It is regular | **1** | **2** | **1** | **4** |
| Feedback on audio recording was very helpful | **1** | **1** | **1** | **3** |
| Useful for self-reflection | **1** | **1** | **--** | **2** |
| It is well organised | **1** | **1** | **--** | **2** |
| Useful to have off-site supervision | **1** | **--** | **--** | **1** |
| Good trouble shooting | **--** | **--** | **1** | **1** |
| Good to get and try ideas and techniques | **--** | **--** | **1** | **1** |
| Good personal support | **--** | **--** | **1** | **1** |
| Good guidance on how to improve treatment technique | **--** | **1** | **--** | **1** |
| Close scrutiny enables excellent training and good level of competency | **--** | **--** | **1** | **1** |
| Close scrutiny to assess adherence to specific approach | **--** | **--** | **1** | **1** |
| Setting and meeting targets | **--** | **1** | **--** | **1** |
| Self reflection makes a rounder therapist | **--** | **1** | **--** | **1** |
| It was my supervision, with support and respect from supervisor | **1** | **--** | **--** | **1** |
| Supervisor based elsewhere allows greater objectivity | **1** | **--** | **--** | **1** |
| Value the experience and skills of supervisor | **1** | **--** | **--** | **1** |
| Multi factor | **1** | **--** | **--** | **1** |
| Contactable | **--** | **1** | **--** | **1** |
| Clear | **1** | **--** | **--** | **1** |
| Honest | **1** | **--** | **--** | **1** |
| Supportive | **1** | **--** | **--** | **1** |
| Structured | **--** | **1** | **--** | **1** |
| Consistent | **--** | **1** | **--** | **1** |
| Focused | **--** | **1** | **--** | **1** |
| Knowledgeable and thorough | **--** | **1** | **--** | **1** |

**KEY: OT=**Occupational Therapist; **P/EP=**Physiotherapist/Exercise physiologist; **PSY=**Psychologist

**Disadvantages of Trial supervision**

Two respondents reported not having perceived any disadvantages in their experience of the trial supervision. The ways in which the rest of the respondents expressed their perception of disadvantages are summarised in table 9.

**Table 9: Disadvantages of trial supervision (N=12)**

| ↓ **Disadvantages of trial supervision** | **OT** | **P/EP** | **PSY** | **Total** |
|---|---|---|---|---|
| Sometimes too much supervision | **1** | -- | -- | **1** |
| Sometimes over scrutinised (too picky during recording reviews) | -- | -- | **1** | **1** |
| Difficulties of having supervision for only part of my job | **1** | -- | -- | **1** |
| Lack of addressing of process, from psychotherapist perspective. | -- | -- | **1** | **1** |
| No reference to transfer/counter transfer | -- | -- | **1** | **1** |
| General psychological issues not as well addressed as CBT | -- | -- | **1** | **1** |
| Telephone supervision not very useful | -- | **1** | -- | **1** |
| Supervision did not seem to forward my career, because of the type of trial | -- | **1** | -- | **1** |
| Felt more like a checking mechanism to ensure therapist compliance with trial rather than personal development opportunity | -- | **1** | -- | **1** |
| Restricted to discussing trial rather than wider research issues | -- | -- | **1** | **1** |
| Supervisor's unawareness of local procedures and their impact re trial | **1** | -- | -- | **1** |
| Long distance between supervisor and supervisee | **1** | -- | -- | **1** |
| Supervisor's other roles aside trial make them difficult to locate | **1** | -- | -- | **1** |
| The majority of one to one supervision was done by telephone | **1** | -- | -- | **1** |
| Emotional aspects were not given enough thought | -- | -- | **1** | **1** |
| Often felt rushed, having to get through all strategies/techniques | -- | -- | **1** | **1** |
| Difficult time wise | -- | **1** | -- | **1** |
| Difficult to assess own development at the beginning if not face to face | -- | **1** | -- | **1** |
| Need to consult colleagues outside trial for physiotherapy advice | -- | **1** | -- | **1** |
| Once competent, there is a significant decline in learning | -- | **1** | -- | **1** |

**KEY: OT=**Occupational Therapist; **P/EP=**Physiotherapist/Exercise physiologist; **PSY=**Psychologist

The disadvantages of the trial supervision perceived by respondents were all individually identified according to respondents' priorities and personal circumstances. Although some responses could be grouped together as temporal restrictions such as difficulties with time, and having to rush, or as professional development or, as professional regulation issues, the specific responses are shown because they provide useful information about the different aspects of supervision and other spheres of supervisees' lives that influence their perception and appreciation of supervision.

**Barriers to supervision within trial**

5 respondents (4 OT; 1 PSY) reported not having perceived any barriers to supervision within the trial. The respondents' perception of barriers to supervision within the trial are summarised below in table 10.

**Table 10: Barriers to supervision within trial (N=9)**

| ↓ **Barriers to supervision within trial** | **OT** | **P/EP** | **PSY** | **Total** |
|---|---|---|---|---|
| Distance from supervisor implied more telephone supervision | **1** | **1** | **1** | **3** |
| Potential conflict of competence rating and supervision roles: power imbalance | **--** | **--** | **2** | **2** |
| With part time workers | **--** | **1** | **--** | **1** |
| 'Up to recent lack of faith in my therapy leads ability created a barrier to comfortably taking on board criticisms given to me about my practice' | **--** | **1** | **--** | **1** |
| Supervisor's other roles | **1** | **--** | **--** | **1** |
| Other sources of supervision, external to trial | **1** | **--** | **--** | **1** |
| No professional physiotherapy supervision | **--** | **1** | **--** | **1** |
| 'Supervision must stick within protocol/set therapy skills for the trial' | **--** | **1** | **--** | **1** |
| 'More training on material outside of trial for senior therapist' | **--** | **1** | **--** | **1** |

**KEY: OT=**Occupational Therapist; **P/EP=**Physiotherapist/Exercise physiologist; **PSY=**Psychologist

The only barrier to supervision within the trial that was identified by respondents from the 3 disciplines was the distance from supervisors. Although only one respondent from each discipline mentioned this in the questionnaire, it is very relevant that they concurred in identifying this barrier. It might also support information regarding previous experience of face to face supervision, which was observed in more cases than other modes. On the other hand, the potential conflict and power imbalance of competency rating

and supervision roles identified by 2 respondents highlighted the possibility of a perception of power relations at work that had not been considered (or specifically identified) by other respondents.

One respondent stated for example that her

> "…*supervisor is in position as 'boss' and quality control monitor as well as supervisor- power imbalance is a barrier to open and honest communication at times*."

All other responses in the table 10 were individual, again according to particular preferences, priorities and circumstances. This also reflected the ways in which different respondents viewed their supervisors' roles and capacities.

While 5 respondents stated not having perceived any barriers in their experience of trial supervision, some specifically pointed out some disadvantages; one respondent stated for example that her supervisor did not know local procedures and their impact on the trial and that it was,

> "*difficult for supervisor and supervisee located at long distance from each other. Supervisor having other roles aside from Trial, therefore at times not being able to locate them that day if a difficulty arises/questions to ask…also receive supervision externally to trial in the unit (who is different profession) and in the Trust (who is lead for professional development and research*)."

This again highlighted both personal circumstances and personal views of supervisees, which was also illustrated in the following excerpt from a respondent's questionnaire:

> "*I felt up to recently I didn't have faith in my therapy leads ability and this created a barrier to comfortably taking on board criticisms given to me about my practice…"*

This quote also illustrated how individual perceptions of their supervisor's capacity or incapacity could help to create or shape barriers against positive communication. Although this could be (and probably rightly so) interpreted as a prejudgement of the supervisor's capacities by the supervisee, it nevertheless highlighted the inter-subjective sphere of supervision, which was to be understood as a personal relationship that would not always be straight forward and clear, as it implied the subjective perceptions and lives of both persons.

**Section 3: Perceptions of the qualities of good or bad supervision**

The 3rd section in the questionnaire listed a number of features of good and bad supervision that had been identified across the allied health professions (Spence et al 2001). Table 11 shows the responses by discipline. *One (OT) respondent marked both disagree/agree in regard to supervisors demonstrating skills.

The qualities agreed by the respondents as good supervision were;

- Respect & empathy
- Consideration of challenging issues
- Supportive & interactive
- Creates a space for thinking
- Using a range of methods; information giving, modelling, observation, problem solving
- Focus on concrete examples from supervisee's clinical activities
- Have clear boundaries set
- Being available & accessible
- Giving advice on crisis management
- Demonstration of specific skills
- Clear, constructive & sensitive written & verbal feedback
- Give suggestions for improvement
- Have a clear contract at outset

The qualities agreed as bad supervision were;

- Administrative issues dominating supervision
- Hierarchical supervision
- Supervisees having a passive role

**Table 11: Perceptions of the qualities of good or bad supervision with disciplinary distinction. All respondents completed this table (N=14), OT=5; P/EP=5; PSY=4**

| | Strongly Disagree | | | Disagree | | | Agree | | | Strongly Agree | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **OT** | **EP** | **PS** | **OT** | **EP** | **PS** | **OT** | **EP** | **PS** | **OT** | **EP** | **PS** |
| Your supervisor should be respectful and empathetic | -- | -- | -- | -- | -- | -- | **1** | **4** | **1** | **4** | **1** | **3** |
| Administrative issues should dominate supervision sessions | **1** | **2** | **2** | **4** | **3** | **2** | -- | -- | -- | -- | -- | -- |
| Supervision should avoid contentious or challenging issues | **3** | **1** | **3** | **2** | **4** | **--** | -- | -- | -- | -- | -- | 1 |
| Supervision should be supportive and interactive | -- | -- | -- | -- | -- | -- | **--** | **2** | **1** | **5** | **3** | **3** |
| Supervision should create a space for thinking | -- | -- | -- | -- | -- | -- | **--** | **2** | **--** | **5** | **3** | **4** |
| Supervision should be hierarchical | **2** | **--** | **1** | **2** | **4** | **2** | 1 | 1 | 1 | -- | -- | -- |
| Supervision should use a range of methods; information giving, modelling, observation, problem solving | -- | -- | -- | -- | -- | -- | **1** | **4** | **1** | **4** | **1** | **3** |
| Supervision should focus on concrete examples of supervisee's clinical activities | -- | -- | 1 | -- | -- | 2 | **2** | **3** | **2** | **3** | **--** | **1** |
| Supervisors should adhere to clear boundaries | -- | -- | 1 | -- | 3 | -- | **2** | **2** | **3** | **3** | **--** | **--** |
| Supervisees should have a passive rather than active role | **3** | **1** | **3** | **1** | **3** | **1** | 1 | 1 | -- | -- | -- | -- |
| Supervisors should be available and accessible for supervision | -- | -- | -- | -- | -- | -- | **3** | **3** | **2** | **2** | **2** | **2** |
| Supervisors should be able to give advice on crisis management | -- | -- | -- | -- | -- | -- | **3** | **2** | **--** | **2** | **3** | **4** |
| Supervisors should describe the specific skills to be learned and demonstrate their use | -- | -- | -- | 1* | -- | 1 | **3** | **4** | **1** | **2** | **1** | **2** |
| Supervisors should provide constructive, non-judgemental feedback (verbal & written) in a clear but sensitive manner | -- | -- | -- | -- | -- | -- | **3** | **2** | **--** | **2** | **3** | **4** |
| Supervisors should give concrete suggestions for improvement | -- | -- | -- | -- | -- | -- | **3** | **4** | **2** | **2** | **1** | **2** |
| A clear contract at the onset of supervision should be negotiated, specifying boundaries, tasks, roles and responsibilities of both supervisor and supervisee | -- | -- | -- | -- | 2 | 1 | **3** | **2** | **2** | **2** | **1** | **1** |

**KEY: OT=**Occupational Therapist; **EP=**Physiotherapist/Exercise physiologist; PSY**=**Psychologist. *One (OT) respondent marked both disagree/agree.

## Discussion

The aim of the study was to identify the perceived experience of supervision within the trial and whether this differed from previous practice and experience. This study has offered insights into the approaches of supervision favoured by therapists and the use of supervision within research studies. The findings have implications for clinical practice and future research studies.

### Prior experience of supervision

Only 8 (57%) respondents had previously experienced group meetings and 6 (43%) had experienced joint supervision. The most common styles of previous supervision experience amongst all respondents were:

- one to one, face to face (100%)
- goal/target setting (93%);
- reflective practice (86%);
- on site supervision (79%);
- peer support meetings (79%); and
- sharing good practice through in-house seminars (64%).

The least common previous forms of supervision experienced were:

- telephone supervision (14%);
- off site supervision (36%); and
- competency rating (36%).

In regard to competency rating, three of the four Psychologists/ cognitive behaviour therapists (PSY) and two Physiotherapist/ exercise physiologists (EP) had previous experience of competency rating whereas all five of the occupational therapists (OT) and three of the physiotherapists/ exercise physiologist had no experience of competency rating. Additionally of the 14 respondents, only the 4 Psychologists/ cognitive behaviour therapists had previous experience of their sessions being audio-taped. Of these 3 reported that the tapes had been reviewed by a supervisor and that they were given verbal feedback (one of them had also received written feedback), while only 1 of them had the tapes reviewed by peers. This may relate to the mandatory

requirement of competency based practice within professional regulation for cognitive behaviour therapists and psychologists (Falendar & Shafranske 2007).

**Previous styles of supervision**

When it came to respondents using their own words to describe specific styles of supervision previously experienced, the descriptor of supervision most often used by respondents was 'face to face and one to one' rather than any specific models or approaches of supervision (van Ooijen 2000). Seven respondents (50%) used this descriptor, and it was noticeable that such a response was evenly distributed within the 3 disciplines.

**Professional Development & Regulation**

Previous experience of supervision for professional development was mainly about creating and using personal development plans, and exploring, reflecting on and enhancing skills and techniques (Hyrkäs et al 2005, Lähteenmäki 2005). Previous experience of professional regulation in supervision was around adherence to and monitoring of professional standards and operational policies (Clouder & Sellars 2004). For example, one respondent described professional development as *"set development plan and identify ideas I wanted to develop"* and professional regulation as "*reviewing clinical cases and ensuring practice is competent".* Another described professional development as "*learning new skills from experienced expert clinicians"* and professional regulation as "*developing evidence based practice in line with standards of practice"*

**Previous Experience & Use of Reflective Practice**

86% of respondents stated they had experience of reflective practice (Table 1). Their description of the use of reflective practice related to the process of reflection, and learning by using diaries, log books, exchange of ideas/ dialogue and discussion to enhance problem solving, practice, knowledge and skills (Fowler & Chevannes 1998, Lähteenmäki 2005, Sellars 2004).

**Experience of supervision within the trial**

All respondents (n=14) indicated that they liked group meetings, review of taped sessions by supervisor and/or peer, and competency rating which in the main had not been previously experienced. The majority (n=13, 93%) liked

one to one, face to face meetings, peer support meetings, self evaluation through reflection and written feedback. In addition, all the OTs liked telephone supervision. All of the EPs stated they would like more peer support meetings. All of the PSYs additionally liked on site supervision, information giving, and verbal feedback. These findings have implications for practice as group supervision, peer support, and review of taped sessions with verbal and written feedback to support development and competency are not common in the professional disciplines surveyed outside of a trial situation (Akhurst 2007, Clouder & Sellars 2004, Sellars 2004, Williamson & Dodd 1999, Wimpenny et al 2006).

**Setting an agenda**

Twelve (86%) respondents stated that they set up an agenda for supervision. This was used mainly by the supervisee to have ownership of the supervision, to prioritise concerns and issues, enable best use of time, and identify key points for discussion. As the respondents were not asked if this had previously been part of their supervision practice it is unclear if this was a new practice due to the trial requirements and protocol (White et al 2007). Others have identified that ownership of supervision by the supervisee, which can be enhanced by setting an agenda, is key to effective supervision practice and relationships (Lyth 2000, Marrow et al 2002, Milne 2006, Sellars 2004, White et al 1998) as well as being part of the cognitive behavioural framework used for supervision within the trial (David & Freeman 2006, Sloan et al 2000, McBride 2007).

**Advantages of trial supervision**

The advantages identified of the trial supervision being regular and well organised and including group supervision, peer support, feedback on session recording, time for self reflection were linked to the elements liked by the majority of the therapists. However, in the main although supported as good supervision practice by others (Edwards et al 2005, Townend 2005, Williamson & Dodds 1999, Wimpenny et al 2006) this combination of approaches were not previously commonly experienced.

One respondent summarised the advantages of the trial supervision as "*It has very much been my supervision. Supervisor respectful of the issues I want to*

*discuss, offering opportunity for support, discussion & guidance as to any next steps, be this in regard to clinical contact, other resources and professional development etc".* Another as "*made me reflect more on what you do and why, which I think makes you a rounder therapist".*

**Disadvantages & barriers of trial supervision**

Although the disadvantages identified in this study were all individual they could relate to categories such as perceived limitation of professional development and, professional regulation misunderstandings, this is congruent with other findings in that hindrances to effective supervision can relate to professional role and training differences, and anxiety (Barnett 2007, Townend 2005, Yegdich 1999).

The predominant barrier to supervision identified was the distance of supervisor from supervisees due to the multi centre nature of the trial being in 6 centres in 3 cities in the UK, this meant that one to one supervision was in the main by telephone rather than face to face. However, one respondent stated that "*as she is not based here [in centre] she can be more objective and offer sound advice".* Other barriers related to the interaction between level of expertise and knowledge of supervisor and supervisee to enhance professional development and, monitoring of adherence to the trial protocol and competency rating for professional regulation. These two elements of professional practice; professional development and professional regulation have been suggested previously as being "conflated under the umbrella of clinical supervision" (Clouder & Sellars 2004, p. 268) and therefore need careful consideration to ensure their balance in supervision.

**Preferred qualities in supervision**

The therapists agreed with the qualities and features required for good supervision as listed by Spence and colleagues (2001). Therapists preferred supervision where they were active participants and had time to think, reflect and discuss knowledge and skills using a range of methods; information giving, demonstration, modelling, observation, feedback and problem solving.

**Implications for practice**

The therapists involved in the trial were initially trained in the specific therapy they were to deliver in the trial. This training was carried out by the same therapy lead that would be assessing competency to deliver the therapy, monitor on-going competence and give supervision. Allen (2007) has suggested that training and supervision are distinct, in that training is where students learn intended skills and supervision where the new professional generalises those skills to clinical practice, both of these elements were identified in the study. It is interesting that some therapists felt their learning had reduced once the training period had finished whereas most felt their professional development and learning continued and was enhanced particularly by group supervision, reflection, peer support and feedback on reviewed audio recordings of sessions.

Hyrkäs and Appleqvist-Schmidlechner (2003) have identified the challenges encountered by supervisors engaged in team supervision and in particular in identifying individual's perspectives on practice. This was acknowledged in the study as some therapists appeared frustrated by off site supervision and the distance of supervisor from their local base whereas others stated a preference for this approach. Therapists also identified elements they liked and then stated they would like less of them, or disliked them but would like more. This highlighted that supervision has to take into account individual preferences, priorities and circumstances, and that barriers to supervision can occur if there is a mismatch between supervisor and supervisees understanding based on undisclosed expectations and prejudgements. Building a supervisory relationship based on trust, respect, rapport, knowledge and a clear framework is paramount.

This was a small survey of 14 therapists from 4 disciplines; psychology, occupational therapy, physiotherapy and exercise physiology and therefore has its limitations due to the size of the sample; however the therapists were employed within 6 NHS trusts in 3 UK cities therefore giving a broader perspective than would be possible in a single discipline or location.

## Conclusion

The key findings of this study were that therapists prefer supervision that is agenda structured, regular (at least once a month) one to one telephone or face to face individual supervision interspersed with group (team supervision), peer support meetings, self evaluation through reflection, peer and supervisor review of taped sessions with verbal and written feedback and competency rating. This has implications for practice and future therapy research that both therapists and managers will need to consider. In particular the implementation of group supervision, peer support meetings and review of audio taped/ videoed sessions for analysis, competency evaluation and feedback in practice to enhance learning and client care.

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# Appendices;

- Questionnaire
- Letter of invitation
- Information Sheet
- Consent form
- Follow up letter

**The Perceived Experience of Supervision within the PACE Trial**

# Questionnaire

Clinical supervision has been defined as; *"A structured, formalised approach (for which time is set aside) for discussing professional practice with a colleague or peer that encourages reflection on, and evaluation of, clinical decision-making and outcomes"* (DoH 2003).

## Section 1: Prior experience of supervision before the PACE Trial

Section 1 will ask you about your experience of supervision prior to being involved in the PACE Trial.

Have you previously experienced supervision as;

(please indicate all that apply)

| | Yes/ No | Frequency daily/ weekly/ monthly etc | Stage after qualification N & or I & or E see key below |
|---|---|---|---|
| One to one, face to face meetings | | | |
| Group meetings | | | |
| Peer support meetings | | | |
| Sharing good practice through in-house seminars | | | |
| Off site supervision | | | |
| On site supervision | | | |
| Joint supervision (supervision with more than 1 supervisor) | | | |
| Telephone supervision | | | |
| Video conference calls | | | |
| Competency rating | | | |
| Reflective practice (using diaries or forms) | | | |
| Goal/ target setting (learning log/ contract) | | | |
| As a supervisee | | | |
| As a supervisor | | | |

**Key to Stage of Qualification**
N = Newly Qualified/ Novice
I = Intermediate (1-4 years experience)
E = Expert (greater than 5 years experience)

Please describe in your own words the style/ approach/ model (s) of supervision you have experienced before the PACE Trial.

……

……

……

Have you previously experienced your sessions being audio-taped? Yes/ No
(please delete/ circle as required)

If Yes,

Were the tapes reviewed by a supervisor? Yes/ No

Were you given verbal feedback on the reviewed tapes? Yes/ No

Were you given written feedback on the reviewed tapes? Yes/ No

Were the tapes reviewed by peers? Yes/ No

What do you feel supervision was previously used for?

**Professional development** Yes/ No
If Yes, how?

……

……

**Professional regulation** Yes/ No
If Yes, how?

……

……

Have you previously used reflective practice? Yes/ No

If Yes, how?

……

……

……

**Section 2 Experience of supervision within the PACE Trial**

Section 2 will ask you about your experience of supervision within the PACE Trial.

What aspects of supervision with the PACE Trial do you like, dislike and would like more/ less of?

(please tick in relevant box)

| | Like | Dislike | Would like more of | Would like less of |
|---|---|---|---|---|
| One to one, face to face meetings | | | | |
| Group meetings | | | | |
| Peer support meetings | | | | |
| Sharing good practice through in-house seminars | | | | |
| Off site supervision | | | | |
| On site supervision | | | | |
| Joint supervision (supervision with more than 1 supervisor) | | | | |
| Review of taped sessions; By supervisor | | | | |
| By peers | | | | |
| Telephone supervision | | | | |
| Reflection | | | | |
| Information giving | | | | |
| Self evaluation | | | | |
| Verbal feedback | | | | |
| Learning logs | | | | |
| Role play | | | | |
| Written feedback | | | | |
| Observation | | | | |
| Competency rating | | | | |

Do you set an agenda for supervision? Yes/ No

How do you use the agenda?

……

……..

……..

What do you view as the advantages in the style of supervision you have experienced as part of PACE?

……..

……..

……..

……..

What do you view as the disadvantages in the style of supervision you have experienced as part of PACE?

……..

……..

……..

……..

Do you feel there have been any barriers to supervision within PACE?

……..

……..

……..

……..

## Section 3: Perceptions of the qualities of good or bad supervision

Section 3 lists a number of features of good and bad supervision that have been identified across the allied health professions (Spence et al 2001).

You are asked to indicate by whether you agree or disagree with the qualities.

- Your supervisor should be respectful and empathetic

  Strongly Disagree  Disagree  Agree  Strongly Agree

- Administrative issues should dominate supervision sessions

  Strongly Disagree  Disagree  Agree  Strongly Agree

- Supervision should avoid contentious or challenging issues

  Strongly Disagree  Disagree  Agree  Strongly Agree

- Supervision should be supportive and interactive

  Strongly Disagree  Disagree  Agree  Strongly Agree

- Supervision should create a space for thinking

  Strongly Disagree  Disagree  Agree  Strongly Agree

- Supervision should be hierarchical

  Strongly Disagree  Disagree  Agree  Strongly Agree

- Supervision should use of range of methods; information giving, modelling, observation, problem solving

  Strongly Disagree  Disagree  Agree  Strongly Agree

- Supervision should focus on concrete examples of supervisee's clinical activities

  Strongly Disagree  Disagree  Agree  Strongly Agree

- Supervisors should adhere to clear boundaries

  Strongly Disagree  Disagree  Agree  Strongly Agree

- Supervisees should have an passive rather than active role

  Strongly Disagree  Disagree  Agree  Strongly Agree

- Supervisors should be available and accessible for supervision

  Strongly Disagree  Disagree  Agree  Strongly Agree

- Supervisors should be able to give advice on crisis management

  Strongly Disagree  Disagree  Agree  Strongly Agree

- Supervisors should describe the specific skills to be learned and demonstrate their use

  Strongly Disagree  Disagree  Agree  Strongly Agree

- Supervisors should provide constructive, non-judgemental feedback (verbal & written) in a clear but sensitive manner

  Strongly Disagree  Disagree  Agree  Strongly Agree

- Supervisors should give concrete suggestions for improvement

  Strongly Disagree  Disagree  Agree  Strongly Agree

- A clear contract at the onset of supervision should be negotiated, specifying boundaries, tasks, roles and responsibilities of both supervisor and supervisee

  Strongly Disagree  Disagree  Agree  Strongly Agree

**Final Question**

What is your professional group? Please circle.

Occupational Therapy

Physiotherapy/ Exercise Physiologist

Nurse

Psychologist

**Thank you for completing this questionnaire.**
**Please now put it in the stamped addressed envelope provided for posting.**

Therapist Address

Date

Dear *name inserted*

You are being invited to take part in this ancillary study as part of PACE to consider your perceived experience of supervision within the PACE Trial. My name is Dr. Gonzalo Araoz. I am a research assistant working at the Centre for Health Research & Practice Development at St. Martin's College. I have been asked to distribute, collate and analyse the findings of the enclosed survey in order to limit any bias and maintain your anonymity and confidentiality.

I have enclosed an information sheet which outlines the study in more detail, a consent form to sign if you wish to take part in the study, the questionnaire to complete and a stamp addressed envelope.

When you are completing the questionnaire, if there are any questions that you would like to give a more detailed response to, please feel free to write on the blank reverse of the related question. If you do this or add additional sheets please remember to indicate which question it relates to.

Please could you return the questionnaire in the stamped addressed envelope whether you decide to take part in the study or not.

If you have any questions about the study please contact me as shown below.

Email: G.Araoz@ucsm.ac.uk Telephone: 01524 844594

Address for correspondence:
Dr. Gonzalo Araoz.
Centre for Health Research & Practice Development
St. Martin's College, Fusehill Street
Carlisle, CA1 2HH

Yours sincerely

Dr. Gonzalo Araoz

**Part 1**

## The Perceived Experience of Supervision within the PACE Trial

# Participant Information Sheet

You are being invited to take part in this study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

- Part 1 tells you the purpose of this study and what will happen to you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.

**Why is the study needed?**

Clinical supervision has been defined as;

> *"A structured, formalised approach (for which time is set aside) for discussing professional practice with a colleague or peer that encourages reflection on, and evaluation of, clinical decision-making and outcomes"* (DoH 2003).

The PACE Trial is an inter-professional multi-centre therapy based randomised controlled trial. The aim of supervision within the trial is to maintain specificity, sustain retention, manage quality control and assurance, monitor competence in delivering therapy and enhance professional development.

The rationale for this study is that the approach to supervision within the PACE trial appears to be different from the previous experience of supervision for many of the therapists within the trial. A review of the literature on supervision and reflective practice has highlighted that there are many models, methods, approaches and factors that influence the effectiveness of supervision (Edwards et al 2005, van Ooijen 2000).

**What is the aim of the study?**

The aim of this study is to explore the experience of supervision within the PACE trial. To consider whether the experience of supervision differs between the therapies and whether previous experience of supervision is similar or different to that within the PACE trial.

**What research questions do we wish to answer?**

- How is supervision perceived within PACE by therapists?
- How are models/ methods of supervision perceived by therapists?
- What are the perceived advantages and disadvantages of the different methods?
- Are there any perceived barriers to use of reflection within the supervision process?
- How does supervision with PACE relate to the therapists on-site service/ management supervision?

- Is supervision perceived differently within therapies and/ or professional groups?

**Why have I been chosen?**
You have been chosen because you are or have been a therapist delivering one of the manualised therapies as part of the PACE Trial.

**Do I have to take part?**
No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way.

If you decide to withdraw your consent after completing the questionnaire we will not be able to identify your data; as all questionnaires will be anonymous.

**How will data be collected?**
In order to reduce this possible influence and limit any potential barriers in gaining information from therapists in the PACE trial a self report questionnaire utilizing survey methodology was chosen rather than qualitative semi structured interviews and focus groups, as the method of data collection (Bowling & Ebrahim 2005). The questionnaire will collect both qualitative (open) and quantitative (closed) data.

To further reduce any bias in collecting and analysing the data and to maintain confidentiality the questionnaire will be distributed, collated and analysed by a research assistant independent of the PACE Trial.

**How will confidentiality and anonymity be maintained?**
All the information about your participation in this study will be kept confidential. The details are included in Part 2.

**Contact Details:**

**Research Assistant**: Dr. Gonzalo Araoz, Centre for Health Research & Practice Development, St. Martin's College, Carlisle. *p.araoz@ucsm.ac.uk*

**Part 2**

**Will my taking part in this study be kept confidential?**
All information which is collected about you during the course of the research will be kept strictly confidential. Procedures for handling, processing, storage and destruction of your data are compliant with the Data Protection Act 1998.

The questionnaires will be distributed, collected and analysed by the research assistant who is employed outside of the PACE Trial. The principal researchers will only see the data once it has been analysed. The questionnaires will be stored in a locked filing cabinet and all data held on computer will be pass word protected. As the questionnaires will be anonymous you will not be identifiable in any way.

**What will happen to the results of the research study?**
This ancillary study could offer insights into the model (s) of supervision favoured by therapists and use of training and supervision within research studies.

- It may identify the need for additional training in the use and application of supervision for therapy leads and/ or therapists.
- It may offer guidance for researchers carrying similar inter-professional multi-centre studies in the future.
- It may offer insight into preferred methods of supervision in relation to level of experience and/ or expertise in a specific field.

**Who is organising and funding the research?**
This study has no additional funding and is being sponsored by the lead organisation for the PACE Trial.

The research assistant is employed by St. Martin's College.

**Who has reviewed the study?**
The West Midlands Multi-centre Research Ethics Committee has reviewed the study. Members of the committee gave the study a favourable ethical opinion.

**References**


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**Thank you for taking time to read this sheet.**

Study Number: ISRCTN54285094 – Supervision Ancillary Study

# CONSENT FORM

**Title of Project: The Perceived Experience of Supervision within the PACE Trial**

**Please initial box**

1. I confirm that I have read and understand the information sheet dated September 2006 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary. ☐

3. I agree to take part in the above study. ☐

**Name of Participant** Date

Signature

If you have any questions about the study please contact me as shown below.

Email: G.Araoz@ucsm.ac.uk Telephone: 01524 844594

Address for correspondence:
Dr. Gonzalo Araoz.
Centre for Health Research & Practice Development
St. Martin's College,
Fusehill Street
Carlisle, CA1 2HH

Therapist Address

06 February 2007

Dear *name inserted*

This is a follow up letter to remind you of the ancillary study as part of PACE to consider your perceived experience of supervision within the PACE Trial.

My name is Dr. Gonzalo Araoz. I am a research assistant working with Dr. Diane Cox at the Centre for Health Research & Practice Development at St. Martin's College. I have been asked to distribute, collate and analyse the findings of the enclosed survey in order to limit any bias and maintain your anonymity and confidentiality outside of the PACE Trial.

I have enclosed a further information sheet which outlines the study in more detail, a consent form to sign if you wish to take part in the study, the questionnaire to complete and a stamp addressed envelope.

When you are completing the questionnaire, if there are any questions that you would like to give a more detailed response to, please feel free to write on the blank reverse of the related question. If you do this or add additional sheets please remember to indicate which question it relates to.

Please could you return the questionnaire and sealed consent form in the stamped addressed envelope. If you have any questions about the study please don't hesitate to contact me as shown below.

Email: G.Araoz@ucsm.ac.uk Telephone: 01524 844594

Address for correspondence:
Dr. Gonzalo Araoz.
Centre for Health Research & Practice Development
St. Martin's College, Fusehill Street, Carlisle, CA1 2HH

St. Martin's College has 3 main campuses Carlisle, Ambleside and Lancaster. I am based in Carlisle, Diane is based in Lancaster.

Yours sincerely

Dr. Gonzalo Araoz