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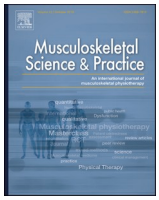

Original article

Factors that influence the quality of the clinical supervision experience in a first contact physiotherapy (FCP) role - The perspectives of supervisors and supervisees – A qualitative analysis

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ABSTRACT

Purpose: First contact practitioner (FCP) roles have been developed to supplement the primary care workforce in managing the burden of musculoskeletal conditions. In order to quality assure and standardise capability of these clinicians an educational framework was developed by NHS England. The Roadmap to Practice (2020) was the curriculum designed to support and develop capability for FCP roles. This secondary analysis of a broader research project aimed to understand the factors affecting the supervisory experience from both a supervisor and supervisee perspective.

Methods: A qualitative design using group interviews and an online survey was utilised to examine the experiences of these clinicians on their journey navigating and supporting the Roadmap to Practice portfolio process.

Findings: Three principal themes were identified that affected the supervisory process; preparation of both supervisors and supervisee; the person (supervisor) and the practicalities associated with supervision.

Conclusion: There were numerous factors influencing the quality of clinical supervision. Adequate preparation of the supervisor and supervisee is critical to success. The attributes of the supervisor were important in the enhancing the quality of supervisory process. Time afforded to undertake supervision and access to appropriate supervisors need to be adequate and accounted for in workforce planning. A paradigm shift in workplace culture is required so clinical supervision is seen as an integral component in maintaining quality and assuring patient safety.

1. Background

Clinical supervision (CS) is widely used in healthcare and is considered to be key in supporting professional development and improving recruitment and retention (Gardner et al., 2023). The NHS Long Term Workforce Plan (NHS Long Term Workforce Plan, 2023) identifies clinical supervision as a key priority for retaining and developing its staff, but also recognises the need for clinical supervision to work differently as part of the education and training reform. It is also a factor in ensuring patient safety and improving the quality of care (Snowdon et al., 2019). Clinical supervision can take many forms and there are differing definitions. Milne (2009) p.440 defined it as; "The formal provision, by senior/qualified health practitioners, of an intensive relationship-based education and training that is case focused and which support, directs and guides the work of colleagues (supervisees)" which addresses the supervision "functions" of "quality control; maintaining and facilitating the supervisee's competence and capability; and helping supervisees to work effectively". White and Roche (2006) p.214 suggest; "it is a process that seeks to create an environment in which participants have an opportunity to evaluate, reflect and develop their own clinical practice and provide a support system for one another." Clinical supervision also aims to bridge the gap in professional experience between the supervisor and supervisee (Snowdon et al., 2019). Despite this variation, the principles of support, reflection and development are common across all definitions. In the context of advancing practice, Harding and Barratt (2023) state that supervision should include the normative, formative and restorative dimensions, as initially outlined by Proctor (2001), and this should not be confined to the clinical aspects of practice.

First Contact Physiotherapist in Primary Care.

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The First Contact Physiotherapist (FCP), one of the First Contact Practitioner roles (NHS Long Term Workforce Plan, 2023) has been developed over several years in response to rising demand and subsequent workforce pressures in Primary Care services. This role was designed to assist with the significant healthcare burden associated with musculoskeletal (MSK) conditions, accounting for an estimated 17–30% of all primary care consultations in England (Downie et al., 2019).

Health Education England (HEE), now part of NHS England, launched the *First Contact Practitioners and Advanced Practitioners in Primary Care: (Musculoskeletal) A Roadmap to Practice* in October 2020 (Health Education England, 2020). This framework was intended to provide a standardised curriculum, role, and supervision model to improve patient outcomes. Quality supervision was promoted as a key part of the implementation of this framework. Undertaking the requirements of the Roadmap to Practice carries a significant supervisory burden on both the clinicians assigned to support the development of these capabilities and the systems in which they operate. This has implications on the capacity of an already stretched system (Carus et al., 2023).

This article aims to explore the perceptions of supervisors and supervisees around what makes for a good supervisory experience and what does not. It will aim to identify the factors that influence this both from a positive and negative perspective and will make recommendations around how clinical supervision can be optimised for supervisee, supervisor, the system and ultimately for the benefit of the patient.

2. Method

2.1. Study design

This study is reported in compliance with the consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007).

This qualitative study is a secondary analysis of a larger England-based project evaluating the experiences of the supervisor and supervisees on the FCP development journey in Primary Care (Carus et al., 2023). This paper considers the outcomes of twelve semi-structured online group interviews using the online platform Zoom. The interviews were conducted by PM & CC, both academic physiotherapists with support from the study team experienced in qualitative research. Participants were a self-selected cohort of FCPs and their supervisors drawn from nine sites piloting the Roadmap to Practice unsupported portfolio route to evidence their capabilities. The pilot sites were selected by the funder to gain a national geographical spread, across both public and independent providers to capture a broad range of perspectives and experiences. Following the initiation of the project, three of the nine sites withdrew (33.3%), one due to the cessation of FCP services, one based on a lack of capacity for staff to participate in the project and one non-responder. The remaining sites provided a broad geographical spread of NHS organisations.

Recruitment was facilitated by pilot site clinical leads, normally a service manager, with whom the research team had explained the project in an initial online meeting. Following the initial contact meeting a participant information leaflet was provided to disseminate to staff providing an explanation of the project and details of how to take part. For the purpose of the online group interviews, those agreeing to participate were stratified into either prospective (those new to enhanced/advance practice, n = 9), retrospective (those already with significant experience of enhanced/advanced practice, n = 12) and those supervising learner FCPs (n = 9). Further detail on the interview development, topic guide and conduct is provided in the earlier paper (Carus et al., 2023).

This qualitative study was based upon a hermeneutic phenomenological approach underpinned by Gadamer's philosophy (Alsaigh and Coyne, 2021) to gain an understanding of the lived experience of participants. This enables a deeper understanding which can be interpreted through rich textual descriptions to understand the meaning of a particular environment. This interpretivist approach can clarify the meaning of the phenomena under investigation (Crowther et al., 2017). This methodological approach acknowledges the relatively small sample size and variation in participant background whilst allowing the experiences of the researcher to provide meaningful interaction within the interviews and engage the participant in conversation based on their in-depth knowledge of the topic.

The group interviews were digitally recorded and electronically transcribed. Data relating specifically to supervision experiences was extracted and provided multiple perspectives in different clinical settings from primary to secondary care. The data were reanalysed according to Braun and Clarke's (2006) six step approach to reflexive thematic analysis (RTA).

Interview transcripts were manually analysed from Microsoft Word, the transcripts were re-read and familiarised by the lead author (PM) who independently generated initial semantic codes followed by a latent coding exercise in collaboration with BS to extract deeper nuances from the dataset (Byrne, 2022). From the initial and latent coding, three primary themes were identified from the data set. These themes were then reviewed, defined, and named for final review (Braun and Clarke, 2006).

2.2. Findings

Key for quotes: GI = Group Interview, Sup = Supervisor, Retro = Retrospective participants, i.e. those with significant clinical experience in an FCP role and retrospectively complying to the curriculum framework. Pros = Prospective participants, i,e. those new to the FCP role and navigating the Roadmap as it was intended, i.e. to complete the requirements prior to entering a primary care role. The first number refers to the group interview number and the second number denotes the particpant within the group.

Data saturation was achieved with the interviews reporting similar findings across multiple participants and groups however analysis continued until all data had been reviewed with no early cessation. Three main themes were identified from the dataset relating to the factors which influence the quality of clinical supervision (1) the person, (2) preparation and (3) the practicalities. These key findings were underpinned by a number of sub-themes (Fig. 1). Results will be presented under these three subheadings with anonymised quotes from the participants presented to illustrate these themes in context.

2.2.1. .The person

A willingness to undertake the supervisory role was seen as pivotal. Supervisors were often selected for the role based on other attributes, such as clinical experience or higher-level academic qualifications. Additionally, many supervisors felt that supervisory duties had been bestowed upon them based purely on their academic credentials rather than a desire to develop others. This also hampered the quality of the supervisory experience as many felt ill-equipped for the role or felt they lacked the necessary skills or attributes to perform this role successfully.

> "Always been an educator, always been a teacher. Didn't come as a huge surprise. Felt comfortable and felt prepared." [GISup2/8]

> "I would actively encourage others to do as check box for someone wanting to get leadership of people. Need to enjoy developing others" [GISup1/1]

> "Suddenly responsible for the development of others. Need help to do it. There needs to be a support programme in place. Chosen based on qual [qualifications] rather than personal attributes … Mentorship would have helped" [GISup1/2]

The seniority or level of clinical expertise of the supervisor also appeared to have an influence on the quality of the supervisory experience.

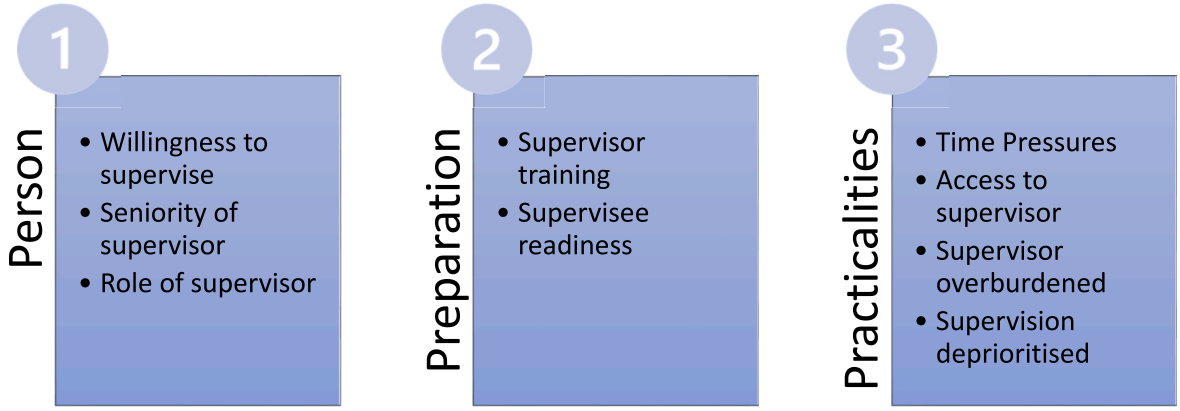

Fig. 1. Thematic map.

"Roadmap supervisor not qualified herself yet [as an FCP] but done supervisors' course." [GIRetro2/4]

"Peer support is helpful but a bit 'nicey-nice'." [GIRetro2/7]

"Good peer relationship with supervisor … Very much a peer discussion. Used to manage this person. We have a mutual respect." [GIRetro5/12]

2.2.2. *Preparation (supervisors' perspective)*

From the data it was evident that preparation for the supervisor was key in achieving a positive supervisory experience. In the context of the FCP roadmap, supervisors were required to attend a two-day preparation course, often delivered online and not necessarily on consecutive days. Many felt this format was too theoretically focussed and lacked practical application. An interval between training days seemed to be favoured by many participants to allow for consolidation time, opportunity to practice the newly acquired supervisory skills and to learn from mistakes.

"Heavy focus on theoretical aspects of supervision. Even after day 2 course had an understanding of the documentation but left a lot of questions and down to interpretation. Content was light on how to do WPBA (workplace-based assessments)" [GISup1/2]

"[need] Less on learning styles. Could have been summarised in a shorter period of time. More about how and when to complete the assessments. More practice and more discussion." [GISup3/9]

"Without a doubt seeing example of COTs [consultation observation tool] being done and actually practicing them would have been really helpful." [GISup1/1]

Some felt that local informal supervisory training conducted by different primary care professionals was more beneficial than the formal course.

"GP [general practitioner] supervision is helpful." [GIRetro2/7]

"Training more locally was much more helpful by local GPs." [GISup3/9]

2.2.3. *Practicalities*

Allocation of ring-fenced time was an important factor in the supervisory process, which many were not allocated. Often the supervisory burden was expected to be incorporated in to pre-existing non-clinical time which should have been used for other activities.

"Time allocated to clinical development but not specifically dedicated for Roadmap completion also included mandatory training and service development tasks" [GIRetro1/1]

"Allocated percentage of time for study. Supposed to be 30% but not just for Roadmap time, for everything." [GIRetro2/4]

"Unrealistic to do it in the time we had … Have to do it outside work. Difficult to link up in person." [GIRetro3/9]

Many participants felt that they did not have sufficient access to their supervisor. Quite often supervision was remote, particularly where they did not share a clinical space. Importantly, many supervisees had not actually met their supervisor in person.

"Don't have regular contact with Roadmap supervisor." [GIRetro1/1]

"Debriefs haven't really happened. Doesn't do formal debrief with anyone." [GISup1/2]

Many supervisors appear to be overburdened with supervisees, which may have affected the quality of individual's experience from both a supervisor and supervisee's perspective.

"Supervisor new in post. Has around 10 supervisees." [GIPros1/1]

"Supervisor has 6 supervisees." [GIRetro4/10]

"40 FCPs 7 supervisors. Huge challenge on everyone to deliver [supervision]. Currently supervising 6 people, so ensuring making clinical hours as well as supervising [challenging]" [GISup2/7]

Consistency was also important in many people's experiences, with many reporting challenges in the frequency and quality of their clinical supervision. In many cases this led to clinicians seeking alternative forms of support, particularly via the use of social media networks.

"Only had peer support through WhatsApp that we set up." [GISup1/2]

"WhatsApp group for FCPs. This has helped me. Helpful with case studies." [GIProsp2/3]

3. Discussion

This study has demonstrated that the supervisory journey is critical in the personal and professional development of individuals in an FCP role. Challenges were commonplace and multifaceted and were linked to both operational and preparatory factors.

Who undertook the supervision was important, not only from the perspective of the supervisee but also the supervisor. Previous research has shown that a supervisee's choice of clinical supervisor is associated with higher quality clinical supervision (Edwards et al., 2005; Baker et al., 2023). Conversely, many supervisors also felt that the role of supervisor had been imbued upon them with little option. It was apparent that supervisors were primarily selected for the role based

purely on their level of academic attainment or their role as a department clinical lead. Both perspectives echoed the fact that supervision should be undertaken by someone who enjoys developing others and has a clear affinity for mentorship.

It was also felt by the participants that clinical supervision should be undertaken by someone with more clinical experience and/or a more senior grade of clinician. The data suggested that peer supervision did not yield much quality. This may have been because there was simply no one else more senior in the locality to undertake this role. It was felt by many FCPs that peer-led supervision lacked sufficient levels of challenge to be meaningful, perhaps so not to appear professionally discourteous or rude. Other hierarchical factors also appeared to play a role. Although peer assisted learning has many developmental advantages (Henning et al., 2008; Carey et al., 2018) in this FCP clinical supervisory context this does not appear to be the case. Perhaps this may have been influenced by the small-scale pilot with clinicians who were acknowledged to be amongst the most experienced in their field with limited opportunity for supervision by senior colleagues within their profession. Despite this, communities of practice of peers have been shown to be of benefit and not only allow for the development of skills and knowledge, but also the construction and formation of professional identity (Amery and Griffin, 2020). However, within the context of peer-assisted clinical supervision it also appears that an element of confirmation bias or 'Groupthink' may damage the integrity of the process (DiPierro et al., 2022). DiPierro et al. (2022) reported that enhancing the awareness of the phenomenon may be helpful in improving quality of care and safety. They also discuss the benefits of 'devil's advocacy' where rather than seeking to agree, perhaps present alternate perspectives and promote critical evaluation of clinical decisions. This point also serves to emphasise the long-standing question of; how does the most senior person in the clinical area get meaningful and developmental supervision? Although the possible solution to this quandary is beyond the scope of this work, it may be worthwhile reflecting on the value of multiprofessional supervision models in these instances from a different professional group, for example General Practitioner (GP) led supervision.

Preparation of both supervisor and supervisee played a key role in the success of the supervisory experience. This has been demonstrated in previous studies particularly from a supervisor's perspective where appropriate training was associated an enhanced supervision experience (Baker et al., 2023). The supervisors' preparation course, which was aimed at training clinicians on how to undertake effective clinical supervision, did not appear to fulfil its purpose from the supervisor's perspective, regardless of which preparatory course was undertaken. It was felt that it did not prepare them for all the complexities of the FCP supervisory experience. This was echoed by many of the supervisees who also felt that the process was sub-optimal. The data frequently pointed to the fact that the course was too theoretically focussed, lacking in practical application, with an imbalanced emphasis on learning styles and expectations of level 7 (Masters') work, rather than the practicalities of the supervisory process. Numerous supervisor participants stated that they would have benefitted more from observing worked examples of how to undertake the workplace-based assessments (WBPAs) in the primary care setting. This could have been facilitated via the use of simulation to model good and poor practice. Rehearsing undertaking these WBPAs as part of the course may also yield helpful benefits. Simulation based learning has many advantages and has been shown to be an effective tool as teaching the 'norms' of practice (Cooper et al., 2012; Moslehi et al., 2022). The data also alluded to the benefits of multiprofessional supervision. Davys et al. (2021) discussed the benefits of interprofessional supervision and the benefits it has in strengthening professional identity and providing a catalyst for new ways of working. This may be of particular benefit when clinicians are stepping out of their normal clinical settings and boundaries (acute care) and into new ones (primary care). Multiprofessional supervision also represents an opportunity to address the long-standing issue of how the most senior clinicians get effective and developmental supervision.

A notable absence from the data was that supervisees did not comment on their own preparedness to undertake clinical supervision. Many did not know what to expect of the supervisory experience, what their roles and responsibilities would be and what steps they could take to optimise the sessions. Preparing the supervisee for supervision may therefore be advantageous. Different professional groups in healthcare have reported the importance of supervisee preparation. This includes exploration of wishes and fears of the supervisee to facilitate the discussion of goals (Berger and Buchholz, 1993). Supervisee orientation to supervision has also been discussed as being of value in eliciting a useful supervisory relationship (O'Neill et al., 2022).

Unsurprisingly, practicality played a significant role in delivering a good supervisory experience. Time allocation for supervision appeared to be crucial. Many reported that time afforded to undertake the complexities of the educational framework was integrated into a clinicians' normal non-clinical time, where no additional workload allocation was afforded. This is echoed by Snowdon et al. (2019) who in their work on Australian allied health professionals (AHPs) claimed that time played a crucial role in a successful supervisory experience. Similarly, King et al. (2020) also identified that a lack of time to develop a useful supervisory relationship was a barrier to effective clinical supervision in their Australian study of nursing and allied health professionals. Snowdon et al. (2019) also discusses that it is the responsibility of the organisation to facilitate the clinical supervision and provide the training. Interestingly, previous studies have demonstrated that although clinicians deem clinical supervision to be important it was felt to be less of a priority than patient care, from both a supervisor and supervisee perspective (Baker et al., 2023). In our study the lack of time presented a source of stress to the supervisor. They often had to undertake other non-clinical duties in their own time to meet the needs of their supervisees. Supervisees also struggled to access the supervisor due to the conflicting demands on their time. Both of these issues may be addressed with appropriate job planning. The new FCP framework's speed of roll-out and timeframes for completion led to many supervisors being overburdened, many had numerous supervisees assigned to them. These findings concur with King et al. (2020) who also found that too many supervisees damaged the overall quality of supervision.

Many clinicians reported inconsistency in supervision and claimed that where they were able to access it, it was piece-meal or often conducted informally. The informal 'WhatsApp' networks appeared to play a significant role in the supervisory process and was a supplementary method of peer support, for both supervisors and supervisees. Although this did appear to be of value and was appreciated by clinicians in that they could get timely support, in some instances this served as the only form of supervision. Although such methods were an important developmental adjunct and may play an important role, this should not be the only method employed in the supervisory process. Post COVID-19 there is greater use of video conferencing software, including to provide remote supervision in healthcare education (Martin et al., 2022). There is no reason that this could not be utilised for clinical supervision where there are operational and geographical challenges. This may also apply to organisations with a large rural and geographically disparate patch (Jordan and Shearer, 2019). Previous studies have demonstrated that online supervision has advantages such as the ability to record supervision sessions. This also provides a useful post-supervision resource for the supervisee which can be referred back to aid with professional development as well evidencing that supervision occurred (Jencius and Baltrinic, 2016). Despite this, relationship development between supervisor and supervisee can be impacted by this mode when used in isolation (Whitehead et al., 2023). However, Whitehead et al. (2023) also suggest that this may be ameliorated by an initial in-person meeting to establish familiarity.

4. Limitations

There are several limitations in this qualitative study. From the

initial project, the pilot sites were selected by the funder which may present the risk of selection bias, and this should be considered in the interpretation of the findings. Importantly the sites were solely NHS organisations and therefore may not be representative of large independent sector providers of FCP services. In addition, as they represented the Roadmap to Practice early implementer sites the participants in the study may have had strong opinions about the process and this may have influenced the decision to participate, introducing potential self-selection bias.

5. Conclusion

In summary there are numerous factors which contribute to clinical supervision being meaningful and developmental. There are however many barriers to acquiring this and the system may need to evolve to where clinical supervision is seen as more of a priority. This may require a culture and emphasis shift with respect to the importance of clinical supervision, not only to support the development of the skills and behaviours of the clinical staff for the benefit of patients, but also to improve retention rates and recruitment of staff for the benefit of the system.

Adequate preparation of both supervisor and supervisee is essential to optimise the supervisory experience. Not only preparing the supervisor for the complexities and challenges of undertaking supervision, but also preparing the supervisee for the process and their role in the relationship. Identifying and developing those with an interest and desire to develop others may also be needed as undertaking clinical supervision of others is not necessarily suited to all people. Peer supervision in a primary care setting may not provide sufficient rigour to the supervisory process and should ideally be undertaken by a clinical and experiential superior. Giving supervisees a choice of their clinical supervisor may also be helpful.

Ensuring that the supervisor is accessible to the supervisee although obvious, is clearly important, and timely access to support is required. This confirms the longstanding notion that ensuring skill mix within a clinical setting is vital for clinical supervision and patient safety. Revised job planning may be required where clinical supervision sits apart from other non-clinical duties and is afforded its own ringfenced allocation of working time.

Ethical approval

Ethical approval was granted for the original project by University of Bradford ethics committee reference (E936) prior to the study commencing. Data was managed in line with UK GDPR regulations and all procedures complied with UK Good Clinical Practice (GCP) guidance. All participants in the group interviews and online survey gave their consent for participation.

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Declaration of competing interest

The lead author (PM) is the programme lead for FCP Programme at the University of Bradford. Beverly Snaith was seconded part time to NHS England as a subject matter expert for advancing practice and imaging.

CRediT authorship contribution statement

P.M. Millington: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Validation, Writing – original draft, Writing – review & editing. **B. Snaith:** Conceptualization, Formal analysis, Methodology, Supervision, Writing – original draft, Writing – review & editing. **L. Edwards:** Conceptualization, Investigation, Methodology, Writing – original draft. **C.A. Carus:** Conceptualization, Funding acquisition, Investigation, Project administration, Writing – original draft.

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