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Experiencing inter-professional peer group clinical supervision – findings from an action research study in health care

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Abstract

This paper provides a summary of an action research study examining an inter-professional peer clinical supervision group (IPPCSG) within a United Kingdom (UK) community healthcare organization.

An IPPCSG was constituted via a four phase action research process (Stringer 2014). A qualitative approach was employed. The involvement of participants as co-inquirers reflected the participatory nature of action research and included engagement with the process of data analysis.

All sessions were audio-recorded and fully transcribed with data analysed using Template Analysis (King 2012). A theoretical framework was developed to support the interpretation of the findings drawing on concepts of democracy and power.

This study revealed the part played by structure and rules in securing a safe supervision space. The incorporation of democratic principles contributed to equalising power relationships within the IPPCSG. Key to equalising power was the deployment of Page and Wosket's 5-stage model (2015), the embedding of a formal contract and the rotation of functional supervision roles within the IPPCSG.

The study illuminated how trust developed and how supervisory relationships matured and provided detail of the transitions between functional peer supervision group roles. The findings suggest that the different professional identities and perspectives within this group did not impinge on the development of effective supervisory transactions. Substantial common ground was revealed regarding issues brought to supervision, professional beliefs and values and experiences. The analysis suggests that processing work-generated emotion should be a core component of supervision.

Key words: Peer groups - clinical supervision – action research –template analysis

Introduction

This paper reports the findings from an action research study examining the implementation of an inter-professional peer clinical supervision group (IPPCSG) within a United Kingdom (UK) community healthcare organization. This was a developmental study involving nurses and allied health professionals.

At the time of the inception of this study (2012) advancing clinical supervision within the local health care environment presented significant challenges in the climate of change resulting from national policy changes and the likely fragmentation of health care provider services (Department of Health

2009). The local development of integrated care services meant that the focus of the research was welcomed by stakeholders. It was appropriate therefore to consider how inter-professional supervision might be developed in order to support practitioners in the delivery of care. Changes to health and social care legislation have resulted in on-going upheaval for providers of health care with the implementation of reforms governing commissioning of health and social care by clinical commissioning groups (The Health & Social Care Act 2012) and Local Authorities (The Care Act 2014).

This research was undertaken as the basis for my doctoral studies and my long standing relationship as an educator/trainer with the research site organization allowed me to occupy a position along the insider-outsider continuum that was unique and valuable for an action research study (Denzin & Lincoln 2003).

The aim of the study was to explore how inter-professional peer clinical supervision might be developed in order to support practitioners in the delivery of community health care. Key objectives focussed on investigating how participants negotiated the potentially competing demands of risk management and support functions in an IPPCSG and examining the development of supervisee-supervisor relationships in an evolving IPPCSG.

Clinical supervision

The established purpose of clinical supervision is promulgated as encompassing clinical governance, life-long learning, development of practice, facilitating best practice and supporting the practitioner (Butterworth & Faugier 1992).

Current definitions used as the basis for most UK nurses and allied health care professionals reflect the definition referred to by UK professional bodies and regulators coined in 1993 by the Department of Health:

‘a formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety in complex clinical situations’ (DH 1993).

Peer-group clinical supervision is defined as:

‘where there is an acknowledged level of equality and the tasks of both facilitator and supervisor are shared amongst the members’ (Page & Wosket 2015, page 140).

Proctor (2008) refers to the absence of a permanent supervisor in peer-group supervision and argues that it is essential that group members ‘participate equally’ in supervisor and supervisee roles.

Clinical supervision remains essentially optional for the majority of health care professionals (NMC 2008, HCPC 2014) though counsellors and clinical psychologists have a mandatory requirement for supervision by their regulatory bodies (BACP 2013; 2015).

This study involved nurses, a podiatrist and an occupational therapist, all of which are protected titles in the UK (DH 2002, HCPC 2013). Importantly, nurses, occupational therapists and podiatrists are all required to complete a re-validation process to maintain their registration with their

respective regulatory body (NMC 2015, HCPC 2014). This process requires practitioners to produce auditable evidence demonstrating their fitness to practise and participation in clinical supervision is identified as an important component of this evidence (HCPC 2014, NMC 2015).

Key themes from the literature

The review of the literature focussed on multidisciplinary/inter-professional supervision and supervision conducted in group format, with an emphasis on research undertaken within health care settings.

Research on inter-professional/multi-disciplinary clinical supervision in health care has focussed on perceptions, experiences and attitudes of practitioners. Findings have emerged regarding operational and organizational factors that influence clinical supervision and the perceived benefits of and barriers to 'good' supervision (White & Winstanley 2010, Lakeman & Glasgow 2009, Deery 2005) and particular concerns raised about conflating 'managerial' supervision with support (Hall & Cox 2009, Strong et al 2003, Cutcliffe & Hykras 2006). Though format and models of group clinical supervision have been explored in both uni-disciplinary and inter-professional/multi-disciplinary research, few studies have employed approaches and methods that allow the process and content of peer group clinical supervision to be investigated as 'live' experience. Indeed, investigations on peer group supervision are scarce using any methodology with the majority of studies on group clinical supervision conforming to a supervisor-led model.

The complexities of developing supervisory relationships in group clinical supervision were evident in the reports of research reviewed. The understanding of group member rights and responsibilities emerges as a crucial aspect of developing effective supervisory relationships in group supervision. In the study by Brink et al (2011) participants emphasised the importance of clinical supervision in dealing with emotion, a function enabled by the supervisory relationship based on the security of using a model and structure to run the group. The notion of the safe space to become vulnerable is referenced in several of the studies on group supervision with the requirement for confidentiality highlighted (Jones 2003, Buus et al 2011, Taylor 2013). This space is thought to be compromised in supervisor-led groups if the supervisor is based in the same work team as the supervisees (Buus et al 2011). Group cohesion was cited as an important factor in two studies on group supervision (Jones 2006, Lindahl & Norberg 2002) and enabled a supportive environment to develop where a sense of common purpose produced positive experiences for the participants. The antithesis of the situation could be adduced from the 'pseudo-cohesion' described in Deery's study (2005) where destructive group dynamics undermined the opportunity to develop a workable supervisory alliance. Jones (2006) suggests that the development of trust and willingness to be open and honest takes time, a position corroborated by Taylor (2013).

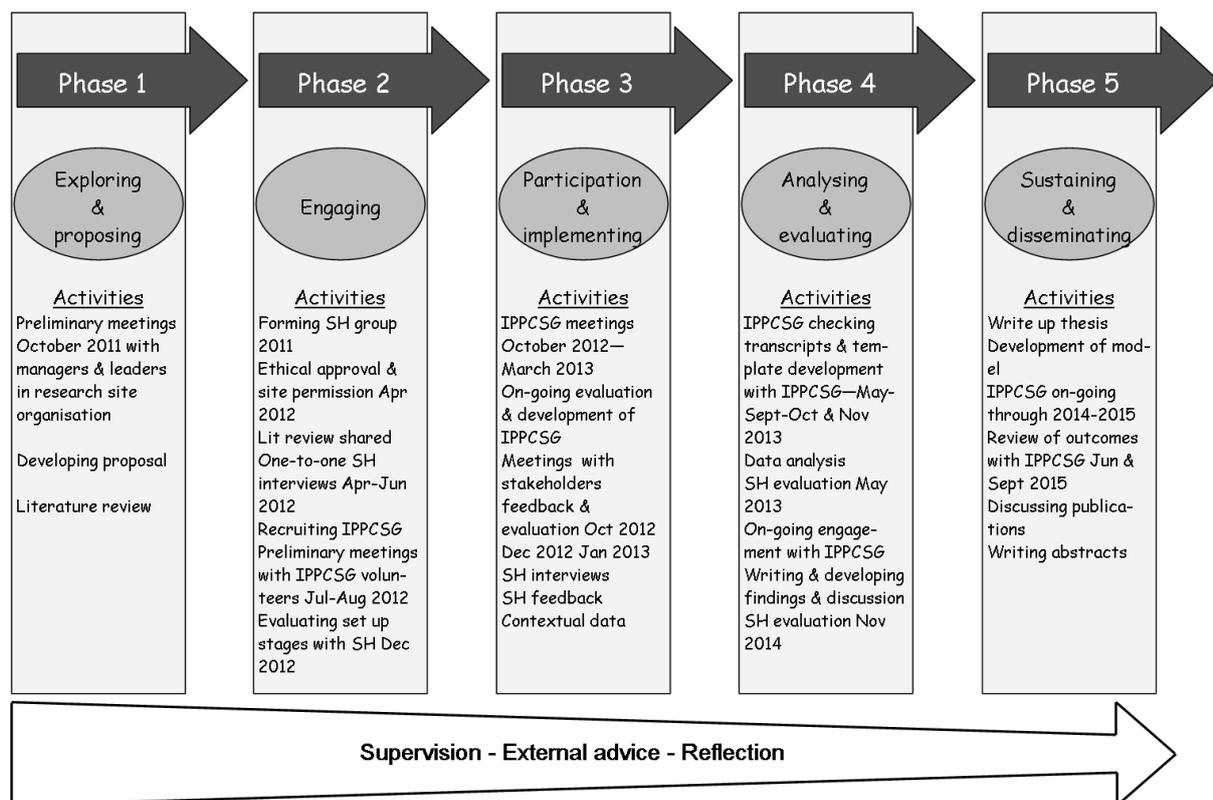
Methodology

The study was located within the 'participatory world view' because it was bounded by context and intended to promote change within a local situation (Koshy et al 2011). A qualitative approach was determined by the nature of the proposed enquiry which was exploratory and developmental and focussed on analysing and interpreting the experience of the IPPCSG (Gerrish & Lacey 2006).

The involvement of the participants as collaborators in the research process is intended to facilitate their personal development and build capacity and confidence in the process of change and evaluation and development of individual theory (Stringer 2014). The participants in this approach are deemed to be collaborators or co-inquirers in the research process. Self-reflection and exposure to multiple perspectives ensured that reflexivity was embedded in the process (Marshall & Reason 2007).

Stringer (2014) advocates the use of action research for a range of purposes, including the development of special projects. The IPPCSG was established as the basis for ‘live’ experiential research where the content and process of inter-professional peer group clinical supervision could be explored and developed. This action research project was conceived as ‘phases’ to make explicit the feedback, reflection, progression and change components (Winter-Munn-Giddings 2001) as depicted in Figure 1 (Johnson 2016).

Figure 1 Action Research Summary Matrix



Methods

Ethical approval, site permission and consent were obtained in 2012. The IPPCSG was established following recruitment of volunteers identified via expressions of interest elicited from practitioners within the research site. The IPPCSG met for six sessions of two hours over a period of six months during 2012-2013. Prolonged engagement is a requirement of good quality action research: the inquiry process considered as beginning at the point of the initial idea and continuing beyond the formal completion of the research (Reason 2006). In this study, exploratory activity began in October 2011 and my engagement continued into 2016. The four stakeholders were drawn from managers

and leaders within the organization. The stakeholder group members' role was to act as champions and facilitators of the project and to influence the context-specific focus of the project.

The project used a purposive sampling strategy to ensure participants represent a number of differing health care professional groups. This was essential to ensure the composition of the group was inter-professional and involved practitioners who are actively involved with clinical practice (Stringer & Genat 2004). Six participants were recruited to form the IPPCSG: Four nurses, of differing grades and job roles and two allied health professionals; one occupational therapist and the other, a podiatrist, formed the group. Co-inquirers names were substituted by pseudonyms: Jane, Margaret, Anne, Dorothea, Frances and Molly. All sessions were attended by at least two of the three professional groups so maintaining the inter-professional composition of the group.

In attempting to achieve an acceptable level of trustworthiness a number of strategies were employed to establish validity in both process and outcomes. Combining methods of observation and audio-recordings for data collection and involving participants in listening to audio extracts and checking transcripts were aimed at promoting validity or trustworthiness (Stringer 2007) and quality (Reason 2006).

Data collection

Data were collected using audio-recording of each of six planned IPPCSG sessions (Koshy et al 2011). I acted as a participant observer in all sessions. Each IPPCSG session lasted one and a half hours and was immediately followed by a half hour feedback session enabling clarification of events for observations to be shared with members. Co-inquirers used this space to offer comments and thoughts on their experiences and to check with each other about their own interpretations of events.

The aim and objectives of the project were developmental and as appropriate with action research principles, it was the co-inquirers (IPPCSG members) who determined what to speak about. The nature of the data generated by 'live' supervision was essentially different from that that may emerge from interview data in that the IPPCSG sessions were not shaped by guides or content-specific questions: The IPPCSG sessions were shaped by clinical supervision structures and the participant stories.

The initial meeting was the contract meeting where the IPPCSG established their expectations of the group and each other. A contract was developed and the group opted to use Page & Wosket's (2001) model of supervision as a way of structuring their sessions (see appendix 1).

Data analysis

As appropriate for this action research study, the focus for analysis was on what was said and done in the IPPCSG and not on what the data said about group members' lives (Wilkinson 2011).

Template analysis is a method of thematic data analysis that uses an evolving framework to code and theme data. It is characterised by a structured process of analysis of textual data with a flexibility that enables the process to be adapted to the needs of any particular study (King 2012). Template analysis allows the researcher to develop a structured, hierarchical coding of data without insisting on a sequential process, for example moving from descriptive coding to

interpretative coding. In addition template analysis does not require a set number of coding levels, but instead enables the development of themes to be focussed on where the richest data occurs in relation to the research aim and objectives (Brooks et al 2015).

The structuring process evolves from the development and application of a priori themes. The use of a priori themes allows the researcher to begin with codes that reflect themes in the literature, the project objectives and an initial reading of transcripts. It is also expected that a priori themes in template analysis may be changed or discarded. Another aspect of template analysis is that predetermined codes are not applied to all transcripts in sequence but rather as King (2012) explains:

‘analysis progresses instead through an iterative process of applying, modifying and re-applying the initial template’(page 458).

Table 1

A priori theme	Description
Supervision process	Includes the roles of being the supervisee and being the supervisor and process aspects of conducting group supervision
Supervision content	Includes the issues brought to supervision by group members and emotions surfacing during supervision
Learning about supervision	Includes learning from each other and with each other

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The initial template was shaped by the a priori themes in conjunction with themes emerging following initial reading of the transcript of the first IPPCSG session (see Table 1). Transcripts were shared with IPPCSG members and excerpts from recordings played with the group. Successive versions of the template were discussed with the co-inquirers, enabling their input to the development of themes, thus supporting the trustworthiness of the study by making explicit how interpretations evolved (Robson 2011). There were eight, successive versions of the template.

Data were manually coded and assigned to themes and as appropriate with template analysis, themes were merged and re-assigned via the iterative process of analysis. Code listings provided a visual summary of the pattern of codes across the five IPPCSG sessions and per individual IPPCSG member (King 2012). This proved a valuable tool in supporting the analysis and provided an opportunity for debate with IPPCSG members.

The final template (see Table 2) provided the structure for further analysis and interpretation of the findings.

Table 2

1 st Level Theme	2 nd Level theme	Sub-themes
1.0 Supervision process	1.1 Being a supervisee	1.1.1 Telling the story
	1.2 Being a supervisor	1.2.1 Providing emotional support for each other
		1.2.2 Challenging each other & giving advice
	1.3 Critical reflection	
2.0 Supervision content	2.1 Issues brought to supervision	2.1.1 Organizational change 2.1.2 The trouble with teams 2.1.3 Clinical decision-making/ethical issues
	2.2 Emotions surfacing during supervision	2.2.1 Emotions surfacing about the work 2.2.2 Emotions surfacing in relation to supervision process
3.0 Learning	3.1 Learning from each other about practice	3.1.1 About practice & identifying common ground 3.1.2 About strategies to deploy in practice
	3.2 Learning with each other about clinical supervision	3.2.1 About models & structures in group supervision 3.2.2 Learning about what clinical supervision is for 3.2.3 About different approaches in clinical supervision
Integrative Themes		
4.0 Trust		5.0 Roles & Identities
4.1 Trusting the process		5.1 Functional roles & identities in clinical supervision
4.1.1 The rules		
4.1.2 Facilitation of the IPPCSG		5.2 Personal & professional identities
4.2 Trusting each other		5.3 Group belonging
4.2.1 Challenge		
4.2.2 Authenticity		
4.2.3 Group format & function		
4.2.4 My relationship with the IPPCSG		
4.2.5 Humour		
4.2.6 Dual relationships		
4.2.7 Naming & noticing behaviours		
4.2.8 Commitment		
4.2.9 Being a research participant		

Findings

A brief summary of key findings are presented here under the main headings identified in the final template (see Table 2). Pseudonyms are used throughout and four of the co-inquirers had the opportunity to review this summary paper.

Supervision process

The process of supervision for the IPPCSG has two main aspects: that of illuminating what it meant to be both a supervisee and a supervisor and how the process of supervision was conducted over the five sessions.

Being a supervisee within a peer supervision group carries with it a responsibility to participate, but also brings the potential for exposure of one's practice and revealing oneself as a person (Bond & Holland 2010). The risk of exposure was made explicit both in the process of gaining consent of participants and also in the detailed discussion leading to the agreed supervision contract.

Being a supervisee - revelations and exposure – telling the story

The experience of IPPCSG members in supervisee mode 'telling the story' was catalytic in that it allowed space and time for detail and clarification. On occasion the telling of practice stories exposed the supervisee to potentially shaming revelations about their practice.

In session 2 Molly recalled a patient complaint via a solicitor following initial assessment carried out by a team colleague. A pivotal aspect of Molly's issue was that this colleague had not informed the patient of the treatment rationale and that she (Molly) had not pursued this failure of communication with this colleague in a robust manner and was worried about the consequences.

Molly: 'I thought, where's my lawyer, because it's alright being honest and truthful but the game isn't about honesty and truth it's about legality because you could get yourself deeper in it.' (S239-42)

During the same session (session 2) Frances recounted her struggles as a team leader following a re-configuration of teams. Frances described an outburst from one team member about a decision she (Frances) had made during which Frances felt humiliated.

'I felt they made me look really small in front of other team members' (S2 638)

During the review stage of session 2, Frances articulated her response to having shared her story:

'I did feel OK about sharing it and was just quite interesting that, you know, people to listen to what you're actually saying and nobody kind of judging... I felt quite appreciated that you're saying "you did the right thing in that situation"...' (S2 1147-1152)

The fact that the initial telling of the practice stories lasted between two and eight minutes suggests that opportunities for uninterrupted accounts of situations need not absorb excessive amounts of clinical time. It is important to highlight that Dorothea did not contribute her own practice story, though she made substantial contributions in 'supervisor' mode.

Being a supervisor – support and challenge – two sides of the same coin

The emotional component of work was recognised as a unifying current for all IPPCSG members and was an aspect that had been previously largely unrecognised by IPPCSG members regarding the

impact on them as individuals in terms of their own well-being and their performance as professionals.

Margaret noticed and named Jane's emotional state when Jane revealed her concerns about perceived inequity within her team:

'I think it is fairly apparent how you feel, because the way you are talking now, you've sort of come down a bit and the way you were talking when you were telling us, you know, you were going red, you were shaking at one point and that just shows how you feel about it and I can understand that perfectly.' (S5 1335-1339)

Demonstration of empathy enabled a feeling of unity to evolve and sheltered the supervisees from feelings of isolation, particularly when exposing issues from practice that were troubling or shaming.

During session 3 Margaret conveyed how empathy can demonstrate that support and challenge are 'two sides of the same coin' when Molly was telling her story about the patient complaint:

'I've done this myself in the past.. I think sometimes we have to be a bit more blunt about what our expectations are of colleagues and rather than hoping they'll volunteer to do something...and I've done it myself... when I've sought the doctor's advice about a patient I'm worried about and come away feeling like I haven't been (interjection "assertive enough")' (S3 188-198)

Emotional support was tempered by challenge to IPPCSG members in both the supervisee and supervisor mode. The challenges delivered related to practice decisions and actions, assumptions made and perspectives and perceptions of supervisees and supervisors about self and others. The challenge component of sessions was critical in reducing the risk of collusion associated with group behaviour and challenge can be characterised as the antidote to collusion.

When Margaret shared her story about her resistance to being coerced to administer additional medication to a palliative care patient by a relative Dorothea immediately asked a challenging question:

'because there's no safeguarding issue here?' (S3 388)

Margaret responded: 'I had no concerns there was any ulterior motive.' (S3 394)

The risk of collusion in supervision is increased as only one side of any story is heard with the potential for supervisees to present partial information and seek to minimise their weaknesses and apportion any 'blame' to others not present (Page & Wosket 2015). The overt challenge via questions and willingness to offer critical verdicts on actions and decisions demonstrated the awareness of IPPCSG members of the requirements of effective supervision and their own accountability as health care professionals for safe and effective practice (HCPC 2013; NMC 2015).

Group members empathised with Frances when her conflict with her team was reprised and cast doubt on whether the manager had informed the team that it was she and not Frances that had made the original contentious decision. Dorothea challenged the group regarding this assumption:

'yeah but she might have, the point is we don't know, we're not giving the manager a fair hearing... we don't know that side of it do we, we only know one person's side...I'm trying to give the other side.' (S4 355-360)

This scenario highlights the potential of a group to make assumptions about what may or may not have been said and done in practice due to the reliance on what is said within supervision and the inevitable tendency to rally to the cause of the 'insider' as being a member of the IPPCSG and with whom relationships are developing.

The cathartic properties of critical reflection were exemplified by IPPCSG members when dealing with emotional feelings generated by troubling episodes in practice (Hawkins and Shohet 2006); here IPPCSG members utilized reflection to enable each other to explore the emotional impact of practice stories and to process the emotions with the intention of 'washing away' or 'putting to bed' the negative feelings.

Supervision content

The content of supervision for the IPPCSG as revealed in the data has two components: issues brought to supervision and emotions surfacing during supervision (see Table 3).

Issues brought to supervision

A summary of issues shared can be seen in Table 3. There was no pre-planned agenda for the supervision sessions and IPPCSG members were not required to undertake any specific preparation in advance.

Table 3

IPPCSG sessions	Issues brought to supervision
Contract meeting October	Ground rules, expectations, agreeing the contract, practicalities, research process
Session 2 November	Impact of organizational issues, patient complaint, documentation & record keeping, team work problems, patient aggression
Session 3 December	Coercion by carers regarding clinical decisions, conflicting perceptions between patients, carers and professionals, professional credibility in jeopardy
Session 4 January	Confidentiality in practice and in research, ethical dilemma in a clinical situation, dual relationships in teams and supervision, role conflict in teams, research process
Session 5 February	Impact of technology on staff & patients/carers, unfair workload, supporting junior staff regarding drug error, perceived inequity in a team
Session 6 March	Tackling work colleague about personal presentation, addressing confidence/competence issues with junior staff, coping with organizational change, research process

The detailed discussion of clinical decision-making and ethical issues faced by IPPCSG members revealed that there was much common ground despite group members having different professional roles. It is possible that the fact that group members shared a relatively similar client population in terms of age (older people predominating) may have helped in this respect.

The exception to this frequently expressed feeling of sharing common ground was Dorothea's stance that implied that the group did not provide her with the level of clinical expertise to help her with specific clinical decisions. Though this was challenged by reminding Dorothea that this was not the stated purpose of this group, it is an important limitation of the function of the IPPCSG from Dorothea's perspective.

Emotions surfacing during supervision

Group members became progressively less tentative about revealing their emotions in sessions, particularly their emotional responses surfacing during supervision. The review stage of sessions became an opportunity to check how each session had felt for each member.

Molly's first story about an on-going situation with a patient complaint revealed that she was concerned about the impact on her professional standing:

'I were grossly worried' (S2 46) and feeling that she was *'letting the side down'* (S2 49).

Molly's language in describing how the situation was making her feel was dramatic as she revealed:

'there's that mental torture where you go over and over again in your mind' (S2 98-102).

There were positive outcomes for IPPCSG members when revealing their emotional feelings about work:

Jane: *'I felt a lot better from talking about it when we had our last meeting ...'* (S6 202-203).

Similarly, IPPCSG members benefitted from honestly discussing how the process of supervision made them feel as occurred when Dorothea had challenged Anne's decision-making in session 4:

Dorothea: *'..but I'm sorry if I did make you feel not very good.'* (S4 941).

The safe space was enhanced by effective facilitation as when Margaret closed down a thread of questions to Frances in session 4 whom she had realised was feeling bombarded. Margaret received positive feedback on this intervention:

Dorothea: *'I was really impressed with that also and I took it on board because I thought I was pushing too much.'* (S4 938-940).

These findings suggest that the IPPCSG provided a safe space for potentially damaging work-generated emotion to be processed, such emotions being perceived as likely to undermine decision-making and practitioner agency. Further, the emotions surfacing related to the process of peer group supervision acted as a stimulus for learning via sharing of stories and contributed to the development of emotional-connectedness between IPPCSG members.

Learning

The findings revealed that IPPCSG members learned about each other's clinical roles and operational services so enabling greater understanding. The process enabled group members to learn from each other about dealing with difficult situations and about developing strategies for addressing practice-related issues regardless of the specific field/profession of group members.

During a discussion regarding the use of mental rehearsal when faced with difficult situations Margaret reflected on how she had drawn on the previous session:

Margaret: *'you see I did precisely that on the lady that I talked about last time. the first time I visited I felt I'd been manipulated....so the next time I went, I went ready, thinking I'm going to make a clinical judgement based on my judgement of the situation rather than being manipulated, which I did.'* (S4 897-907)

The learning was frequently vicarious with topics and problems shared as yet not encountered by some group members. This was particularly helpful given the different roles and responsibilities held by IPPCSG members within the organization so, for example, stories about addressing competency issues with junior staff were helpful to IPPCSG members who had not yet been required to deal with this scenario.

An overarching aspect of this theme was the explicit demonstration of the IPPCSG members 'learning to be a group'. This included the roles within group clinical supervision such as being the facilitator, but also the more nuanced learning about being a group member such as turn-taking, contributing and establishing and developing relationships.

Margaret: *'I think though it helps you focus on what's important by knowing that, because I could have waffled on, if we were here until five o'clock, I could have waffled on all day about that one situation. So knowing that you've got a limited amount of time makes you focus on what you really want to get out of the conversation doesn't it?'* (S3 1078-1082)

The developmental nature of this process learning was demonstrated by the transition from somewhat mechanical application of the 5-stage process model (Page & Wosket 2001) in the early sessions to the more natural and implicit use of the model as guiding structure as sessions progressed.

Anne: *'..being the facilitator, it's knowing these stages.. , where they don't overlap, because there is overlapping isn't there and knowing how to direct the conversation in a way a little bit, not direct it, but.. how to move things along and I think that obviously will come with practice.'* (S2 960-967)

Integrative themes: Trust and Roles and Identities

Trust

The development of trust between IPPCSG members over the series of sessions has two key elements: trusting the process and trusting each other. The foundations were laid during the contract meeting before actual clinical supervision commenced. Key components of the contract meeting that contributed to establishing trusting behaviours are characterised as boundary setting, detailed common understanding of what is meant by *this* group in terms of confidentiality and the limits to confidentiality in a professional context.

Jane: *'I think that's why it's good to have the contract to say what's said in here stays in here.'* (S2 1265-1266)

Other attitudes and behaviours identified in the contract meeting were rooted in respect for each other and their expectations of these behaviours and attitudes were reflected in the agreed rules for operating the IPPCSG.

Molly: *'I wouldn't speak (Jane: if you felt uncomfortable) yeah, if I thought somebody were to be, you know disclosing things, or I don't know, being sort of false.'* (S2 1262-1264)

Trust was not unconditional or unlimited with IPPCSG members being hesitant to explore some stories. For example, where dual relationships were concerned as when Jane highlighted an issue about Anne, who was absent from the session that day:

Jane: *'I just felt a bit uncomfortable because she's best friends with one of the bosses.'* (S5 899-900)

IPPCSG members also expressed concern occasionally that they had revealed too much information in light of sessions being audio-recorded:

Frances: *'I just thought oh, maybe because I am an open and honest person, I'm saying too much and...not being funny but, this is being taped (Molly: yeah, that's what I thought last time) and what is actually going to come out of this and therefore I was kind of thinking, are there going to be repercussions for me..?'* (S4 995-1000)

On-going consent is a key component of action research (Winter & Munn-Giddings 2001) and the agreement with the IPPCSG was re-visited in open discussion on several occasions.

Deploying challenging questions and comments may have contributed to members being convinced of the authenticity of transactions as it demonstrated that the challenger cared about the supervisee's issue and took it seriously. The challenger may also have attracted hostility from other group members, so that making a challenge was not risk free.

Honest appraisal of group function contributed to the establishment of trust as when Frances gave feedback during the review of session 3:

Frances: *'I'm not saying you weren't listening...but it was because Dorothea would say something and Margaret would say something.'* (S3 1257-1260).

IPPCSG members recognised the importance of their commitment to the group in facilitating the development of trusting relationships:

Margaret: *'I think we all understand. I think if it was one person that was persistently not turning up and it was a different excuse every time, I think you'd get a bit fed up of that because you have that trusting relationship don't you, I do feel like, you know we've built up quite a good relationship and ... I think in quite a short space of time we've built up quite a nice (Anne: I think so) trusting relationship.'* (S6 1246-1252)

The development of relationships between members as co-supervisors enabled a working alliance to be established with a measure of interdependence best exemplified by Anne's comment pertaining to Frances' absence at session 6:

Anne: 'And because Frances is missing today, I think, oh like she's one of our sisters now and it's like she's missing, you know and you feel a bit like that really..because you get used to everybody being here don't you?' (S6 1253-1256)

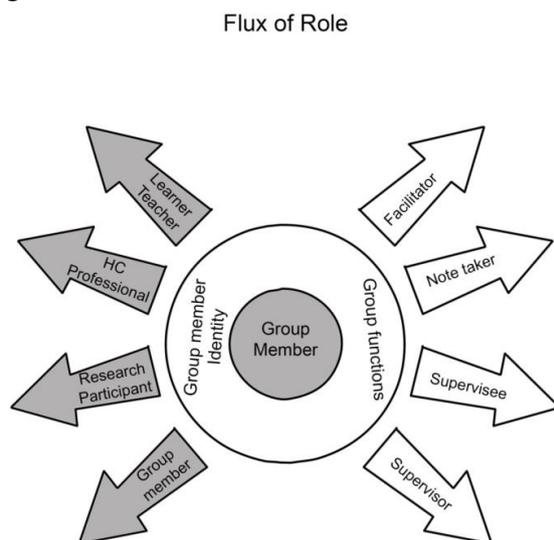
Roles and identities

The fluxing of roles and identities in IPPCSG sessions is depicted in Figure 2. Seamless role transitions managed by IPPCSG members across all five sessions are an important finding of this study and can be claimed as contributing to effective group function. Members of the IPPCSG did not have to compete for 'air time' (Bond & Holland 2010) and the opportunity to take turns in functional roles was decided at the start of each session. These effective transitions could be seen as supporting the development of supervisory relationships within the group as the non-competitive environment is conducive to reducing power asymmetry within the IPPCSG (Proctor 2008).

The professional identity of each group member was explicit as IPPCSG members usually attended sessions in uniform, nurses wearing different shades of blue and allied health professionals white. The wearing of uniform may have confirmed the 'clinical' aspect of clinical supervision for the IPPCSG members. Nurse members may have been more conscious of power differentials within the group as the shades of blue denote 'rank' so providing a visual reinforcement of the hierarchy.

It is important to note that although IPPCSG members held different professional roles and pay grades within the organization, and their attendant responsibilities were explicit in the content of several stories, the findings indicate a strong intention to leave specific roles such as 'manager' or 'team leader' outside the 'room'.

Figure 2



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Discussion of the findings

With repeated reading of the data and refinement of the template in regard to both process and content of IPPCSG sessions, the egalitarian nature of the developing IPPCSG began to take

prominence leading to the employment of power and democracy as an exploratory theoretical framework.

Democratic principles as applied to peer-group clinical supervision resonate most readily with a utopian version of democracy where, in a very small group each individual has an equal right to participate in decision-making and to have her voice heard (Proctor 2008, Arblaster 2002).

Power can be described as the capacity to influence the behaviour and attitudes of others (Bernard and Goodyear 2014). This definition concurs with the notion of interpersonal power in peer group clinical supervision and resonates with the concept of learning and personal development as IPPCSG members influenced each other's thinking, attitudes and behaviours. Johnson and Johnson (2013) extend this definition alluding to power as the capacity to affect the outcomes of one's self and the environment as well as influencing others. This is relevant when considering the power of IPPCSG members to engage in the process of personal development and capacity building for their own clinical supervision and their opportunity to influence the development of clinical supervision within the organization. The concept of 'power over' draws on Foucault's work with particular reference to surveillance (Foucault & Gordon 1980). This idea has resonance in clinical supervision when considering professional accountability and standards of practice (Proctor 2008).

Four key themes relating to the development of supervisory relationships within the IPPCSG are discussed here.

Group cohesion

Hawkins & Shohet (2006) suggest that preoccupation with group dynamics can usurp the intended purpose of a clinical supervision group to explore and address practice-related issues. The findings of this study did not reveal a preoccupation with group dynamics other than the overt consideration of supervision interactions. A credible catalyst for development of group cohesion within this study is the celerity with which common ground became established in terms of both practice-related experience and the attendant emotions and feelings. This common ground ensured the energy level in the group did not diminish, a component considered essential in maintaining healthy group function (Page & Wosket 2015). There was no indication in the findings of tension or alienation as a consequence of inter-professional perspectives extant within the IPPCSG.

A high level of uniformity within a peer clinical supervision group could be a significant threat if the desire to belong and fear of rejection by the group hindered constructive challenge and diminished either group or personal accountability for practice (Proctor 2008). This IPPCSG achieved what Proctor (2008) describes as the requirement of being 'supervisor-full' so ensuring the maintenance of ethical and competent practice.

Structure and rules in peer group supervision

The notion of mutuality is the key to the idea of a working alliance and within the context of a peer group model this essential element can only be obtained via an egalitarian structure and operation of the group. The IPPCSG contract provided the democratic structure for the group and the use of the 5-Stage Model (Page & Wosket 2001) fostered equality of participation, exemplifying the enactment of the democratic principles of liberty and participation (Lively 1975). The regularity of

timing and pre-booking of sessions in IPPCSG members' electronic calendars contributed in a positive way to the structure of supervision. This continuity assisted in creating the 'safe space' for supervision with all IPPCSG members able to think in advance about what issues they may wish to share. The importance of protected time for the IPPCSG cannot be overestimated: Previous studies of clinical supervision have highlighted lack of protected time as undermining all attempts to enable clinical supervision to become an established component of practice (Deery 2005, Buus et al 2011, White & Winstanley 2010). Group supervision could be seen as more problematic in this respect given the multiplication of potential constraints in identifying mutually convenient dates and time slots. However, managers frequently favour group modes for clinical supervision as a more efficient use of practice time and a more practicable solution to the dearth of clinical supervisors (Jones 2006, Bond & Holland 2010). This seemingly benign preference can present significant problems if clinical supervision groups are inappropriately configured as a result of being seen as a way to save costs rather than as a means of developing effective supervisory relationships (Jones 2003, Bogo et al 2011, Hawkins & Shohet 2006). The commitment of the four stakeholders to this study proved pivotal, corroborating the findings of several studies where the lack of organizational support defeated attempts to implement effective clinical supervision (Deery 2005, Strong et al 2003, Buus et al 2011). Where clinical supervision becomes an ad hoc arrangement it does not provide the safe space for effective supervision (Bogo et al 2011, White & Winstanley 2010).

The role of facilitator in ensuring the contract was adhered to and the model was applied, including the allocation of equal air-time was a crucial element of the structure of the IPPCSG. The facilitator role was rotated, so enabling each IPPCSG member to take a turn at being in control, ensuring that dominant individuals did not automatically assume authority. The application of the 5-Stage Model (Page & Wosket 2001) fostered a loose division into recognisable, consistent stages and allowed the IPPCSG to operate without members clamouring to speak or displaying any indication that they had been denied an opportunity to be heard.

The structure and rules of supervision can only influence the ethos and conduct of a peer supervision group if the agreed rules, model and contract are embedded within its operation. Models and structures as abstract concepts can be thought-provoking, but this may not be sufficient to influence the practice of supervision. The findings of this study suggest that it was the embodiment of the contract and the model in the 'doing' of group supervision and the explicit notice by IPPCSG members of that 'doing' of supervision that internalised the experience .

Building trusting relationships

The review stage of each session was an important catalyst for developing trust as it enabled group members to explicitly discuss the process of supervision. This permission to speak about what had happened and express feelings allowed members to be open and honest. The notion of trust was openly discussed and ensured that, even when negative feelings were disclosed, the IPPCSG were able to manage the process without eliciting anxiety or hostility.

The rules of supervision set out in the contract could be seen as pivotal to the development of trust as the structures, regularity and continuity of sessions afforded IPPCSG members the safety they had indicated as a requirement at the outset and may have supported the rapid relationship building which impressed the IPPCSG members.

Demonstrable commitment from IPPCSG members by being ‘there’, participating in discussion and providing thoughtful reflections and feedback, neutralised any taint of superficial or tentative engagement which could have undermined trust in the group.

In a peer supervision group, reciprocal disclosure is a key requirement of trust engendering acceptance and support (Johnson and Johnson 2013). Mutual trust and support provided this platform for group members to reveal weaknesses and mistakes and this increased the value of the supervision group to its members (Bernard & Goodyear 2014).

Emotional connectedness

The rawness of the emotional content of sessions was a matter of surprise and even shock to IPPCSG members during sessions and when reading transcripts and listening to excerpts from recordings.

In day-to-day practice nurses, occupational therapists and podiatrists are required to manage their reception of and response to ‘stimuli’ (rewards and punishers) (Rolls 2007) whether produced by interacting with or thinking about patients, colleagues or managers (Horschild 2012, Smith 1992). The array of emotional states and feelings vented during IPPCSG sessions included anger, guilt, fear, sadness, apprehension, pleasure and relief. Others have contended that this creates an unacceptable level of vulnerability for the supervisee (Gilbert 2001) or that it could resemble ‘therapy’ (Alleyne & Jumma 2007). The findings of this study suggest that the opportunity to vent these emotions and feelings, uncover their likely origin and explore ameliorating actions was a positive experience and highly valued by IPPCSG members as corroborated by Brink et al (2011).

The review stage of all IPPCSG sessions became a catalyst for the development of emotional connectedness, enabling IPPCSG members to notice and name their own and other members’ emotions and feelings. This process aligns to the principle of reflexivity in feminist supervision (Falendar 2010) and relates to the notion of reflection in action (Hawkins & Shohet 2006). The development of emotional connectedness within the IPPCSG contributed to affirmation of ‘self’ rather than the person being subsumed within the identity of ‘podiatrist’, ‘nurse’ or ‘occupational therapist’.

The findings indicated that on occasion the emotional states or feelings experienced by IPPCSG members were potentially paralyzing, undermining actions and decision-making processes.

Action research evaluation

In evaluating the action research process it is essential to pay attention to the different realities of those involved (Winter & Munn-Giddings 2001). In this study this included me, my co-inquirers (IPPCSG members) and the stakeholders. An evaluation framework was applied using seven key indicators (adapted from Koshy et al 2011, Hart & Bond 1995, Winter & Munn-Giddings 2001) to assess the performance of the action research project as depicted in Table 4

Table 4 Evaluation Framework

Being context-specific
Being participatory
Enabling learning and personal development of those involved (including the researcher)
Changing practice – even in a small way

Being future –oriented and focussed on improvement
Embedding Reflection and evaluation in the process
Outcomes should be meaningful to the participants

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Table 5 summarises feedback from the co-inquirers on how they perceived their engagement in the key stages of the study.

Table 5 Co- inquirers’ engagement in developing the IPPCSG

Set up	Laying the foundations- preliminary meetings & contract meeting
Implementation	Leading & learning- Facilitation & clinical supervision skills, shaping process, critical reflection
Feedback & evaluation	Template development, data meetings & follow up sessions reviewing transcripts listening to recordings
Maintaining & developing clinical supervision	Continuation of IPPCSG, seeding new groups, contribution to organizational development of clinical supervision

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An important aspect of action research as a context-specific methodology is to facilitate capacity building of participants and facilitate change and development, either at a personal level or within the wider organizational context (Koshy et al 2011). The transcript review process, template development meetings and evaluation by IPPCSG members identified important learning. Some key areas of capacity building and personal development demonstrated by IPPCSG members are listed here:

- ▶ Developing skills as a research participant
- ▶ Self-awareness & critical reflection
- ▶ Developing acceptance of other perspectives
- ▶ Developing confidence as supervisees, supervisors & facilitators
- ▶ Knowing what clinical supervision ‘is’
- ▶ Becoming key enablers of clinical supervision for the organization

An effective IPPCSG was developed as a result of this action research study so fulfilling the first objective for stakeholders and co-inquirers: the key outcome being the provision of a protected space for the honest critique of clinical practice. Members of the IPPCSG reported their increased confidence in doing and facilitating peer group clinical supervision and identified that their participation has developed their understanding of what ‘good’ clinical supervision feels like and what supervision is for. Group members have felt able to initiate new peer supervision groups within their own settings, including inter-professional, and one IPPCSG member contributed towards strategic discussions on the development of clinical supervision across the organization. Group

composition changed over time and the remaining IPPCSG members have been engaged in scrutinising this paper and will participate in further publications going forward.

Limitations

This context-specific action research study used a qualitative approach and as such it is not intended to claim that the findings are directly applicable to other groups or settings. In addition, my pre-existing relationship with the research site may have influenced the procedure of the study and my interpretation of the data.

There were limitations in the procedures of the study regarding methods employed, in respect of the audio-recording of sessions. This method of data collection produced rich data, however there was cause for concern on occasion for IPPCSG members in regard to confidentiality. This may have constrained IPPCSG members in sharing practice-related issues.

A limitation in the methods employed relates to the time scale over which data were collected: six months; a longer period of data collection may have seen on-going development in the supervisory relationships within the group, for example, the member who did not assume a supervisee role may have felt more able to discuss practice concerns over time.

The audio-recording of sessions was not used in conjunction with other methods such as individual interviews of IPPCSG members to uncover personal perceptions. Observer notes were used and the researcher's reflections provided different insights when analysing the data. Prolonged engagement provided the opportunity to retrieve reflections of IPPCSG members. The involvement of IPPCSG members in the development of the template coupled with their reviewing of transcripts and feedback in data review meetings provided a method of verification for the accuracy of interpretations.

Implications for practice and research

Effective peer group clinical supervision for health care practitioners can be accomplished with a relatively modest allocation of time – between four and six practitioners accessing the IPPCSG for one and a half hours each month.

This study suggests that action research is an effective methodology for clinical supervision group development. The role of the stakeholders in championing and facilitating the action research study was a crucial factor in developing and establishing the IPPCSG

The findings indicate that embedding the contract and establishing expectations before and during the process contributed to equalising the power relationships within the group and established democratic principles within supervision; perhaps the most critical feature being the rotation of the functional roles of facilitator, supervisee and supervisor. This process was an important factor in establishing a rapid and enduring mutual trust between IPPCSG members.

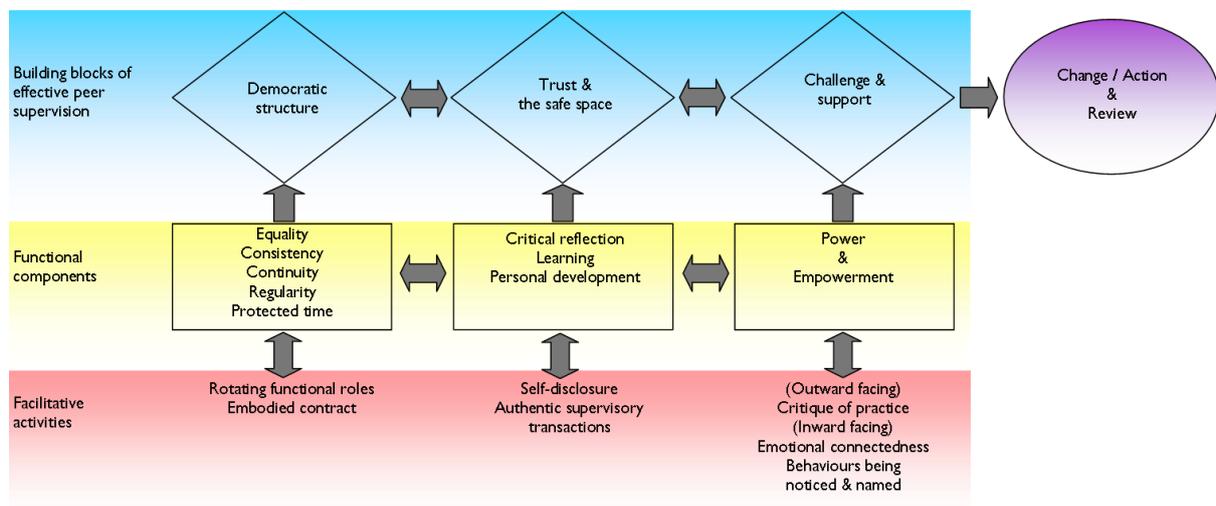
The value of the review stage in group supervision was demonstrated in enabling behaviours, emotions and skills to be noticed, for challenge and reflection to take place and for actions and outcomes to be monitored.

An important finding is that trust is conditional and in this study, one IPPCSG member chose not to take on the supervisee role citing lack of requisite technical knowledge in regard to her role and such issues should be considered when configuring IPPCSGs.

Substantial common ground between members was revealed in terms of issues shared, professional values and beliefs and experiences. Different professional identities and perspectives within this group did not impede the development of supervisory relationships. Hierarchical issues did not impinge on group relationships or undermine supervisory relationships.

The findings indicate that the safe space provided by the IPPCSG enabled work-generated emotion to be processed and managed rather than masked. Emotions relating to the process of supervision were an important aspect of the review stage of each session and those engaged in group clinical supervision should consider promoting the explicit naming and noticing of emotions relating to the supervision experience with a view to fostering the development of emotional connectedness between group members. This study suggests that failure to deal with work-generated emotion may have a paralysing effect on professional performance. A visual representation of the dynamic interaction of group behaviours and functional roles is provided in Figure 3 (Johnson 2016).

Figure 3 Interactive components that secure effective peer group supervision



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Conclusion

The IPPCSG was an effective learning space for members in developing their skills and confidence in participating in and facilitating peer group clinical reflection supervision. Having the courage to challenge each other was an indication of mutual trust and a signal of authenticity – so challenge became the antidote to collusion. In this way the IPPCSG was able to provide sufficient rigour in the scrutiny of clinical practice with IPPCSG members assuming legitimate power as co-supervisors and accepting shared responsibility.

The study demonstrated that by embodying democratic principles, two main purposes of clinical supervision; challenge and support, can be achieved in inter-professional peer group clinical supervision. The IPPCSG continued after the completion of the study.

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Appendix 1

IPPCSG contract

The group met for the first time on Wednesday 3rd October 2012 and developed the ground rules which form the contract on which the group will operate.

The group agreed that all aspects relating to work and practise are appropriate for our group clinical supervision. We decided that this includes our psychological well-being in relation to work and how we feel about work and how we are functioning.

Confidentiality

We will speak out without fear and will work to make sure we feel comfortable in sharing thoughts and concerns. What is said in the room stays in the room. This is the case apart from important professional aspects such as when situations are shared that relate to safeguarding issues for patients/service users, risks of harm to ourselves or others and where there are wider public concerns. This includes when poor practice is revealed. This does not mean that any mistake or error we share and discuss will require us to take the issue outside the group but rather that the group will discuss any issues regarding standards of practice or risk and support the group member concerned to take any appropriate action should it be required. This may mean the group member escalating the issue to a manager or other person but the group will not escalate the issue without the agreement of the group member concerned unless this person is not prepared to take any action. This will be a last resort.

Commitment

We agree to see the group through – our agreement is initially for 6 months, though we all accept there may be issues beyond our control that could get in the way eg sick leave.

We agree to make the group a priority in our workload and stay for the full 2 hours per session. We do however acknowledge the difficulties of wider work pressures.

The group agree to support individuals to take any appropriate action.

Participation

Everyone agrees to participate but no-one will be made to feel obliged to contribute in any session though it may arise that the group need to explore a situation if a member is not speaking. We will take seriously our responsibility to contribute especially when the subject relates to an area of our expertise.

Learning

We will focus on learning from each other and agree that there will be occasions when some of the learning could be beneficial to others outside the group such as ideas about practice or solutions to problems. In these circumstances the group can agree to share some learning with those outside the

group such as team members but only by the specific permission of the whole group and particularly any individual who generated the learning.

Trust & respect and being open to different perspectives

We will explore different ideas and will not attack the person presenting different views personally. We will not gang up on any individual. We will encourage each other to think about things from different perspectives and use questioning to clarify and explore situations.

Records

The group agree that each member can take notes during the session – this may be about learning or action points. In addition one person will agree to make brief notes of the session on behalf of the group, but these notes are only bullet point notes to record key themes discussed and any agreed action

Facilitator role

The facilitator role will be taken on by group members in turn and the facilitator will also be the time keeper. Another group member will make the brief notes

Dates, time & venues

Topics

The group agreed that in addition to focussing on specific issues raised by individual group members for each session we would generate a list of relevant topics that we all relate to as options for discussion.

Signed (all members)