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A guide to implementing clinical supervision



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A guide to implementing clinical supervision

INTRODUCTION

The purpose of this information paper is to provide:

- a definition of clinical supervision and an overview of its principles;
- an understanding of its benefits to patient care and relevance for continuing professional development
- guidance to support implementation of clinical supervision in the workplace and
- an addition to a series of information papers on systems to enhance patient care.

The target groups for this paper are:

- Managers, clinical governance facilitators and CPD leads/coordinators etc wishing to set up new or update existing clinical supervision systems
- Staff wishing to gain a greater understanding of the clinical supervision process

The key points covered in the paper are summarised as follows:

- Recognition of the benefits of clinical supervision as one of several support systems physiotherapists and physiotherapy assistants can use to improve services/outcomes for patients
- Understanding that recording and evaluating learning from patient experiences through clinical supervision is a valid informal learning activity which demonstrates commitment to continuing professional development (CPD)
- Principles to guide implementation of clinical supervision systems
- Practicalities to consider when implementing and evaluating clinical supervision systems
- Action plan checklist for implementing clinical supervision

CONTEXT

Clinical supervision forms part of the wider health and social care agenda concerning quality, accountability and efficacy of practice. It provides a support system for practitioners to ensure the provision of high quality treatments or services through



the evaluation of practice or services and is one method of supporting the clinical governance agenda of the government, by encouraging practitioners to learn from experiences within the workplace¹. Both the CSP² and the Health Professions Council³ consider it as an appropriate and valuable CPD activity. It is, however, recognised that practitioners will be engaged in other activities to ensure clinical effectiveness and this paper intends to highlight the principles and practicalities of clinical supervision without detracting from other systems of support such as audit, mentoring, appraisal. All staff should ideally have access to these support systems including support workers, newly qualified and senior staff. The type, content, and regularity of clinical supervision will vary depending on the role and experience of staff but the support offered by any system should be equitable to all.

Clinical supervision is also one activity which can contribute to practitioners continuing professional development, the importance of which is recognised in the NHS Plan⁴. The Chartered Society of Physiotherapy (CSP) acknowledges its members undertake a range of learning activities, both formal and informal, to support practice and these will differ as individuals progress throughout their careers⁵. The process of clinical supervision also helps practitioners to develop skills of reflection, narrowing the gap between theory and practice and enabling a deeper understanding of what it means to be an accountable professional.

WHAT IS CLINICAL SUPERVISION?

While physiotherapists are undoubtedly using what equates to clinical supervision on an informal basis, research shows that the majority of physiotherapists are unaware of what formal clinical supervision is and how it can support them in their practice⁶. Clinical supervision has its origins in psychotherapy, social care and counselling and is prevalent in nursing as a way of supporting both new and established nurse practitioners. However, its use as a support mechanism within the allied health professions is still relatively new^{7 8 9}.

Definition

Clinical supervision can be seen as a collaborative process between two or more practitioners of the same or different professions. This process should encourage the development of professional skills and enhanced quality of patient care through the implementation of an evidence-based approach to maintaining standards in practice. These standards are maintained through discussion around specific patient incidents or interventions using elements of reflection to inform the discussion.



Clinical supervision has been defined in the literature with varying degrees of detail. In the nursing literature Butterworth states it is best described as an exchange between practicing professionals about a specific patient incident or intervention¹⁰.

A further description states it is a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety of care in complex clinical situations. It is central to the process of learning and to the expansion of the scope of practice and should be seen as a means of encouraging self assessment and analytical and reflective skills¹¹.

Whilst the above present useful definitions, models of clinical supervision vary¹². No one model is recommended here as it is expected that local need and workplace type should dictate the preferred model.

What it is not

The term clinical supervision in itself has led to misunderstanding within the health and social care sector. The use of the term for physiotherapy since 1997 is in line with other health and social care professions and reflects government recommendations. To further emphasise the above definition, it is useful to clarify what clinical supervision is not.

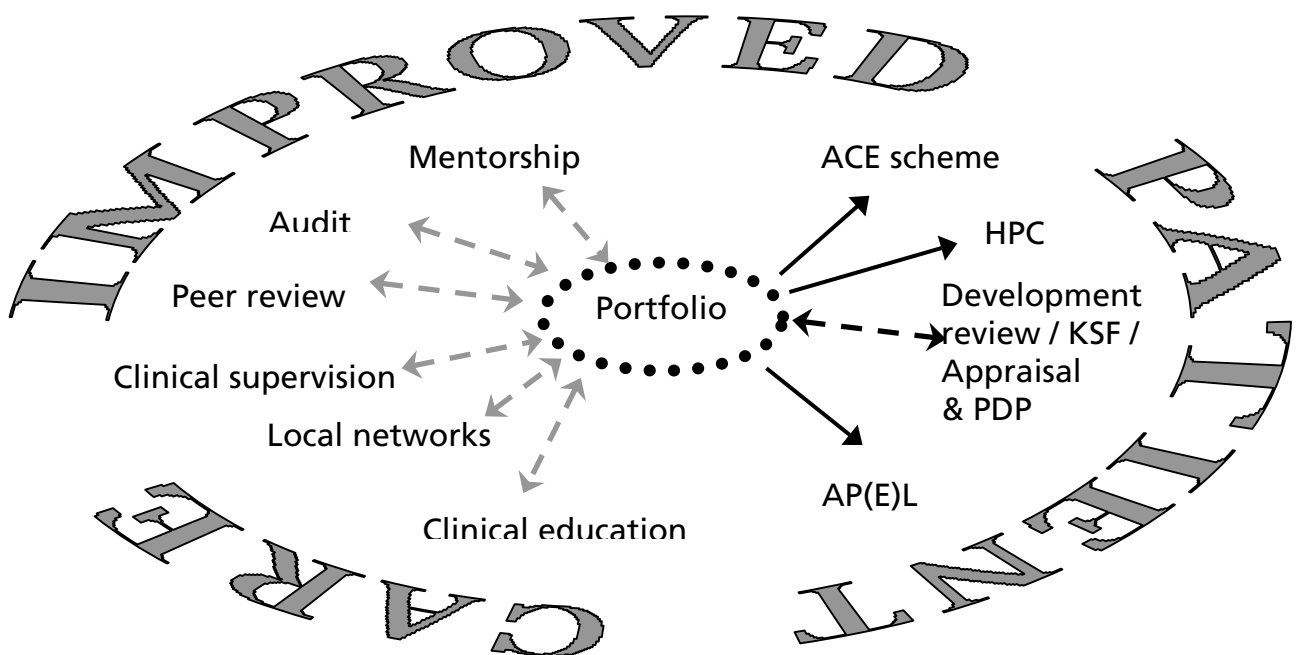
- Fieldwork/clinical education – the education and training of students on pre- and post-qualifying programmes
- Mentorship – a nurturing relationship between an experienced professional and one who usually has not progressed as far in their chosen career which involves discussion on broader personal and professional development, not specifically clinical development. Those involved are not necessarily of the same professional background
- Appraisal/development review – a formal, management-led assessment of the quality completion of set professional objectives and personal development activities. Usually done on a 6 or 12 monthly basis with additional formal reviews as deemed appropriate
- Peer review – an evaluation of the clinical reasoning about a patient episode by a peer at a similar clinical level using patient case notes to guide the discussion. Practitioners should select their own peer or peers and the process is

carried out informally. Peer review tends to have a narrower professional focus than clinical supervision

- Counselling – a therapeutic process encouraging resolution of personal, emotional issues linked to past experiences. The counsellor is not usually of the same professional background
- Preceptorship – a term predominantly used in nursing indicating the support period undertaken to support newly registered nurses

The left hand side of Figure 1 below shows how some of these systems integrate with one another. It is recognised that elements of clinical supervision will be similar to, and may overlap with, other systems of support identified above and below. It may also be the case that the outcomes of clinical supervision will identify a need for practitioners to access some of these other systems of support.

Figure 1





PRINCIPLES OF CLINICAL SUPERVISION

The success of implementing clinical supervision is dependent on creating a culture where individuals are valued and this value is demonstrated in terms of time for personal and professional development to support practice in its broadest sense. Based on a review of existing models and underpinned by the Society's approach to CPD⁵ the following principles have been developed. Local arrangements will need to take account of these guiding principles in developing systems which meet the requirements of all individuals.

Clinical supervision should be undertaken within a culture of learning and should:

Principles

1. Support and enhance practice for the benefit of patients
2. Develop skills in reflection to narrow the gap between theory and practice;
3. Involve a supervisor and practitioner or group of practitioners reflecting on and critically evaluating practice;
4. Be distinct from formal line management supervision and appraisal;
5. Be planned and systematic and conducted within agreed boundaries;
6. Be explicit about the public and confidential elements of the process;
7. Facilitate clear and unambiguous communication, conducted in an atmosphere of beneficence;
8. Define an outcomes based action plan. The outcomes could then be more broadly developed to assist the practitioner's professional development through the appraisal process;
9. Be evaluated against set standards from the time it is initially developed and implemented;

Process

10. Involve all individuals in the service, signed up to by staff and supported and resourced by management;
11. Be developed in partnership with managers and practitioners;



12. Be supported by appropriate resources (time, training, replacement staff);
13. Facilitate practitioner access to their chosen model of supervision, as appropriate;
14. Support a local system for supervisors to further develop their skills in facilitation;
15. Be developed in parallel with collating a portfolio of learning, so that the practitioner further develops skills of reflection, articulating and evidencing experiential learning.

WHY UNDERTAKE CLINICAL SUPERVISION?

Research and evaluation carried out within the allied health professions on the benefits of clinical supervision has highlighted a range of positive outcomes for all staff, irrespective of grade, length of service or occupational setting^{13 14 69}. The extent that these are felt will depend on the extent to which clinical supervision is properly implemented.

Much of what has been written about clinical supervision is anecdotal but while more research into the benefits of clinical supervision in the allied health professions needs to be carried out, audits of existing systems have highlighted positive outcomes.

Clinical supervision:

- enhances patient care
- encourages clinical effectiveness
- promotes evidence-based practice
- enhances professional knowledge
- increases analytical thinking
- develops reflective skills
- is a useful system to support continuing professional development
- increases self confidence
- enhances staff morale
- supports staff retention
- complies with government and statutory body agendas

WHO DOES IT INVOLVE?

The format of clinical supervision delivery will vary depending on the experience of staff involved but it is generally conducted between two or more practicing professionals, one of whom has a sufficiently extended level of skills, knowledge and



abilities to support the development of the other(s). This does not necessarily mean that the supervisor will be of a higher grade than the supervisee.

Clinical supervision should not be a management control of staff performance or a replacement for formal appraisal but management support is essential to ensure resources are made available to develop and maintain the system.

Provision should be made to ensure that supervisors are also supervised to enhance their own development. Implementation of a pairing system between supervisors can enhance their support network.

The following are possible scenarios for supervision:

- One-one with a supervisor from the same or different clinical setting or profession
- One-group with a supervisor from the same or different clinical setting or profession
- Peer one-one/group – where there is no hierarchy but different experiences facilitate the discussion. This is very similar to the peer review process but tends to involve a wider focus than review of patient notes, may involve peers that do not have a similar background and occurs on a more frequent basis
- Triadic – one to one supervision with a third party as observer giving feedback to both
- Network – similar to peer group supervision, but where those involved do not work together on a regular basis

The above systems can be applied to those who work alone, in remote areas or in small practices and have been shown to work well¹⁵. It is essential that practitioners who have limited access to colleagues are still able to link in to support networks, whether within their own clinical interest or occupational group, or by looking outside the physiotherapy profession.

Practitioners working single handedly may be able to collaborate with other members of their occupational group. However, where this presents a conflict of interest, it is feasible and acceptable to engage with another professional outside physiotherapy practice where this can enhance knowledge and skills. For example a physiotherapist working in craniosacral therapy could receive clinical supervision from an experienced cranial therapist. A cancer specialist may supervise a physiotherapist working in oncology and palliative care. Practitioners have also highlighted benefits from being supervised by psychotherapists and psychologists. A practitioner working in the community may need to use other means of communication than face to face contact. Clinical supervision has been carried out using telephone and email either



independently or to support infrequent face to face meetings. However, individuals should select the most appropriate support system for them. Clinical supervision is only one support system available to practitioners and others should be used where they are deemed more realistic for a particular group.

If physiotherapy practitioners engage as clinical supervisors for colleagues from another profession, they are advised to be aware of the guiding principles for the other profession's clinical supervision arrangements, as these may differ from those specified in this document.

The range of clinical supervision scenarios should be selected to suit local need and can involve more than one of those listed on page 8. The end system will depend on individual practitioner preference and organisational resources - practitioners may prefer the detailed focus of one-one, but it may prove less resource intensive to arrange one-group supervision during an existing in-service session.

Those involved in the process of clinical supervision should be aware of their individual requirements in order to make the process effective. This will require an educative approach for all to ensure they are clear about how clinical supervision can benefit patients, staff and organisations and the skills required to undertake it effectively. Detailed training on clinical supervision can be provided by internal or external trainers to facilitate this.

A clinical supervisor should be, or be able to become:

- open minded
- analytical
- trustworthy
- constructive in their feedback
- non-directive
- challenging
- clinically knowledgeable
- questioning
- active in their listening
- supportive
- self-aware

The supervisee needs to be aware of the requirements and attributes of a clinical supervisor and should mirror some of these attributes themselves. Clinical supervisees should be:



- open minded
- reflective
- trusting
- organised
- receptive to new ideas
- proactive

It is highly likely that supervisors and supervisees will already have some of these skills from existing activities they engage in as they are all highly transferable and will apply to many other CPD activities.

DEVELOPING CLINICAL SUPERVISION SYSTEMS

The following good practice guidelines have been developed from an examination of existing systems within the allied health professions, drawing on additional experience from nursing. It relates to the key guiding principles (KP) indicated on page 6 and expands on these accordingly. Elements may however be discarded if inappropriate to local systems.

Introducing the system

In order for clinical supervision to be accepted by the service, it is essential that all clinicians are involved in the process (**KP10**). A clinical supervision system implemented from the top down can be seen as another process of management control and may alienate the clinicians it is intended to support. However, although a 'bottom up' approach is recommended, it must have the support of management as this level will be responsible for allocating resources to support the system and for assessing the impact of clinical supervision on the service (**KP12**). Therefore the development and establishment of clinical supervision should involve both managers and staff (**KP11**).

Sufficient time should be given to introduce a system that all staff will see as a high priority (**KP12**). Ensure a clear and realistic timeframe is set to introduce, deliver and evaluate formal clinical supervision. Depending on the size and complexity of the organisation, a small pilot could be carried out as part of the planning stage before rolling out clinical supervision to the rest of the organisation/department. In addition to time spent on the process of implementing clinical supervision, practitioners' time away from patients during sessions adds pressure to their involvement in the system. It is essential that both staff and management recognise and accept that time is well spent in clinical supervision. The CSP recommends that a minimum of half a day per month should be allocated to personal learning time and clinical supervision as an informal CPD activity can be allocated time from this¹⁶. It may also be worthwhile



supplementing existing in-service sessions for clinical supervision sessions when appropriate.

It is recommended that an initial stage of knowledge gathering and awareness raising is carried out. This will ensure that staff are aware of the aims and benefits of clinical supervision and buy into the concept (**KP10**). The key principles of clinical supervision must be emphasised. This can be done by informal talks to staff, provision of reading materials, a 'taster' of clinical supervision itself or undertaking a training course. This should be supported by further training by internal or external providers, if clinical supervision is implemented.

Justification for the implementation of clinical supervision should focus on:

- the current political agenda, highlighting links with clinical governance, evidence based practice, continuing professional development and quality assurance;
- the professional agenda, highlighting links to the CSP Standards of Physiotherapy Practice and the Rules and Code of Conduct and;
- the organisational agenda, highlighting the benefits linked to appraisal, corporate objectives, service delivery and competence.

Whilst best practice literature indicates that clinical supervisees select their supervisor rather than having a supervisor appointed to them, this is unrealistic in the vast majority of cases. To ensure supervisees' involvement and buy-in to the clinical supervision process, however, any concerns the supervisee may have about a supervisor, and vice versa, should be addressed before supervision sessions commence.

In order to strengthen staff acceptance of clinical supervision, clinical supervision systems should avoid mirroring existing line management roles of reviewing workload and appraisal objectives (**KP4**). However, this does not mean that line managers are unable to clinically supervise a member of their staff. In these instances, however, clear boundaries must be set to avoid confusion between the two relationships and additional training may need to be provided in this area. Again it is worth emphasising that clinical supervision is not a replacement of the appraisal process, but outcomes of clinical supervision sessions can be fed back into the appraisal process to support staff development.

It is essential that preparation of supervisors and supervisees is done thoroughly as clinical supervision is not an innate skill: it has to be learnt (WMCSLS 1999). Initial training on the principles of clinical supervision can be developed in house or provided by an external training provider. Some detailed elements of training



around facilitation (**KP14**) may only be necessary for clinical supervisors, but all stakeholders should have an understanding of the following:

- various models of clinical supervision
- various scenarios of clinical supervision i.e. one-one/group supervision
- roles and responsibilities of clinical supervisors and supervisees including key skills of each
- techniques of reflective practice
- ethical and legal issues
- administration of sessions i.e. setting up and ending of relationship, delivery, recording and evaluation of sessions and auditing of overall scheme

As much of the clinical supervision process relies on the ability of supervisees and supervisors to reflect on practice, additional training and support may be needed to develop reflective skills (**KP2 & 3**). Reflection is a key element of clinical supervision as it is the method which enables learning at a subconscious level to be brought to a level where it is articulated and shared with others. This process occurs every time a practitioner interacts with a patient and this interaction should be recognised as a learning opportunity¹⁷. Reflective practice is seen as a key facet of CPD and it underpins a range of activities such as peer review and mentoring, as well as the clinical reasoning process. Improving reflective skills whether as part of clinical supervision or not is seen as essential¹⁸.

The CSP has produced materials to support reflective practice which are available in Developing a portfolio: a guide for CSP members¹⁹ and an information paper on workplace learning¹⁷ and workshops on this theme. Higher education institutions and other training providers should also be approached to support staff in developing reflective practice skills.

In addition to several in-house training programmes on clinical supervision, the Open University and the West Midlands Learning Set^{20 21} have both developed resources to support the implementation of clinical supervision through the training of all staff (**KP12 & 14**). Again, higher education institutions and other training providers may be able to provide guidance on training.

Commencing the clinical supervision sessions

Each supervision relationship should be formalised using a straightforward contract that sets out clear rules and procedures for supervision sessions. This should be done during the first supervision session and clarifies a range of issues before supervision



commences properly. Contracts can include the following information (**KP5, 6, 7, 8, 13**):

- average duration & frequency of session
- review date of relationship
- type of model and scenario
- support materials – practice journal, case notes review, results of measuring outcomes, effects of implementing national or local clinical guidelines, results of patient feedback, reflective statements, joint patient assessment etc
- statement around public and confidential elements of the session including an explanation of legal/ethical responsibilities
- role and responsibility of clinical supervisor and supervisee
- record keeping and related issues
- reasons for and process of terminating relationship

Clinical supervision relationships should engender integrity and trust between those involved and there should be clear guidelines about which elements of sessions are public and which are confidential (**KP6 & 7**). The process of clinical supervision, for example regularity and duration of sessions, type of sessions, reasons for cancellation, will form part of the public evaluation process of the clinical supervision system. Records of the session kept by the clinical supervisee which document learning outcomes, future learning needs and possible changes to practice are beneficial for the supervisee to keep in a portfolio. These are also useful for supervisors and line managers to have to highlight staff professional development needs, for example as part of the appraisal process. It is not expected however that general discussions which take place within the session will be shared with other colleagues outside unless expressly agreed between supervisors and supervisees at the start of the process.

Conflict may arise in the unlikely event that issues come to light in clinical supervision sessions which violate Rule 5 of the Rules of Professional Conduct²² and these should be reported outside the clinical supervision relationship, in line with internal and professional misconduct reporting guidelines. It should also be recognised that the clinical supervisor has a duty of care to the clinical supervisee and harm to a patient as a direct result of clinical supervisor advice will impact on the clinical supervisor.

It is essential that both the supervisor and supervisee prepare sufficiently before a session. As organisation of the session tends to be the responsibility of the supervisee, the emphasis is on them to consider what they wish to focus on - preparing specific questions prior to the session will help to focus thinking and reflection. To avoid demotivation within sessions, they should consider the context they work in and avoid discussing issues that cannot be influenced by any party.



The format of the session will generally involve presentation of a clinical issue or patient case by the supervisee followed by discussion and feedback from the supervisor. The supervisor may use questioning to aid the supervisees reflection and encourage them to reach new conclusions, the supervisor may demonstrate a particular treatment for a given situation or draw attention to a particular guideline or outcome measure and may suggest further information gathering through reading.

It is essential that an outcomes-based action plan is agreed at the end of each session. It is recommended that the supervisee records the learning outcomes and action plan from the session. A detailed description of discussion is not necessary but writing down elements of the session will formalise learning and encourage action to be taken forward (**KP8**) into practice to improve future patient outcomes (**KP1**).

Reflective skills developed within the supervision session can and should be used between sessions to extract learning from day to day practice. Learning recorded both during and outside of the clinical supervision session should be stored in a portfolio of learning as evidence of the individual's ability to critically evaluate and improve on practice (**KP15**).

Evaluating clinical supervision

In order for clinical supervision to be seen as an effective process, an audit of the system must be carried out (KP9). Assuring staff and management of the benefits of the system will safeguard its continuation. Potential audit markers are:

- safer clinical practice
- better assessment of patient/client
- improved patient satisfaction surveys
- reduced untoward incidents & complaints
- greater staff awareness of accountability
- better targeting of professional & educational development
- improved delegation
- increased innovation
- improved reflective skills
- reduced staff sickness
- improved staff retention
- better input into management appraisal systems



In addition to evaluating the above, it is also essential to evaluate the process – planning, implementation and evaluation systems and documentation. The CSP Standards of Physiotherapy Practice² provides a framework and a range of tools by which members can measure and monitor the performance of their service.

All those involved in the clinical supervision process should complete an evaluation tool to assess its impact on the individual. Whilst there are several forms this might take (interview, workshop, questionnaire), the clinical supervisee and supervisor should be asked whether clinical supervision:

- improves clinical practice
- effectively challenges working practice
- encourages planning of learning
- contributes to clinical development
- increases awareness of new areas of professional knowledge
- aids reflection on strengths/weaknesses
- assists in managing stress at work
- improves self confidence
- facilitates team working

(Taken from South Hams and West Devon PCT & Plymouth PCT Clinical Supervision feedback form 2003)

An audit of the process of clinical supervision can involve gathering information from clinical supervision contracts and clinical supervision logs. These may produce material on the types of models being used, pros and cons of support materials, frequency and duration of meetings, and reasons for cancellation of meetings. Using this data can assess if the process is working well.

A national survey of comparable clinical supervision and mentorship systems for nurses²³ concluded that employers should recognise and capitalise on the benefits of clinical supervision and mentorship as it will form part of a human resource strategy that facilitates recruitment, retention and CPD. A similar survey would be welcomed within physiotherapy to assess whether the benefits are transferable across the healthcare professions.

SUMMARY

Clinical supervision is promoted by the CSP as one of a range of systems that can support its members in critically evaluating practice to meet the demands of clinical governance and provide evidence of CPD. There are several systems of clinical supervision already in place throughout the UK but to date there has been only a limited evaluation of these. Further evaluation and audit of existing systems is



recommended and the Society would welcome feedback from these to inform current principles and processes around clinical supervision. This information should be sent to: Sarah Fellows, CPD Adviser, CPD Unit, Chartered Society of Physiotherapy, 14 Bedford Row, London WC1R 4ED. Tel: 020 7314 7820 Fax: 020 7314 7855 Email: fellowss@csp.org.uk



APPENDIX 1 - CLINICAL SUPERVISION ACTION PLAN

The following provides a useful checklist for organisations implementing clinical supervision systems. Those involved in managing the process should consider whether all steps are essential and tailor their workplan accordingly.

Stage	Action	Date achieved
Planning	Informal agreement is given by management on implementation of a clinical supervision process	
	A clinical supervision lead (individual or group) is appointed to work on implementing the scheme	
	Understanding of and interest in clinical supervision is assessed among all staff (group workshop, questionnaire) to assist with future planning and training	
	Presentation of findings to management including: <ul style="list-style-type: none"> ▪ resource implications for implementing clinical supervision ▪ expected outcomes for staff, organisation and service delivery Management commitment to implementation is required before moving to next stage	
	Development of evaluation mechanism to gauge how effective clinical supervision will be: <ul style="list-style-type: none"> ▪ what are the anticipated outcomes for staff, the service, patients? 	
Set up	Presentation made to all staff on generic issues around clinical supervision: <ul style="list-style-type: none"> ▪ definition, purpose, roles and responsibilities, process, outcomes 	
	Clinical supervisor volunteers are requested for training – open to all appropriate staff	
	Training given to clinical supervisors on required skills, knowledge and abilities	
	Relevant documentation is created to support the system i.e. generic contracts, session records, action plans	
	All staff have access to a clinical supervisor	
Clinical supervision sessions commence		



	Follow-up training/support provided by lead as appropriate	
Evaluation	Evaluation with all staff carried out at previously agreed review date: <ul style="list-style-type: none">▪ individuals development and benefits evaluated▪ process of implementing and executing system evaluated	
	Review and improve documentation as appropriate	
	Present evaluation report to management and make recommendations for continuation of/alteration to system accordingly	



APPENDIX 2 - GLOSSARY OF TERMS

Accredited Clinical Educator (ACE) scheme

The term to be used by qualified CSP members who have achieved the Society's recognition of their professional status as work place educators, e.g. with pre- and post-qualifying physiotherapy students, junior staff, assistants, carers, patients and other health care professional learners

Accreditation of prior experiential learning (APEL)

A process of quantifying and qualifying informal learning in order to gain academic credit from an academic institution

Audit

A way of measuring the quality of healthcare provided by a service: performance is benchmarked against pre-set standards; changes where needed are then effected to provide care in keeping with that standard.

Clinical effectiveness

The provision of high quality treatments or services in a way that allows the recipient(s) to achieve the maximum health gain. This will include the provision of interventions/services that are known to be effective (evidence-based practice), and providing those services within a system that allows the recipient to benefit to the maximum

Clinical governance

Framework for NHS organisations to demonstrate accountability and to continuously improve the quality of their services and safeguard high standards of care by creating an environment in which excellence in clinical care will flourish.

Continuing Professional Development (CPD)

Ongoing learning by which individuals maintain, enhance and broaden their professional knowledge, understanding and skills.

Evaluation

A process of assessing and analysing to determine whether outcomes have been met in order to identify areas of development.

Knowledge and Skills Framework (KSF)



A development tool, also linked to pay progression, whereby an individual would need to apply the knowledge and skills in a number of dimensions to achieve the expectations of their job. Refer to www.doh.gov.uk/agendaforchange/index.htm

Learning outcome

An explicit statement of achievement about what a person knows or can do as a result of undertaking formal or informal learning.

Learning need

An gap in skills, knowledge or abilities that must be filled to allow an individual to meet a particular objective

Personal Development Plan (PDP)

A formal record of learning objectives normally derived from the individual performance review or appraisal process.

Portfolio

A private collection of evidence that demonstrates learning and development as well as a tool for planning and evaluating future learning.

Reflective Practice

Professional activity in which the practitioner thinks critically about their practice and as a result may modify their practice and/or modify their learning needs.



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