CLINICAL SUPERVISION: A BRIEF OVERVIEW

Looking through the practice & educational literature, there is no single definition of clinical supervision, but one that is often cited within healthcare (comes from a nursing perspective) that seems to capture the purpose of the supervisory relationship comes from Butterworth & Faugier (1993)

'An exchange between practising professionals to enable the development of professional skills'

This is a useful definition because of how it aligns with an outcomes-based approach to CPD which is consistent with the HCPC's expectations of registrants, & the CSP's expectations of its members.

Implementation of this model of clinical supervision can sometimes cause tension in practice – because of the link between clinical supervision & clinical governance. If clinical supervision is directly linked to clinical governance, questions need to be asked about the supervisory relationship: is clinical supervision in place to facilitate/enhance individuals' learning & development? or is it about enabling the organisation to evaluate the competencies of individual members of staff?

There is no right or wrong here. What's important is that the supervisor & supervisee both know what clinical supervision is doing – because that will influence how the supervisory process & relationship are managed.

Some of the more recent literature around models of supervision is helpful in taking the idea of supervision as an (empowering/enabling) relationship between 2 people to one that takes account of/acknowledges the organisational context in which that supervisory relationship is happening. It then becomes possible to critically evaluate how clinical supervision can enhance outcomes (at an individual & organisational level) as well as how organisational cultures/practices can limit/enhance that development.

Clinical supervision in practice

On a practical note, it would wise be to explore what staff want from 'clinical supervision' (what are the outcomes) & to consider how that aligns with organisational requirements. If they are vastly different, you would then need to start evaluating the relative benefits of different approaches - & how it might be possible to develop a model of supervision that meets staff's expectations of supervision that also enables a department/service to meet organisational targets/demands & governance (e.g. how might your model of supervision enhance client outcomes, staff recruitment/retention, productivity etc). It would also be advisable to support your argument with reference to professional expectations e.g. HCPC's standards of conduct, performance & ethics, & CSP's Code of professional values & behaviours etc.

Based on a review of existing models and underpinned by the Society's approach to CPD, CSP has drafted a set of prompts to help members develop systems of clinical supervision with meet the requirements of all individuals.

Principles.
Clinical supervision should:
1. Support & enhance practice for the benefit of patients/service users
2. Develop skills in reflection to narrow the gap between theory & practice
3. Involve a supervisor & practitioner or group of practitioners reflecting on & critically evaluating practice
4. Be distinct from formal line management supervision & appraisal
5. Be planned & systematic & conducted within agreed boundaries
6. Be explicit about the public & confidential elements of the process
7. Facilitate clear & 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 & implemented

The clinical supervision process should:
10. Involve all individuals in the service, signed up to by staff & supported & resourced by management
11. Be developed in partnership with managers & 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 is supported to develop & demonstrate skills of reflection & evidencing learning from experience.

Additional resources:
DoH (2010) Preceptorship framework for newly registered midwives, nurses & AHPs

CSP's Physiotherapy Framework defines & describes the behaviours, knowledge & skills used by the physiotherapy workforce – at 6 levels of practice. Its content might be helpful for thinking about the nature of/requirements for clinical supervision at different levels of practice as well as the behaviours/knowledge/skills gained through supervision. Click **here** to access a workbook based on the CSP Physiotherapy Framework domains/descriptors from the CSP's website.

February 2017