Position Paper

The Provision of Clinical Placements: Stakeholder Roles & Responsibilities

March 2003

Position Paper – 2003

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Introduction

1. It is essential that the profession continues to attract and retain those individuals committed to achieving excellence in speech and language therapy; and that their experiences as students equip them to be 'fit for purpose' in the delivery of effective speech and language therapy care.

2. Clinical placements provide the opportunity for students to develop clinical awareness and the skills of reflection and self-evaluation, together with the opportunity to develop interpersonal skills with both clients and colleagues. In addition, clinical teaching aims to clarify the role of the speech and language therapist in the different settings in which a service is provided. It also provides experience of related health care and educational provision, day-to-day administration in speech and language therapy settings, and wider organisational and management issues. The organisation of clinical placements during a qualifying course is therefore a crucial element in the preparation of a competent clinician.

3. There is currently significant pressure on networks of established placements due to government initiatives, such as the NHS Plan (DoH, 2000) targets for increased training commissions in the allied health professions, and service requirements. This means that there is an urgent need for the profession to tackle persistent shortages in the provision of clinical placements.

4. A perception can exist in services that there are too few staff to cope adequately with student placements. Heavy caseloads, vacant posts and the needs of newly qualified therapists who require time and support from colleagues, contribute to the concern that offering clinical placements may detract from client care. However, many of these issues are surmountable given new innovative models of clinical placements and effective partnership working between stakeholders.

5. This paper explores the expected roles and responsibilities of the stakeholders involved in student training in relation to the provision of clinical placements, e.g.: Royal College of Speech and Language Therapists (RCSLT); speech and language therapy (SLT) service managers; higher education institutions (HEIs); individual therapists; pre-registration course commissioners; and students.

6. The guidelines were drawn together by RCSLT's Management Board and Academic Board, in conjunction with the Committee of Representatives of Education in SLT (CREST) as a means of encouraging the provision of clinical placements in the UK.

Royal College of Speech & Language Therapists

7. RCSLT's key responsibilities are to set out a framework for the provision of clinical placements, and to acknowledge and promote the importance of taking students for the benefit of the whole profession.

8. The *Joint RCSLT/Health Professions Council (HPC) Guidelines on the Accreditation of Courses Leading to a Qualification in Speech & Language Therapy* (2002) state that the minimum amount of clinical experience required by students within a qualifying programme is 150 sessions. A definition of appropriate clinical experience is also provided (see Appendix 1). RCSLT/HPC joint accreditation visits to qualifying programmes include a review of the timing, length and assessment of placements and the level of tutor/supervisor support for all students undertaking clinical practice. Through this process, RCSLT also encourages and supports the development of partnerships between HEIs and services.

9. The Code of Ethics and Professional Conduct states that therapists have a duty to ensure adequate supervision of students. *Communicating Quality 2* (RCSLT, 1996) also provides guidelines on good practice in clinical placements in relation to the clinician's responsibilities, the student's responsibilities and the HEI's responsibilities.

10. RCSLT highlights the importance of services taking students on placement through the standards of the professional accreditation scheme '*Signed up to Quality*'. This scheme seeks to establish whether a service is committed to training the workforce of the future and if there is a clear policy on the management of student placements within the department.

11. Students help develop a therapist's reflective practice. Such activity continues to be recognised by the professional body as contributing to a therapist's continuing professional development and may be recorded on the RCSLT personal log as part of the annual CPD requirement for re-registration.

SLT Service Managers

12. As part of recruitment and retention within the profession, the manager's role encompasses the encouragement, facilitation and provision of clinical training for SLT students. Service managers therefore hold responsibility for ensuring:

- That there is a clear policy on the management of student placements in the service;
- Student placements are regularly arranged and managed in the service;
- The importance of taking students and their development is promoted;
- The role of SLTs as clinical supervisors[1] is reflected in job descriptions;
- The service has developed explicit links with at least one HEI and pre-registration course commissioning body (e.g. a workforce development confederation);
- A service commitment is made to provide a minimum number of student placements over a period of time (e.g. 5 years, or the duration of an HEI's contract with the workforce development confederation);
- An identified member of staff takes responsibility for student placements; including communication, liaison and feedback to the HEI and clinical teaching team;
- The service works in partnership with the HEI to ensure that clinical supervisors are supported;
- Regional managers' groups include representatives from HEIs;
- Lines of responsibility and insurance issues are clear to all parties, especially in relation to placements in education and social care settings (bearing in mind that students do not have professional indemnity insurance and that the duty of care rests with the supervising clinician);
- HEIs are informed of the level of police checking required by the service, together with the occupational health arrangements;
- Student issues are a standing item on the agenda at staff meetings;
- The service responds to the evaluation of the student's learning experience;
- Students are provided with an induction to the service;
- The service promotes speech and language therapy as a career.

13. A commitment to students by services is not stated, for example, in terms of a minimum number of sessions, as this can vary from region to region and in relation to how closely a service is involved with local HEIs. A survey of clinical placements offered over a clinical year within a particular region (Gascoigne and Parker, 2001) demonstrates some excellent, good and poor examples of clinical placement provision by services in the London region (see Appendix 2). It is suggested that services aspire to a level of provision somewhere between the good and excellent levels identified in the study.

[1] Clinical supervisors are defined as clinicians supervising students while on clinical placement.

Statistics should also be kept by HEIs and services on the level of clinical placements being provided.

Higher Education Institutions

14. HEIs have a responsibility to promote, develop and improve links with local managers and pre-registration course commissioners in order to ensure the provision of sufficient clinical placements.

15. HEIs should continue to build on current good practice and relationships between themselves and local clinicians. Arrangements will include training courses on clinical supervision (developed and provided in cooperation with local managers); provision of information on assessment methods, structures and responsibilities; access for clinicians to university seminar programmes and library facilities; and input from clinicians to revisions of the qualifying programme.

16. Clinical placement co-ordinators/facilitators at the HEIs should be readily available to clinical supervisors and regularly liaise with services to develop partnership working.

SLT Service Managers and HEIs

17. It is the joint responsibility of the HEI and service providing a placement to ensure that clinical supervisors are prepared for their role so they can confidently facilitate student learning through supervision and assessment. HEIs should be able to assure themselves that clinical supervisors know what their responsibilities are during the period of placement learning, e.g. the provision of learning opportunities; their role in the assessment of students; and the health and safety of students.

18. HEIs should define students' own responsibilities and rights for their clinical education, and ensure they are provided with appropriate guidance and support in preparation for, during and after their placements. It is essential from the outset of their course that students have a clear understanding of how their clinical experiences relate to the rest of their education. Students should understand how their placements are planned and their value in terms of assessment.

19. It is expected that all placement providers will organise placements for students that are of acceptable quality. To help meet this objective, a set of Clinical Education Placement Standards (CPCG, 2002) has been drawn up by placement co-ordinators from the HEIs (see Appendix 3). This self-assessment system is intended to be used as a working document, allowing placement providers to monitor their own performance, and to give pointers for future development.

20. There should be a creative collaboration between HEIs and clinical placement providers to promote and provide a diversity of placements (e.g.

individual/paired/team) at a local and national level, and to build on different models of student learning. This might include alternative ways of providing both student placements and therapy for clients such as:

- HEI in-house clinics;
- Facilitating placements in education, social care and independent settings;
- Developing outreach clinics;
- Setting up and evaluating innovative work, and sharing this information locally and nationally;
- Exploring how more clinical placements can be utilised outside of the immediate HEI catchment area;
- Joint appointments between the NHS and HEI (posts involve co-ordinating existing placements and developing new placements, supporting supervisors and students).

Individual Therapists

21. Speech and language therapists should commit to taking students two years post-qualification or after one year, providing appropriate ongoing support is available from either their own service and/or the HEI. For therapists employed in posts Band 2 and above, renumeration for the supervision of students on clinical placement is incorporated into their salary scales. College therefore expects members to take on this responsibility for assuring the future of the profession and the provision of services.

Independent Therapists

22. Independent therapists should be recognised as a source of provision of placements for students. Members of the Association of Speech and Language Therapists in Independent Practice (ASLTIP) will all have had over two years clinical experience and be appropriately qualified. HEIs and local NHS services should therefore be prepared to offer both development opportunities and ongoing support to independent practitioners in the role of clinical supervisors. Independent therapists should not be expected to provide accommodation or transport (although some may offer these).

Pre-registration Course Commissioners

23. Pre-registration course commissioners across the UK should consult with service managers and HEIs to ensure that clinical placements are available for students and that, if necessary, funding is available for both travel and accommodation to ensure that the most appropriate placements can be utilised. They should also consider how patterns and processes of commissioning affect clinical placement providers.

24. Managers should identify through local contacts what arrangements are in place for the performance management of Trust CEO's (e.g. by Strategic

Health Authorities in England) in supporting education and training through the provision of clinical placements.

Students

24. Students should be aware of their responsibilities for managing their learning and professional relationships, and for alerting the clinical supervisor and HEI to any problems with the placement that might prevent progress or satisfactory completion of the placement. They should also understand that the priority for a clinician is the client.

References:

Clinical Education Placement Standards. SLT Clinical Placement Co-ordinators Group Working Party, July 2002

Communicating Quality 2: Professional Standards for Speech & Language Therapists (RCSLT, 1996)

Code of practice for the assurance of academic quality and standards in higher education: Section 9: Placement learning (Quality Assurance Agency, 2001)

Gascoigne, M and Parker, A, 2001, All Placements Great and Small: An Analysis of Clinical Placement Offers Made by SLT services. *International Journal of Language and Communication Disorders*, **36**, 144-149

*Joint Accreditation Committee of the Health Professions Council and Royal College of Speech & Language Therapists: Guidelines on the Accreditation of Courses Leading to a Qualification in Speech & Language Thera*py (RCSLT, Revised May 2002)

NHS Plan (DH, 2000) [www.doh.gov.uk/nhsplan]

Report of the RCSLT Education Policy Review Forum: Education for Practice II (RCSLT, 2000)

Police Checking

Guidance on Criminal Records Bureau (England & Wales) checks by NHS bodies can be located on the Department of Health website. The guidance covers the circumstances in which checks should be made, the appropriate level of disclosure, and checks on students and health care trainees [www.doh.gov.uk/crb]. See also information on Disclosure Scotland [www.disclosurescotland.co.uk].

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APPENDIX 1

Annex 4 of the Joint Accreditation Committee of the Health Professions Council and RCSLT Guidelines on the Accreditation of Courses Leading to a Qualification in Speech & Language Therapy

Definition of Acceptable Clinical Experience

This Annex clarifies the Joint Accreditation Committee's interpretation of the phrase 'tutored clinical experience' as laid down in paragraph 19 of the accreditation guidelines.

Amount of clinical experience
The minimum amount of clinical experience required within courses leading to a qualification in speech and language therapy is 150 sessions.

Clinic-based experience
Of these 150 sessions a minimum of 100 should be under the direct supervision of a qualified speech and language therapist and reflect diversity of clients by age, aetiology, and complexity; as well as diversity of clinical settings and methods of intervention. The remaining 50 sessions may be clinically related.

The supervising clinician will normally have a minimum of two years' post-qualification work experience and be a registered member of the Royal College of Speech & Language Therapists

Clinical settings are defined as any setting where speech and language therapy services are delivered (see *Communicating Quality*: Service Locations). Students should normally have experience of working in a range of different clinical settings.

Non-clinic based experience
It is recognised that clinical and professional skills may be developed outside speech and language therapy service delivery through a range of experiences. The following is a list of acceptable experiences for developing these skills:

Related experience: for example, placements in and visits to nurseries, playgroups, schools, residences for the elderly, services for adults with learning disabilities, hospitals, support groups; sessions with other professionals (e.g. physiotherapists, occupational therapists, health visitors, GPs, educational psychologists, etc).

Focused clinical teaching: discussions of videos of clients, students and clinicians; 'master' classes; simulations and role-play; case presentations; tutorial discussions; clinical seminars; client/carer interview workshops; guided practice with clinical resources; videoed discussions.

Student-directed learning: interactive videos; case-based workbooks; client/case studies; student-directed seminars; peer tutoring; video/audio analyses.

APPENDIX 2

ALL PLACEMENTS GREAT AND SMALL: AN ANALYSIS OF CLINICAL PLACEMENT OFFERS MADE BY SLT SERVICES

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This paper will present the results of a survey of clinical placement offers for one academic year in one particular region. The data presented confirm that there are issues of shortfall and inconsistency across speech and language therapy (SLT) service providers within this region. This information has been analysed in a variety of ways and presented to SLT managers within the region and the lead NHS Consortium responsible for purchasing SLT training, in the context of a 'Workforce Cycle'. Suggestions will be made as to possible ways forward using these data.

Introduction

Securing clinical placements for student speech and language therapists has become an increasing challenge for Universities throughout the UK. However, whilst those in the Universities responsible for the clinical education programme have shared their anecdotal evidence concerning this issue, to date, there have been no published data available regarding the extent of the issue and its implications.

This paper presents the results of a survey of clinical placement offers in one region of England for one year, in the context of wider issues of educational philosophy and management. The power of the survey is enhanced by the fact that it is a result of collaboration between City University and University College London, the two universities seeking clinical placements in this particular region. This collaboration has allowed a clear picture to be formed as to where clinical placement offers are made and where they are not. Furthermore, the use of the 'Workforce Cycle' has provided a representation of the shared responsibility of the SLT profession in relation to student training.

Collaboration - partnership for placements

The two Universities involved in this study have developed a partnership model in relation to clinical placements for a number of reasons. These include the following:

- A desire to work collaboratively
- To prevent unhelpful competition in securing clinical placements in the same geographical area
- To make it easier for SLT services to make offers by having common central systems

- To continue and improve relationships with SLT services using resources of both Universities to provide Supervision Skills Workshops
- To establish a basis from which to promote innovative practice in clinical education

The partnership between two different Universities was possible partly due to the personal commitment of the individuals concerned, but also because of some shared values and philosophies in respect of clinical education. Among the shared philosophies was the acknowledgement of the limitations of a technocratic model of student learning (Bines and Watson 1992) and a view that diversity rather than uniformity in clinical experience is an ideal to be promoted. This view is underpinned by the belief that student clinical education is on a continuum with continuing professional development. As such, the key goal for a student speech and language therapist is to be able to apply knowledge and skills gained in one setting to a new and unfamiliar setting. A qualifying SLT should therefore be assessed on the basis of what they are capable of doing and not merely what they have had the opportunity to experience directly in clinical placements. A further strength of this partnership is that this common view is held in the context of two different curricular structures in each University. The programme of 20 jointly run Supervision Skills Workshops during the academic year that is the focus of this paper allowed approximately 400 SLTs to access support for their skills in supervising and managing student SLTs in clinical settings. This training was offered free of charge to SLTs who were currently offering or intending to offer placements to students from the two Universities.

Workforce Cycle

Traditionally service management and workforce planning have been seen as separate entities from SLT education including clinical placements, however, the cycle represented in Figure 1 suggests how these are integrally linked.

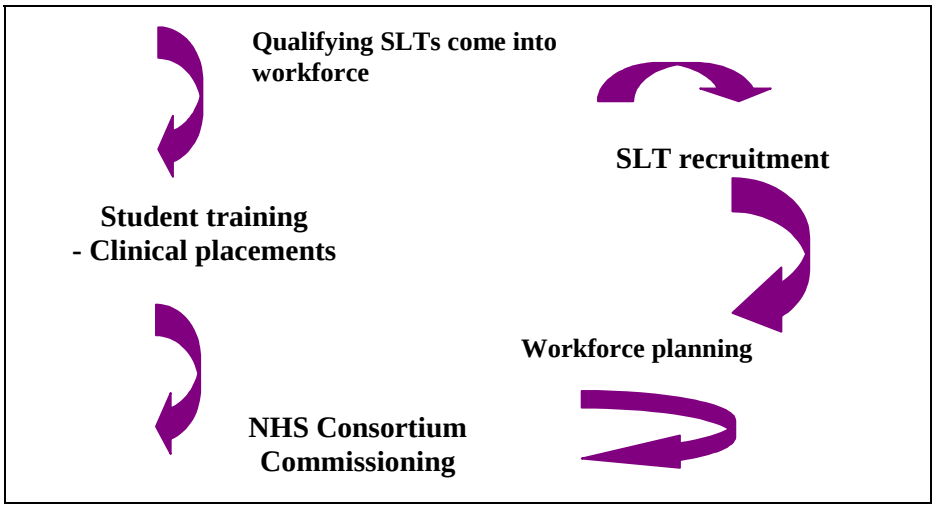

Figure 1. Workforce cycle

Recruitment and retention within the SLT profession is a growing concern (Rossiter 2000). SLT managers report difficulty in recruiting to posts across a range of grades and client groups. As a consequence, workforce-planning consultants are recommending increases in the number of student training places commissioned by the NHS Consortia. This comes at a time when the NHS Plan (Department of Health 2000) outlines plans to significantly increase the numbers of therapists entering the health professions including speech and language

therapy, adding yet another driving force towards increasing the number of commissioned training places. Both the Universities reported in this paper have been approached to increase the numbers of SLT students in this and future cohorts. However, whilst it may be possible to accommodate additional students in lectures, the shortfall in clinical placement offers has been the primary factor causing resistance to increasing student numbers. This in turn will result in fewer qualifying SLTs than might otherwise have been the case and so the cycle is complete.

Clinical placements offers 1999/2000

The two Universities jointly require approximately 30,000 placement sessions per academic year (where a session is equivalent to half a day or approximately 3.2 hours). The Universities operate clinical training programmes which fulfil the Royal College of Speech and Language Therapists guidelines for the award of a Licence to Practise. However, each programme has its own configuration linking to the specific curricula of each university.

An annual request for placement offers for the following academic year takes place in the Spring in which a joint information pack is circulated to managers and placement co-ordinators of services providing speech and language therapy in London and the South East of England. A common offer form is used which a speech and language therapist making an offer returns to the appropriate university. A clearing-house system is in operation for placement offers where there is no preferred university indicated and for the rare occasions when a preferred university is unable to make use of a specific offer. Typically, fewer than 50% of the 30,000 sessions required are secured via the annual request for placements.

Offers per SLT service

Inspection of the data in Figure 2 immediately raises some interesting points. All of the SLT services had staff in post. The total number of sessions offered was 14592 which equates to 49% of the total required by both Universities. Nine of the services offered no clinical placements to either University. One service offered in excess of 4000 clinical sessions in the same academic year. The average (arithmetical mean) number of sessions offered per service was 347.

Offers as a ratio to whole time equivalent staff in post

Through collaboration with the lead NHS Consortium for SLT pre-registration courses, workforce planning data were obtained for these London Region SLT services which enabled conversion of the raw data for sessions offered to a ratio showing the number of placement sessions per whole-time-equivalent therapist in post. These ratios are presented in Figure 3.

Inspection of these data reveals a slightly different picture. There continues to be considerable variability in the range of ratios (from 0 to 86 sessions per w.t.e SLT). Only eleven services offer more than 20 sessions per academic year per whole time equivalent SLT. This means that in 75% of SLT services in this region, each SLT offers less than the equivalent of a 20-session placement which typically is realised as either one day per week for one academic term or a two-week block.

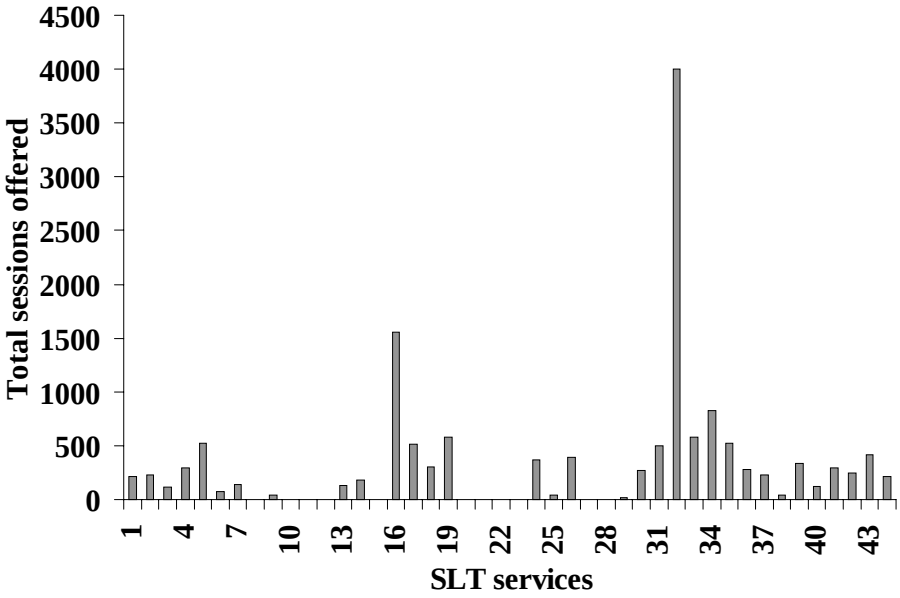

Figure 2. Clinical placement sessions offered by SLT services in London Region for academic year 1999-2000

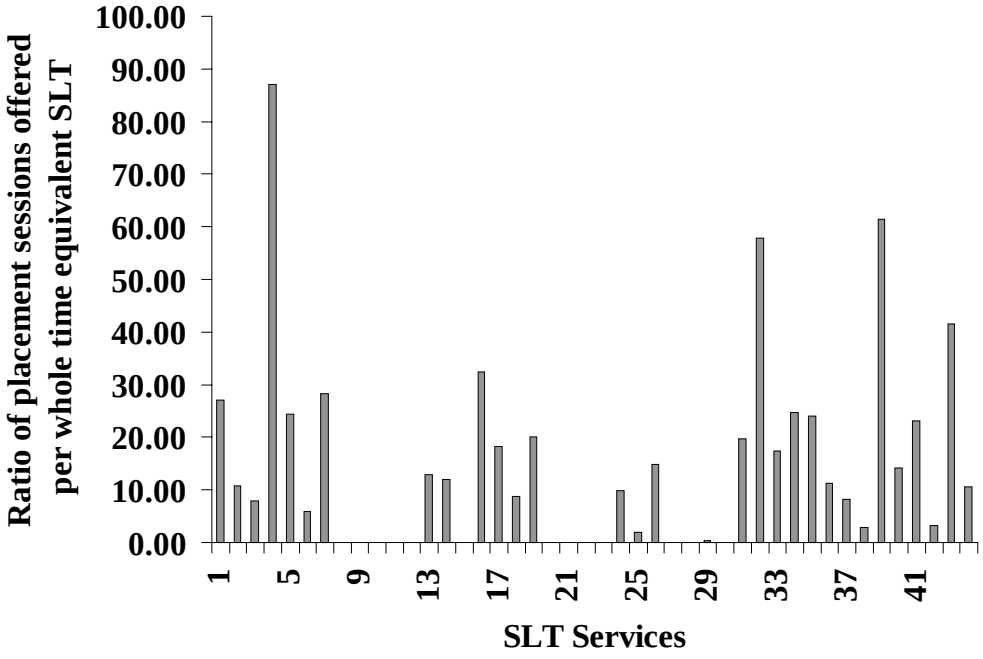

Figure 3. Ratio of placement sessions offered per whole time equivalent SLT

Individual differences
Services 4 and 32 offer interesting exemplars. In Figures 2, service 4 does not appear exceptional. However, it has a very small staffing establishment with a strong commitment to clinical education. Consequently, each SLT within the service makes a significant contribution which is reflected in Figure 3. Service 32 is also interesting in that it offers significantly more placement session than any other service in this survey as can be seen in Figure 2. However, it also, has one of the highest ratios of placement offers per whole time equivalent SLT as demonstrated in Figure 3. This service is of particular interest in that it is a large service but also has a strong commitment to clinical education. It is currently the only service in this region which has explicit guidelines for staff as to what is considered a reasonable commitment to student clinical placements.

One important factor which is not transparent in these data is the contribution of individual SLTs within a service. There are a number of SLTs individually providing in excess of 200 sessions of clinical placement experience for students, that is, more than twice the highest service ratio and in many cases more than the number of sessions offered by an entire service.

Summary

A number of key points have emerged from this survey:

- The joint annual request yields less than 50% of offers needed
- The remaining offers are secured by individual personal contact
- There is wide variability of offers across services which cannot be attributed to staffing numbers alone
- Individual therapists make a significant contribution
- The overall imbalance places greater demands on those individuals and services that do make offers
- Only one service in this sample is known to have an explicit policy about amount of expected commitment to students for individual therapists
- Only two services in this sample commit to students over a longer time frame than one year. Typically each individual placement provided has to be re-negotiated every year

Discussion

The provision of clinical experience for student speech and language therapists continues to be the source of much debate. This paper presents the data for one academic year in one region of the UK. However, the data presented show a typical pattern for this particular region based on records held by both Universities. The data highlight both shortfall and inequity in commitment to student clinical education.

Models of teaching and learning for adult education are also evolving. Student SLTs need to experience clinical settings as active learners, contributing to the setting as well as benefiting from the experience available. Models of clinical placement are also evolving. Students regularly experience paired and group placements as well as one to one supervision. The concept of a 'time-loop' (Morris and Parker in preparation) where a student learns independently in the clinical setting without being with the clinical supervisor all of the time, offers creative opportunities for student learning. Several special projects have been developed where the needs of a SLT service and the student learning needs have been brought together to offer radical alternatives to traditional models.

There is currently no agreed standard as to what is a reasonable commitment to clinical education either as an individual or as a service. The authors do not intend to make

recommendations in this area. The Universities' partnership is working with the managers to develop a local policy. However, the data presented do offer some direction. It would seem reasonable to expect a full time therapist with two or more years experience to offer a minimum of two student placements a year.

A therapist might choose to meet this commitment in a number of ways, for example a paired placement for two or three terms, two students on different days for an equivalent period of time, or a term-time weekly and a block placement. Part-time therapists could contribute to such commitments pro rata.

Finally, the workforce cycle demonstrates how the future development of the profession is integrally linked with a commitment to student clinical education. It is a shared dilemma which neither the Universities, SLT services or NHS Consortia can solve in isolation. The presence of student speech and language therapists in clinical settings needs to be considered the norm and not the exception. The reality is that more SLTs are required in the workforce but they cannot be trained without clinical experience as students.

References

Bines, H. and Watson, D., 1992, *Developing Professional Education* (Buckingham: Society for Research into Higher Education and Open University Press)

Department of Health 2000, *The NHS Plan: A Plan for Investment. A Plan for Reform* (London: HMSO)

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Rossiter, D., 2000, Leaving the profession. *Bulletin of the Royal College of Speech and Language Therapists,* **576**

APPENDIX 3

Speech and Language Therapy: Clinical Education Placement Standards (CEPS)

Bernadette Boyle, Francesca Cooper, Maggie Cooper,
Clare Henry, Gill Rose

Content:

- **Introduction / rationale**
- **Record form**
- **Guidance notes/ examples**

Clinical Placement Co-ordinators' Group Working Party
February 2003

Speech and Language Therapy:
Clinical Education Placement Standards (CEPS)

Introductory Information

"A quality assurance system is a systematic approach to identifying and responding to the needs of users by providing an appropriate service consistently and to agreed standards. You should also be able to provide evidence that you are doing so." (Farley, 1997)

Background

The need to ensure high quality clinical education has been raised by the SLT profession, students, universities and the government.

Validation and monitoring processes with various bodies have frequently asked how the quality of placements is monitored to ensure that the students have equity of experience.

Different universities and services have their own systems for this, but these would seem to have been focused on individual placement requirements.

A subgroup from the universities Clinical Placements Co-ordinators' Group has developed guidelines for best practice standards in clinical education. These needed to be fairly broad, to encompass both long block placements and the one-day-a-week placements, and also to cover on-site university clinics.

It is the intention for this system to complement current quality assurance initiatives within the NHS, and RCSLT "Signed up to Quality 2".

Purpose

To support Trusts in taking students, to share good practice, to raise the profile of SLTs as clinical educators with Trust managers and to identify areas for development in partnership with the universities.

We wanted to arrive at a document that would give placements a workable structure for organising their own placement provision. It was decided that the preferred method would be a self-assessment document. In this way, placement providers could see what they might aspire to. They could assess their own performance against a number of standards, which would also provide pointers for future development.

The self-assessment system

There are 6 standards in the document. Each standard is defined, and two levels are identified - Basic and Enhanced level. The 6 standards are as follows:

1. **Commitment to quality**
2. **Organisation and administration**
3. **Roles and responsibilities of the clinical co-ordinator**
4. **Roles and responsibilities of the clinical educator**
5. **Networking and partnerships**
6. **Monitoring and evaluation**

Items under each standard are listed at two levels (Basic and Enhanced), so that good practice can be identified and developed at both levels.

On first completion, the clinical co-ordinator reviews each item to see whether, in their Trust, the item is "not met", "nearly met" or "fully met". They will be the judge as to which category applies. If items are "nearly met" or "fully met", samples of evidence for this should be brought together in a portfolio. For each item, examples of what this evidence might be are provided. These lists are not exhaustive, however, and each Trust will be able to contribute their own ideas.

Such a portfolio, along with the completed self-assessment form, will provide good evidence of the quality of a placement. The form will show clinical co-ordinators exactly where the needs are in their own placement organisation. Items marked as "not met" should not be seen as failures. Each placement is different, and some items may not be applicable to all.

The document is intended to help clinical co-ordinators to plan the future direction of their work on placement organisation.

Completion of the document

1. The document should be completed by whoever has the main responsibility for placement organisation within a Trust/location. The service manager may wish to be involved in its completion.

2. Read through the standards to get a feel for what is being assessed. You may wish to make several copies of the standards, or use different coloured pens for each update.

3. For each standard, look at the individual items and decide which of the three columns to tick, depending on whether that item is "not met", "nearly met" or "fully met". There are no right or wrong answers; you may find that some of the Enhanced items are ticked as "fully met" in any one standard, even though not all the Basic items are ticked.

You may decide that it would be helpful for each clinical educator to keep a copy of standard 4 for their own self-monitoring purposes.

4. As you rate items as "nearly met" or "fully met", note the evidence that you will be able to provide for these assertions. Some of the evidence will be the same for a number of different items.

5. If items are rated as "not applicable" it may be helpful to comment on the reason for this.

6. Collect examples of evidence together in a portfolio to keep with the completed form.

7. Reflect on the profile you have drawn up of the student experience on placement in your Trust/location. What are the key areas to address? What resources do you need to help address these? Who will help? Do not try to tackle everything at once.

8. If you feel there are items specific to your work which have been omitted, do add them in. This should be a working document which you can use in any way you feel appropriate.

9. Review and update progress on a regular basis.

It is intended that this document be retained by the SLT team for reference, and used to identify and prioritise needs via regular reviews, using the standards.

As with any new procedure, once the standards have been evaluated initially, subsequent reviews will be quicker.

Piloting:

The working party drew up a draft document which has now been piloted in a number of NHS Trusts nationwide, small and large, primary care and hospital trust, urban and rural.

Contributors were asked to complete the standards, comment, and respond to a set of questions on their use.

Constructive feedback:

Amendments were made, in response to feedback, and documentation was shortened and streamlined, with clearer guidelines and examples given.

The term "Clinical Educator" (CE) is used, in preference to" supervisor" or "clinical teacher", in line with interprofessional terminology used nationally and internationally.

Positive feedback from the pilot included the following responses, which give an indication of how the standards may be useful:

An overall comment was *"Overall excellent- it was just what I wanted."*

In response to the question " Please comment on the guidance notes. How clear are they?"

" Clear and easy to follow. Positive and gets the message across that it allows for flexibility and interpretation. Seems to cover all aspects of clinical placement well."

Q. "Can you see this document fitting in to your system of placement organisation?"

" Yes, it has already given us ideas where we can improve things further, such as regular team discussion of student issues / action plan/ developing interprofessional placement links."

"Yes, providing a structured formal evidence-based framework …will help it to be a more team –based approach."

"It has many benefits from my point of view because it highlights what is lacking … in the service and provides a forum within which issues can be addressed."

Q. How might such a portfolio of evidence help your SLT department?

"Useful as part of documentation for RSCLT accreditation."

"Raise our profile as a department within the trust."

"Informs the identification process for department training funding."

"Provides evidence for specific time allocation to CC post."

Identified CE training needs have been used to support bids for external funding from confederations, as part of workforce planning initiatives.

Appendix 1

Composition of working group who devised the standards

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References:

Farley T, (1997) *Practical Quality Assurance System for Small Organisations*, Charities Evaluation Services.

Speech and Language Therapy: Clinical Education Placement Standards (CEPS)

RECORD FORM

1. COMMITMENT TO QUALITY

Standard: The placement provider commits itself to providing a high quality clinical experience, and appropriate learning opportunities.

	Basic level	Evidence	Not met	Nearly met	Fully met	Action to take
1B.1	The placement provider adheres to RCSLT guidelines on placement provision.					
1B.2	The placement provider will have a best practice / quality assurance (QA) statement for student placements.					
1B.3	The placement provider will have an annual action plan for student experience.					
1B.4	All clinical educators (CEs) are aware of this statement and the action plan, and are involved in its implementation.					
	Enhanced level					
1E.1	There is an annual review of the best practice / QA statement and action plan which is disseminated.					
1E.2	The placement provider can demonstrate an awareness of good practice from other disciplines within the Trust, and makes use of this knowledge to develop work with students.					

2. ORGANISATION AND ADMINISTRATION

Standard: The placement provider has the administrative procedures in place to organise a quality clinical education experience for students.

	Basic level	Evidence	Not met	Nearly met	Fully met	Action to take
2B.1	The placement provider specifies a named clinical placement co-ordinator who is a speech and language therapist.					
2B.2	There are agreed channels of liaison and information sharing between the placement provider and the university.					
2B.3	There are identified processes for sharing this information within the Trust.					
2B.4	There is a student induction pack (see Communicating Quality 2 page 241).					
2B.5	Time-scales are adhered to regarding provision of information to universities (e.g. names of CEs, return of report forms).					
2B.6	The placement provider will notify the university immediately should any changes occur which could affect the provision of a placement & vice versa.					

2B.7	Appropriate pre-placement information will be sent to relevant parties involved in the placement.					
	Enhanced level	**Evidence**	**Not met**	**Nearly met**	**Fully met**	**Action to take**
2E.1	There will be an agreed number of clinical sessions/placements provided each academic year.					
2E.2	The clinical co-ordinator has ring-fenced time allocation for the role.					

3. ROLES AND RESPONSIBILITIES OF THE CLINICAL CO-ORDINATOR (CC)

Standard: The placement provider has a named clinical co-ordinator (CC) who has sufficient skills and support to oversee the management of an effective placement.

	Basic level	Evidence	Not met	Nearly met	Fully met	Action to take
3B.1	The CC has an overview of therapists' availability to provide student placements.					
3B.2	The CC collates clinical education issues and development needs identified by CEs and disseminates them.					
3B.3	The CC ensures that CEs are aware of their roles and responsibilities.					
3B.4	The CC provides support and offers development opportunities for CEs.					
3B.5	The CC liaises with the university at appropriate times.					
3B.6	The CC has responsibility for a student induction pack.					
3B.7	The CC disseminates information to other clinical teachers.					
3B.8	The CC is responsible for maintaining and updating information provided for students and universities.					
3B.9	The CC is familiar with the specific requirements of universities from whom they take students.					
3B.10	There is an adequate number of suitably trained CEs to provide quality placement experience.					

	Enhanced level	Evidence	Not met	Nearly met	Fully met	Action to take
3E.1	The CC organises in-house SLT meetings to discuss student issues.					
3E.2	The CC develops student network systems outside the Healthcare Trust with other CCs.					
3E.3	The CC enables inter-professional networking on student issues within the Trust.					
3E.4	The CC develops departmental resources on clinical teaching.					
3E.5	The CC facilitates opportunities for in-house training on student issues.					
3E.6	The CC monitors the quality of the students' placement experience.					

4. ROLES, RESPONSIBILITIES AND PROFESSIONAL DEVELOPMENT OF THE CLINICAL EDUCATOR (CE)

Standard: The clinical educator has sufficient skills and support to provide an effective placement.

	Basic level	Evidence	Not met	Nearly met	Fully met	Action to take
4B.1	The CE demonstrates a positive commitment to SLT clinical education, and uses CE development opportunities.					
4B.2	The CE liaises with the clinical co-ordinator in the Trust, and with the university as appropriate.					
4B.3	The CE provides a range of learning opportunities for the student.					
4B.4	The CE negotiates and reviews placement objectives and progress with the student at agreed times, e.g. at the beginning, middle and end of the placement.					
4B.5	The CE provides adequate time for regular and structured feedback.					
4B.6	The CE completes documentation within the given time scales, e.g. student's report.					
4B.7	The CE has had at least one year's clinical experience since qualifying.					
4B.8	The CE has normally attended a CE training course at the appropriate level, such as new/experienced, and updates clinical education knowledge/skills at least every 3 years.					

4B.9	CEs identify their CPD needs regarding clinical education training.					
4B.10	CEs have time allocated to attend CE training.					
	Enhanced level					
4E.1	Some CEs participate in a CE support group/ network.					
4E.2	Some CEs contribute to CE training courses.					
4E.3	Participation in postgraduate CE training courses leading to accreditation/award.					

5. NETWORKING AND PARTNERSHIPS

Standard: A quality placement involves working in partnership with interested parties (e.g. RCSLT, HPC, Workforce Development Confederations, including Scottish Executive, National Assembly of Wales).

	Basic level	Evidence	Not met	Nearly met	Fully met	Action to take
5B.1	The SLT team providing the placement have knowledge of, and contact with, other departments within the Trust regarding clinical education.					
5B.2	The SLT team providing the placement maintains professional and interprofessional links, regarding clinical education, at regional and national level.					
5B.3	There is a partnership agreement in place between the placement provider and the university, regarding clinical education.					
	Enhanced level					
5E.1	Networking at executive level within the Trust, with the aim of raising the profile of clinical education.					
5E.2	There are links which allow input at recruitment level, for potential SLT students, and in the assessment of students.					
5E.3	Some CEs contribute to university courses for students at undergraduate and postgraduate level.					

6. MONITORING AND EVALUATION

Standard: The placement provider monitors the student placement experience and evaluates the quality.

	Basic level	Evidence	Not met	Nearly met	Fully met	Action to take
6B.1	The placement provider has a process for monitoring the placement experience, from the perspective of the student, the CE and the CC.					
6B.2	The placement provider acts upon feedback.					
6B.3	The placement provider liaises with the university to share feedback from students and CEs.					
	Enhanced level					
6E.1	The placement provider monitors the year on year improvement in the quality of placement provision through a clinical education Annual Action Plan.					
6E.2	The findings of this evaluation process are shared internally, and with partners and funders.					

1. **COMMITMENT TO QUALITY**
2.

Abbreviations: CC - Trust clinical coordinator
CE - Trust clinical educator

Standard: The placement provider commits itself to providing a high quality clinical experience, and appropriate learning opportunities.

	Guidance Notes	**Examples**
	Basic level	
1B.1	See Communicating Quality 2, pp 232-242.	A university "placement expectations" form.
1B.2	Devise a best practice / quality assurance (QA) statement.	CE's job description over grade 2. Written standards in department. Department business plan.
1B.3	Devise an action plan.	Action plan. Department meeting minutes.
1B.4	Demonstrate that clinical education is reviewed on a regular basis.	Staff newsletter. Department meeting minutes. Regular item on staff meeting agenda.
	Enhanced level	
1E.1	Give an example of your documented processes for discussing the best practice / QA statement.	Copy of plan with details of monitoring. Example of how ideas and suggestions are collected.
1E.2	Summary outcomes of inter-professional meetings within the Trust on student-related issues.	Liaison with other disciplines.

2. ORGANISATION AND ADMINISTRATION

Standard: The placement provider has the administrative procedures in place to organise a quality clinical education experience for the students.

	Guidance notes	Examples
	Basic level	
2B.1	Named therapist, known within the trust and to the university.	Job description, IPR statement, university documentation.
2B.2	Describe channels, meetings, forms, newsletters.	University paperwork.
2B.3	Describe the processes.	Staff meeting agendas/minutes, newsletters, in service training. How the SLT manager and CC make staff aware of clinical education issues.
2B.4	Student welcome induction packs sent to students in advance and updated copy sent to university (see Communicating Quality 2 p 241).	Copy of pack on each site.
2B.5	CC provides the university with information regarding CEs and placements by agreed dates.	Internal flow chart. Procedures list, names of CEs, return of reports.
2B.6	Prompt liaison with the university regarding any changes to venue, timetable, travel issues, need for a car, occupational health checks, attendance at induction course.	University/internal paperwork.

2B.7	Appropriate pre-placement information will be sent as required to the student, university and CEs involved in the placement.	Welcome letter and induction pack, timetables.
	Enhanced level	
2E.1	Adhering to agreed quotas of student placements and finding alternative suitable placement within the Trust if a placement becomes unavailable.	
2E.2	CC's job description and timetable. Copy of bids for CC post to the Trust / confederation (as appropriate).	Job description.

3. ROLES AND RESPONSIBILITIES OF THE CLINICAL CO-ORDINATOR (CC)

Standard: The placement provider has a named clinical co-ordinator (CC) who has sufficient skills and support to oversee the management of an effective placement.

	Guidance notes	**Examples**
	Basic level	
3B.1	Database outlining names of CEs, where they are each day, clinical speciality, when they have had students, attendance at CE training.	Database.
3B.2	Discuss which issues will be delivered in training for CEs, and by whom (Trust/ university).	Ask CEs what their needs are. Identification of CC's willingness to facilitate CEs' training sessions.
3B.3	Encourage CEs to be committed to standard 4 of CEPS (roles and responsibilities of the CE).	Self –evident. CEs each have a copy of this standard for self-monitoring.
3B.4	Setting up a CE support group to discuss issues re. students.	Self-evident.
3B.5	Returns information as required by dates given. Attends CE meetings in university / trust.	Names of CEs and timetables.
3B.6	Updates and disseminates student induction pack to the student and the universities.	Self evident.
3B.7	Prompt dissemination of information from universities.	Via memos to staff and electronically.
3B.8	Self-evident.	Ensures all CEs are using only the current handbook and forms from the universities.

3B.9	Know where to access information.	Most recent version of clinical handbooks.
3B.10	Outline your progression planning for SLTs to become CEs and develop their clinical education skills.	Monitor which CEs take students, their training needs, range of opportunities for new CEs to gain experience (e.g. observation by nursing students, prospective SLT students), mentoring, attendance at courses for new CEs.
	Enhanced level	
3E.1	Regular agenda item.	Minutes, agendas of meetings with CEs and managers.
3E.2	CC seeks networking opportunities with other CCs.	Summary of meetings with CCs from other Trusts.
3E.3	CC seeks networking opportunities with other professions, e.g. other healthcare professions.	Summary of meetings, contact lists.
3E.4	Encourage CEs to share resources/ ideas on clinical education and develop central resources, include generic teaching and learning materials to be used with students and for mentoring.	Library, sharing ideas in file, “rainy day” activities for students, available to all CEs.
3E.5	The CC cascades knowledge on clinical education, collates CE training needs and liaises with university / other training providers.	Agendas for training days, staff meetings.
3E.6	CC has an overview of the quality of learning opportunities provided by individual CEs and devises a mechanism for student feedback.	Proformas, feedback forms for students and CEs.

4. ROLES, RESPONSIBILITIES AND PROFESSIONAL DEVELOPMENT OF THE CLINICAL EDUCATOR (CE)

Standard: The clinical educator has sufficient skills and support to provide an effective placement.

	Guidance notes	Examples
	Basic level	
4B.1	Placement expectations will be shared between the student and the CE at the outset, with an agreement of how difficulties will be addressed should they occur. Respond to feedback from students and / or university regarding quality of the placement, and identify how any changes required will be made.	Expectation of placement form jointly discussed between CE and student. Feedback evaluation form obtained from students.
4B.2	Contact with CC and university.	Maintains record of correspondence with CC and university (e.g. letters, phone calls).
4B.3	Consider what learning opportunities could be offered.	Details of range of clients (disorder & severity), assessment and ongoing therapy, range of management opportunities, liaison, review, discharge, administration, interprofessional working, consideration of students' different learning styles.
4B.4	Student and CE both discuss placement aims and complete expectations / learning objectives forms at outset.	An informal formative evaluation undertaken part-way through placement, date and method of summative feedback negotiated.
4B.5	Discussion with student of preferred method of giving and receiving feedback. .Negotiated times for ongoing feedback.	Record of feedback given.
4B.6	Self-evident.	Return of report/details of placement to university by required date.
4B.7	Self-evident.	
4B.8	Keep record of own clinical education development.	Certificate of attendance at university/Trust/regional CE training courses.
4B.9	Discussion of CPD needs included in the department's clinical education training plan.	RCSLT log.

4B.10	Negotiate time with line manager to attend clinical education courses.	Attendance certificate from annual training course.
	Enhanced level	
4E.1	Seek opportunities to network with other CEs.	Dissemination of discussions in support group.
4E.2	Facilitation of aspects of CE training, sharing good practice within the Trust.	Workshop.
4.E.3.	Self-evident.	Credits / award

5. NETWORKING AND PARTNERSHIPS

Standard: A quality placement is valued and recognised by working in partnership with interested parties (e.g. RCSLT, HPC, Workforce Development Confederations, Scottish Executive, National Assembly of Wales).

	Guidance notes	**Examples**
	Basic level	
5B.1	Shared good practice with CEs within the trust (SLTs and / or interprofessional).	Contact details, notes of meetings
5B.2	Through meetings, workshops, conferences.	Action plans
5B.3	Commitment to joint staff development.	Joint planning and delivery of courses
	Enhanced level	
5E.1	Inform executive level of SLT department's achievements re. clinical education.	Meetings with human resources dept. re work force planning / HPC strategy group.
5E.2	Participation in interviewing, joint assessment of students' clinical skills/ assessment.	Interview dates / clinical vivas / joint assessment.
5E.3	Self-evident.	Lectures to students, running workshops, clinical tutoring, facilitation of CE workshop sessions.

6. MONITORING AND EVALUATION

Standard: The placement provider monitors the student placement experience and evaluates the quality.

	Guidance notes	Examples
	Basic level	
6B.1	Description of evaluation process.	Student's evaluation form. CE's own reflection. Overview of placement experiences.
6B.2	Documents feedback from students. Addresses issues identified from feedback.	Examples of forms. Outlines of action taken following feedback.
6B.3	The CC contacts the university to share good practice and discuss how changes required might be made.	SMART objectives to support a CE's development. Sharing positive feedback e.g. from student / university. Facilitating team discussion on what makes a good placement.
	Enhanced level	
6E.1	The CC facilitates implementation of the clinical education Annual Action Plan.	Copy of plan with details of monitoring.
6E.2	The quality improvements are highlighted at SLT staff meetings, and good practice shared at annual study days. .The university and confederations / Trusts are informed of the evaluation process and outcomes.	Verbal / written report.

Clinical Education Placement Standards (CEPS)

Feedback form

Your comments on CEPS would be gratefully received. Please use a separate sheet if there is not enough room here for what you want to say. This form should be returned to the university tutor who gave you this document, or to a member of the working group (see details at end of form).

1. Please comment on the guidance notes. How clear are they?
2. Is it clear what each standard means? If not, which standards need to be clarified? Can you suggest re-wording?
3. Are the individual items under each standard easy to understand? If not, which items need to be clarified? Can you suggest re-wording?
4. How easily were you able to rate the items as "not met"/"nearly met"/"fully met"?

5. Were the examples of possible evidence sufficient? Were you able to identify areas of need? Could you prioritise these needs?

6. Can you see this document fitting into your system of placement organisation? If so, how?

7. How might such a portfolio of evidence help your SLT dept?

Can you make any comments about how this system needs to be adapted or improved?

Approximately how long did it take you to complete the CEPS document?

Please return this feedback form to the university tutor who gave you the CEPS document or return to Gill Rose, School of Speech & Language Therapy, B522 Baker Building, University of Central England, Perry Barr, Birmingham B20 3TG [tel: 0121 331 5517 / Email: Gill.Rose@uce.ac.uk]

Thank you for your help.