**Key Practitioner Messages (62 words)**

* Safeguarding supervision was viewed as a child-focused, helpful activity that has led to practice improvements.
* Negative comments were in the minority and related to perceptions of its intrusive and punitive nature, the time involved and competing priorities.
* Improvements advocated were safeguarding supervision should include discussion about children whose care is problematic but who are not the subject to formal child protection proceedings.

**KEY WORDS:**

Child safeguarding, Supervision of healthcare practitioners

## BACKGROUND

## The focus of this report is a qualitative evaluation of the supervision of safeguarding children’s care carried out at a UK community nursing service. Bell (2009) defines safeguarding supervision as: ‘any form of discussion, consultation or support received in relation to child safeguarding work’ (p.1). Other authors also trace the links between safeguarding supervision and clinical supervision. For example, Botham (2013) argues that there is little evidence to suggest that safeguarding supervision and clinical supervision are not one and the same.

The over-riding focus of safeguarding supervision is to ensure that the needs of children are being met. However, safeguarding supervision is also about improving and developing professionals’ future practice and providing effective support which is of importance in reducing the long-term negative emotional impact of safeguarding work (Appleton and Peckover 2015). Central to the supervision process are opportunities to reflect on practice with an experienced supervisor. However, there appears to be confusion and suspicion, amongst health and social care professionals, as to its rationale with Rowse (2009) suggesting that safeguarding supervision is sometimes seen as a: ‘a management surveillance tool’ (p660).

There is international literature about safeguarding supervision that maybe of relevance to the UK context. For example, an Australian author, Gibbs (2001) suggests use of reflective supervision as a possible strategy for lowering the high attrition rates amongst child protection professionals. A move from an emphasis on surveillance and accountability to use of professional support strategies is also advocated by Gibbs. Lietz (2008) in a qualitative study involving social care staff in the US examines the introduction of group supervision for staff working with child welfare cases. The model put forward by Lietz is less focused on the supervision of individuals (as in the UK); nevertheless, the model of supervision deployed does encompass similar principles of support for staff dealing with the emotional aspects of child safeguarding work.

Accounts of evaluation of safeguarding processes are scant. A study by Botham (2013) carried out a literature review of safeguarding supervision provided to community nurses. Most of the reviewed studies were literature reviews (n=6) or conceptual analysis (n=3) of clinical supervision. Only three of twelve papers reviewed focus on evaluation of safeguarding supervision (Hall 2007, Green-Lister and Crisp 2005 and Rowse 2009). These studies were qualitative in nature and use focus group or interview methodologies. Two studies had community nurses as participants (Hall 2007, Green-Lister and Crisp 2005) whereas Rowse’s (2009) study involved hospital-based paediatric nurses. All these authors recommend the need for formal, regular safeguarding supervision, which is largely identified as being beneficial.

**THE INVESTIGATION**

This background literature gave the impetus to the evaluation undertaken the aim of which was to:

* Investigate the effectiveness of safeguarding supervision offered by a community nursing service and identify factors that may facilitate or hinder its delivery.

**Context**

We define Safeguarding supervision as a process by which Safeguarding Nurse Specialists work with case-holding health visitors and school nurses who are responsible for the healthcare of children who been the focus of a safeguarding review. The children concerned have been the subject of official child safeguarding proceedings including an interagency case conference. In the service where this study was carried out the approach to Safeguarding supervision is underpinned by the restorative model of clinical supervision described by Wallbank and Hatton (2011) and is a time-protected, formal process whereby the healthcare related to individual children is discussed and written records kept of actions taken.

The community service where the investigation was undertaken has expanded provision of safeguarding supervision over the last few years and wanted to evaluate the systems being used. This desire was identified at the regular liaison meetings practice staff have with link university lecturers. It was known that the University had small amounts of funding available that could potentially be used to conduct the evaluation. This funding enables lecturing staff to increase their engagement with practice-based research activities. It was on this basis that a partnership between the Service and University was developed and which enabled the present analysis to be undertaken.

**Methods**

In 2015, an evaluation of Safeguarding supervision was carried using quantitative methods. Eleven face-to-face, in-depth digitally recorded interviews lasting about one hour each were undertaken. To maximise the amount of data available an on-line open-ended questionnaire was also administered and those who did not want to be interviewed were given the opportunity to complete an on-line survey.

**Participants**

There were approximately 59 community practitioners and Safeguarding Nurse Specialists eligible to take part in the investigation. Twenty-five participants, or 42% of the total population, agreed to participate. Eleven participants were interviewed and fourteen were survey respondents.

**Interview and questionnaire schedule**

The interview schedule consisted of a series of open-ended questions. The questions had been developed from findings of a literature review and discussions with the named safeguarding nurse. (The named safeguarding nurse is the lead nurse in an organisation who has a statutory child safeguarding role.) Questions posed addressed such things as the participant’s experiences of safeguarding supervision, its positive and negative aspects and what improvements could be made to the processes.

**Ethics**

Prior to commencement of the evaluation the Community Nursing Service’s Research Governance Department was contacted and it was confirmed there was no requirement to obtain formal ethical approval. Similar advice was given that it was unnecessary to gain university ethical approval. Nevertheless, all the usual ethical procedures were adhered to when undertaking the investigation. An information sheet was sent via email to the potential participants when they were recruited to the investigation. The participants’ written consent was also obtained at the time of the interview as was the participants’ permission to record the interview. Assurances of confidentiality and anonymity in data analysis and data reporting stages of the investigation were given and adhered to.

**Data analysis**

A thematic content analysis described by Miles and Huberman (1994) was employed to analyse data. This type analysis has its roots in the philosophical traditions of several qualitative research approaches including those of grounded theory (Denzin and Lincoln 2013). There were several reasons for choosing this approach including it is a relatively simple and straightforward method to identify the main features of a data set whilst retaining the potential to report on the richness and minutia of data.

The interview recordings were transcribed verbatim which resulted in 180 A4 sheets of data being available for analysis. The analysis involved reading and re-reading the data, whilst listening to the interview recordings. Illuminative, relevant and recurring patterns of responses were identified which led to organising data into themes and categories. Data themes represented broad areas of importance and data categories were clustered under each data theme. Analysis checks were also made by members of the research team cross-sampling and verifying each other’s analysis. Analysis of the survey data contributed to the initial development of themes and categories developed from the interview data. Finally, exemplars from the transcriptions and survey responses were used to illustrate contrasts of opinions within each data category.

**FINDINGS**

**Participants**

Of the 25 participants who took part in the investigation five were Safeguarding Nurse Specialists and 20 were case-holding practitioners. The majority’s professional background was health visiting or school nursing. They had been employed by the community nursing service for between one and five years. The demographic and employee characteristics of participants are identified in Table One

**Data themes and categories**

 Five data themes and eighteen data categories were identified and are given in table two. Due to word limitations, greater emphasis is given to the ‘Helpful’ and ‘Unhelpful’ themes as it is believed the content of these themes have the most interest and relevance to the wider audience.

*Context of safeguarding supervision and its processes*

Everyday practicalities, for example, time pressures or the lack of available office space posed challenges to implementing safeguarding supervision. Participants described how meeting the trust’s target driven objectives took priority over making time for safeguarding supervision and they described having to balance competing priorities. Identifying these local issues is important in understanding how context influences safeguarding supervision practices and identifying areas for improvement

*Helpful aspects of safeguarding supervision*

Many participants identified helpful aspects of supervision. For example, interviewee nine who was also an experienced health visitor described:

‘When first they said, we were getting safeguarding supervision I was slightly sceptical. But no I have found it beneficial. You can get a bit blinkered to what is going on. You can become a bit entrenched in what you are doing. Safeguarding supervision makes you think outside the box’.

Several comments were made about how the safeguarding supervisors are very supportive. For example, interviewee ten who was also a school nurse said:

‘I have had a particularly serious safeguarding case. It’s being going on for 18 months. I have lived and breathed the case. It’s been traumatic and stressful. Safeguarding supervision has been a life saver. The help and support of the safeguarding nurses has been tremendous.’

The child-focused emphasis of safeguarding supervision was also positively evaluated by many of the participants with interviewee eight who was one of the least experienced health visitors interviewed identifying that:

‘They (the supervision meetings) need to be child-focused, because ultimately that’s who our client base is. It’s very easy for parents to sort of over-shadow with their own problems and concerns. Our role is to make sure we are the voice of the child and we’re their advocates’.

Some of the interviewees also described how safeguarding supervision has helped develop their practice. For example, interviewee four who was also a newly appointed Safeguarding Nurse Specialist said:

‘I’m thinking of when I first started as a health visitor to where I am now. I can see massive development and improvement in my practice. I think this is down to my safeguarding experience and the supervision that I’ve had along the way’.

Some thought it improved their reflective skills whilst others believed that the safeguarding supervision helps gives greater clarity to practice situations. For example, interviewee seven who was an experienced school nurse said:

‘When you’re a practitioner on the ground you sometimes don’t see things because you’ve got your blinkers on. (Supervision) it makes you think. Questions like ‘have you thought of this or that?’.

*Unhelpful aspects of safeguarding supervision*

Comments made by the interviewees concerning unhelpful aspects of safeguarding supervision were fewer in number. However, some did feel it was repetitive with a survey respondent writing that it:

‘It feels like a tick box exercise to show supervision is offered: it can be done from the notes rather than with the practitioner. I feel supervision should be offered on complex cases that don't meet the Child Safeguarding or Looked After Children thresholds’.

Finally, a Safeguarding Nurse Specialist related how a small number of practitioners seemed to think safeguarding supervision was unhelpful and even punitive in nature and said:

‘I think some think it (safeguarding supervision) is intrusive, punitive. The Trust covering their own backs I think they think. I have had a comment from one health visitor who said she couldn’t see the purpose of supervision. She should be out there seeing children, that kind of comment. A few don’t see it as important and won’t always make themselves available’.

*Accountability issues*

Participants described how supervision could also play a role in addressing poor practice and was part of wider issues of accountability. Mainly incidents of poor practice the interviewees knew about related to inadequate record keeping. Participants suggested that additional education may help to address poor practice.

*Developing existing practice*

Finally, suggestions were made to develop future provision of safeguarding supervision. Included were such things as amendments to the presently used safeguarding supervision documentation. Other concerns were that practitioners needed to spend more time preparing for safeguarding supervision which largely emanated from the Safeguarding Nurse Specialist interviewees. Finally opening supervision out to include the healthcare of children whilst problematic but not necessarily in the formal safeguarding arena was suggested by many of the interviewees.

**DISCUSSION**

Authors such as Appleton and Peckover (2015) describe how safeguarding supervision is an essential element of the professional development of healthcare staff who work with neglected or abused children. Those involved need to have access to good quality, regular supervision which is also cognizant of the stress experienced by all professionals involved in child safeguarding work. For example, in a US context Ross (2016) describes how regardless of age, profession, training, or years on the job, child protection work often has a profound effect on those involved. Such stress is reported by several authors to be on the increase both nationally and internationally (Bennett et al 2010, Goddard and Hunt 2011, Rooke 2015). Challenging clinical environments with low staffing levels and greater public expectations are also reported to be compounding factors. For example, in the UK Wallbank and Hatton (2011) describe how there is anecdotal evidence that morale in health visiting services nationally is low with retention and high levels of long-term sickness being problematic.

As described earlier there are relatively few studies that have evaluated safeguarding supervision. Those that have been conducted largely describe similar findings to the present investigation. For example, Hall (2007) in a small focus group study examining community nurse perspectives on safeguarding supervision found that supervision for those studied was largely seen as being essential and positively evaluated. Slightly less positively Green-Lister and Crisp (2005) found that there were differing experiences of safeguarding with some seen as being less than favourable than others. Similarly, in the present investigation a minority of practitioners also viewed safe guarding supervision in negative terms referring particularly to the time involved and the intrusive and punitive nature of the process.

Reactive supervision as described by Proctor (1987) was used by many of those studied to seek advice and support from Safeguarding Nurse Specialists. However, there was also a call to have greater flexibility introduced into the ‘official’ safeguarding interviews. This flexibility could enable, for example, discussion about children for whom practitioners were concerned about but who were not subject to formal safeguarding processes. In doing so it was thought that the valuable time allocated to safeguarding could be used more productively and not just as a tick box exercise of doing it for the sake of saying it had been done. This could be achieved using the model described by White (2008) when both complex and non-complex cases are bought to safeguarding supervision, the choice resting with practitioners.

Of importance to practitioners is the potential safeguarding supervision has to improve practice, for example, several suggestions were made by participants to how safeguarding supervision can be improved. Many of these issues are relevant to other service providers involved in child safeguarding. Better staff preparation, time-limiting the safeguarding interviews and improvements in record-keeping were some items mentioned. Comparable with the views of Goddard and Hunt (2011) and Rooke (2015), there was an over-riding consensus on how safeguarding supervision provides valuable opportunities to reflect on practice, share good practice and improve future practice. The promise that safe guarding supervision offers to improving future practice being applicable to all professionals who care for vulnerable children.

**CONCLUSIONS**

 There are several study limitations to this study including its relatively small sample size and the single-sited nature of the investigation. Also, whilst recognising the importance of multi-professional and multi-agency input to child safeguarding word limitation also prevented detailed exploration of how the findings of this study are applicable to other professional groups. Nevertheless, the in-depth data obtained does allow for new and detailed insights into what is generally an under-researched area. New evidence is given that good quality regular safeguarding supervision is valued by those studied.

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Table one: Sample characteristics (n=25)

|  |  |  |
| --- | --- | --- |
| Characteristics | Categories  | Frequencies |
| Current post | Safeguarding Nurse Specialist  | 5 |
| Health Visitor  | 13 |
| School Nurse  | 5 |
| Children’s Nurse  | 1 |
| Team Leader | 1 |
| Qualification associated with current post | Health Visitor  | 16 |
| School Nurse | 8 |
| Children’s Nurse  | 1 |
| Length of time in current post | 1-5years  | 12 |
| 6-10 years  | 6 |
| Over 10 years  | 7 |

Table two: Processes of safeguarding children supervision, helpful and unhelpful features: data themes and categories.

|  |  |
| --- | --- |
| Themes | Categories |
| Context & processes of safe-guarding supervision | Approaches to supervisionPreparation,VenueRecord keepingTime issuesPrioritising child-protection workTrust & target driven objectives  |
| Helpful aspects | General positive commentsManagement of distress & desensitisationChild focusedImproving practiceReflection on practiceProvides clarity & expert advice |
| Unhelpful aspects | Negative commentsTicking boxes, an audit-approachPunitive & directive |
| Accountability Issues | Poor practice & resolution |
| Developing existing practice  | Suggestions for improvement |