Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Safeguarding Supervision Policy

This procedural document supersedes: PAT/PS 13 v.4 Safeguarding Supervision Policy

Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Executive Sponsor(s):	Karen Jessop - Chief Nurse
Author/reviewer: (this version)	Vicki Baker - Named Nurse for Safeguarding Children
Date written/revised:	August 2024
Approved by:	Strategic Safeguarding Committee
Date of approval:	5th September 2024
Date issued:	23rd September 2024
Next review date:	September 2027
Target audience:	Trust wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 5	23 Sept 2024	• Significant additions and amendments to all sections and appendices, please read in full.	Vicki Baker
Version 4	28 June 2021	• Minor changes – titles and department name changes only.	Elizabeth Boyle
Version 3	9 July 2018	• Updated in accordance with changes to National Policy and Guidance. • Organisational titles and roles updated.	Elizabeth Boyle
Version 2	21 April 2015	• Addition of midwifery supervision and safeguarding adults supervision with other changes to update – please read in full • Equality Impact Assessment Form included at Appendix 2.	Deborah Oughtibridge
Version 1	2011	• This is a new procedural document, please read in full.	Gill Genders

Contents

1 INTRODUCTION 4
2 PURPOSE 5
3 DUTIES AND RESPONSIBILITIES 5
4 PROCEDURE 6
4.1 Fundamentals of supervision 7
4.2 Models of Supervision 7
4.3 Process of Supervision 8
4.4 Responsibilities within the supervision process 9
4.5 Safeguarding Supervision Contracts 10
4.6 Safeguarding supervision documentation 11
4.7 Ad-Hoc Safeguarding supervision 11
4.8 Medical staff – safeguarding children supervision 12
4.9 Patients lacking capacity 12
5 TRAINING/SUPPORT 13
6 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT 13
7 DEFINITIONS 14
8 EQUALITY IMPACT ASSESSMENT 15
9 ASSOCIATED TRUST PROCEDURAL DOCUMENTS 15
10 DATA PROTECTION 16
11 REFERENCES 16
APPENDIX 1 – SAFEGUARDING CHILDREN SUPERVISION FREQUENCY TOOL 18
APPENDIX 2 - COMPETENCE INDICATORS FOR SUPERVISOR CHECKLIST 20
APPENDIX 3 – KOLB SUPERVISION CYCLE 22
APPENDIX 4 - SUPERVISION DISCUSSION TEMPLATE 28
APPENDIX 5 - SAFEGUARDING SUPERVISION CONTRACT 30
APPENDIX 6 – SIGNS OF SAFETY TOOL 32
APPENDIX 7 – WHAT DO YOU KNOW? 33
APPENDIX 8 – GENOGRAM SYMBOLS 34
APPENDIX 9 – ECO MAP 35
APPENDIX 10 – RESILIENCE AND VULNERABILITY MATRIX 36
APPENDIX 11 – ASSESSMENT FRAMEWORK 37
APPENDIX 12 – SUPERVISION COMPLIANCE TEMPLATE 38
APPENDIX 13 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING 39

INTRODUCTION

Doncaster and Bassetlaw Teaching Hospitals NHS Trust is committed to providing the highest standards of quality and safe patient care. All health care practitioners have a significant role in relation to ensuring that children, young people and adults at risk are safe and protected from harm, and therefore require a robust structure of safeguarding supervision to support their practice. Whilst there is currently no statutory guidance around adult supervision, it is recognised as good practice. This policy therefore also relates to practitioners working with adults at risk or where adult safeguarding processes are instigated.

Safeguarding supervision is a formal, accountable process, which supports, assures and develops the knowledge, skills and values of an individual, groups or team. Restorative supervision aims to improve the quality of the practitioners work, achieve agreed objectives and outcomes whilst promoting good standards of practice to ensure children and young people are protected from harm through sound professional judgement, critical reflection, legislation and research findings.

Effective supervision can play a critical role in ensuring a clear focus on a child's welfare and supports practitioners to reflect critically on the impact of their decisions on the child and their family (Working Together 2023). The provision of robust safeguarding supervision arrangements also provides a level of assurance that the Trust is meeting its statutory responsibilities to safeguard children.

Safeguarding supervision is separate and additional to clinical supervision and does not replace it. This policy applies to all practitioners working with children, families and adults across all hospital sites. This policy **MUST** be followed by all colleagues employed by DBTH; including those on temporary contracts, honorary contracts, volunteer contracts, secondments, Bank / Agency colleagues and students.

All colleagues must receive effective supervision according to the requirements of their job role (appendix 1 - Supervision frequency tool in relation to employee role). The safeguarding team take a professional lead on safeguarding supervision developments and coordination across DBTH. In addition to the formal supervision arrangements across the Trust; the safeguarding team are also available to provide support, advice and guidance relating to any safeguarding issue for any colleague at DBTH.

1 PURPOSE

The purpose of this policy is to provide a clear framework for safeguarding supervision for all relevant DBTH colleagues, depending on their role. The policy aims to build on the development of effective, competent and confident practitioners and provides a planned systematic approach to the care provided and delivered to children and families taking into account the broader definition as defined in Working Together 2023 (pages 7-8). It will set out the appropriate level, type and frequency of safeguarding supervision that they should access and or provide, when working with children and families and where there are concerns about the welfare of the child. The policy will also clarify practitioners' access to nominated safeguarding supervisors within individual practice areas and the named safeguarding professionals in accordance with identified role requirements (appendix 1).

This policy aims to build on the development of effective, competent and confident practitioners and provides a systematic approach to the care provided and delivered to children, families and adults at risk of harm.

Good quality safeguarding supervision promotes:

- Collaboration
- Professional curiosity
- Critical thinking
- Reflection
- Emotional containment
- Professional challenge

This policy is written with the intention of providing practitioners with guidance and structure, it is not intended to remove professional judgement. Individual practitioners remain accountable and as such need to be able to justify their decisions at all times. Safeguarding supervision does not replace nor should it delay the individual's responsibility to refer concerns about children or adults to statutory agencies where there are concerns that a child or adult may be at risk of significant harm.

2 DUTIES AND RESPONSIBILITIES

Executive team
The Chief Nurse is the Executive lead for Safeguarding and is supported by the Deputy Chief Nurse to ensure that the importance of safeguarding throughout the organisation is championed and that systems and processes are in place.

Divisional leads
Ensure all people working on behalf of Trust Business in their areas comply with this policy, alongside other trust safeguarding policies and national and local guidance that have been referenced. Ensure that the appropriate level of safeguarding training is undertaken by all employees within the divisions

and in alignment to roles and responsibilities. Should ensure the appropriate level of support is in place and signpost to the Trust Safeguarding team where additional support is identified.

Safeguarding Professionals within the organisation

The Head of Safeguarding, supported by Safeguarding professionals working within the Trust should ensure any updates required to this policy are undertaken timely in line with local and national guidance. Provide support to Trust employees who may need additional guidance to understand and apply the principles of this policy.

All employees of the Trust

Have a duty to access safeguarding supervision if relevant to their job role, and follow Trust policy and work in line with additional local and national procedures and guidance that has been outlined in Section 1 of this policy. Escalate to their line manager, other senior manager or member of the Trust safeguarding team any concerns they may have in relation to applying this policy to their practice. Ensure that Safeguarding procedures and processes are followed and safeguarding escalations are undertaken in line with Trust Safeguarding Policies.

3 PROCEDURE

All colleagues will be informed by their Line Manager at induction of the organisation's supervision framework, including specific children's safeguarding supervision and the expectations of them to engage in supervision.

Those providing safeguarding children supervision should be trained in safeguarding supervision skills and have an up-to-date knowledge of the legislation, policy and research relevant to safeguarding and promoting the welfare of children (Working Together to Safeguard Children, 2023). All supervisors should be committed to ensure their knowledge, skills and practice are current and evidence based.

All safeguarding supervisors who are new to the Trust will be expected to undertake a competence indicator self-check list (appendix 2) in order to assure the safeguarding team and Trust that their knowledge, management skills, attributes and commitment to their own development meets the standard of the self-check list tool.

Formal safeguarding supervision for those practitioners, who are on a professional register and working with children, young people and families, should take place every 6 months as a minimum, preferably in a group setting. Each session should not exceed 2 hours duration. Safeguarding supervisors will receive formal supervision from the DBTH Safeguarding Team, which will be facilitated by a specialist safeguarding practitioner (appendix 1 - Supervision frequency tool in relation to employee role).

Any practitioner requiring additional safeguarding supervision should contact DBTH Safeguarding Team.

Compliance reporting

It is the responsibility of the Departmental / Divisional Leads to provide DBTH Safeguarding Team with supervision compliance data on a quarterly basis. This information should be provided via the generic safeguarding team email address dbh-tr.safeguarding@nhs.net on a quarterly basis using the supervision compliance template (appendix 12).

4.1 Fundamentals of supervision

Safeguarding supervision will:

- Be supportive and facilitate practitioners in their development from 'novice to expert', and address practice issues.
- Be practitioner led, as it is intended to support the practitioner to prioritise and manage safeguarding casework.
- Where there are children of concern, it will ensure concerns are escalated to the appropriate level e.g. Early Help or referral to Children's Social Care.
- Enable colleagues to reflect on practice and escalate safeguarding issues where single agency intervention has not resolved concern, or where partner organisations do not recognise the level of concern raised by the health practitioner.
- Complement existing safeguarding policies and procedures by providing practitioners with a further opportunity to develop skills, knowledge and understanding to aid continuous professional development and learning, and to identify training needs and signpost to appropriate resources.
- Support practitioners and empower them to cope with emotions and possible stress relating to safeguarding duties and responsibilities.
- Facilitate a communication channel between the practitioner and their team to identify the training and developmental needs of the practitioner so that they have the skills and knowledge to provide an effective service.
- To identify, in partnership with the practitioner, any difficulties in ensuring policies and procedures are adhered to.

4.2 Models of Supervision

There are a number of models of supervision, which can include 1:1, or group supervision arrangements. Group supervision is suited to practitioners in acute services; however, there may be instances when 1:1 safeguarding supervision may be required dependent on the circumstances and context of the case. Group supervision is a negotiated process whereby members come together in an agreed format to reflect on their work by pooling their skills, experience and knowledge in order to improve both individual and group capacities (Morrison 2005). The Kolb supervision cycle (appendix 3) is a useful tool to support practitioners navigate

the supervision process. Group supervision can be based on a specific topic or a ‘case’.

Benefits of group supervision include the following:

- It promotes a culture of peer /team support and accountability
- It expands the skills – pool and knowledge base
- The diversity of a group widens perspectives
- It enables a focus on a process as well as a task
- It is a source of emotional support from peers
- It increases options, ideas, and innovations
- It fosters a sense of group or team cohesion
- It is an opportunity for supervisor to identify potential themes within the team.

4.3 Process of Supervision

The supervision process includes the following elements:

- To ensure when supervision relates to individual children, pregnant women or adults at risk, that each discussion is documented within the individual’s health record. Refer to section 4.6 of this policy for details about recording supervision in patient records.

- When supervision relates to either retrospective cases or scenario situations within a groupsetting, this should be clearly documented within the relevant supervision documentation. No patient identifiable information should be included on this form, this is to capture the ‘key themes’ of what has been discussed (appendix 4 – Supervision discussion template).

- Where issues are identified that suggest individuals have safeguarding training needs, the supervision discussion template should capture a plan to address those needs, and this should be re-visited at the next session and until the training need is completed.

- Where issues of concern arise with respect to individual practice, values and attitudes,these will be discussed with the practitioner on a 1-1 basis and where necessary the practitioner’s manager in order to address the concerns. The practitioner will be informed of the supervisor’s intentions. This will be documented on a supervision discussion template relevant to the individual practitioner, including plans to address the concerns and follow up arrangements at a mutually agreed time.

- Supervision will include consideration of diversity issues in order to promote best practice.

- The boundaries of confidentiality within safeguarding supervision will be clearly communicated and understood.

Bunker and Wijnberg (1988) identified the role of the supervisor as embedded within both the management system and the professional practice system as a key element in each and as an essential link between the two systems. The outcomes of safeguarding supervision should focuson improvement. This could include reduction of risk to a child, family or adult at risk and as such, improvement in patient care. For practitioners it should lead to increased knowledge and skills, including knowledge of policies and procedure and improved documentation.

4.4 Responsibilities within the supervision process

The Supervisee should:

- Participate fully in reflection, exploring issues and the development of action plans.
- Implement the actions identified in the supervision session and monitor the progress of the desired outcome(s) for the child or adult at risk.
- Bring to the attention of the supervisor when experiencing any difficulties/ unable to implement action plans agreed.
- Take responsibility for own personal and practice development.
- Have an explanation of confidentiality expectations within the terms of this agreement.
- Discuss stressful aspects of the work, be given support and be directed to further source of support if he/she wishes.
- Have protected time for supervision.
- Be prepared to bring cases and examples to discuss within a supervision session.
- Engage in the agreement within the supervision contract.

The supervisor should:

- Agree the supervision contract with the supervisee.
- Assist the supervisee to reflect on practice using a reflective model (e.g. Tony Morrison) and provide constructive feedback to enable best outcomes for children and adults at risk.
- Ensure the safeguarding supervisee has a clear understanding of their role and responsibilities in relation to promoting the wellbeing and safety of children / adults at risk.
- Acknowledge the stressful nature of working with vulnerable children / adults at risk and ensure that any necessary support available is offered to minimise the risk to the child / adult, the supervisee and DBTH.

- Identify with supervisees any children, families or adults who should be discussed with the Line Manager in order to provide additional support.
- Support the supervisee with issues arising from the reflection in relation to beliefs, values and past experiences.
- Inform the appropriate manager if a supervisee is unable to engage in the minimum number of supervision sessions due to a lack of cooperation, sickness or concerns about practice.
- Promote adherence to relevant policies and procedures e.g. child / adult safeguarding.
- Discuss openly with the supervisee any concerns about their performance and agree / inform of any action to be taken.
- See the practitioner's record of supervision in the patient's record in all cases.
- Identify in the group, who will take responsibility for recording the supervision on the patient record.

4.5 Safeguarding Supervision Contracts

All practitioners who receive regular formal supervision will complete a written contract with their safeguarding supervisor. This contract will identify the roles and responsibilities of both the supervisor and the supervisee (appendix 5).

The purpose of the contract is to ensure:

- Reflects the significance of the activity.
- Clarity of expectations.
- Roles and responsibilities are understood.
- Practical issues are agreed
- Represents a positive modelling of behaviour.
- Ensures the supervisee is aware of his/her responsibilities and roles within supervision.
- Clarifies accountability.
- Provides a basis for reviewing and developing the supervisory relationship.
- Acts as a bench mark against which supervision can be audited.
- Promotes the interests of the children and young people, adults at risk /and colleagues accessing Safeguarding Supervision.
- Ensures that the standard of supervision afforded to colleagues by the provider is of an appropriate quality.
- Places a duty on colleagues to demonstrate continuing development (Adapted from Morrison2005).

A copy of the contract will be held by the supervisor and the supervisee. The supervisor will take responsibility for monitoring and reviewing the contract with the supervisee as necessary

4.6 Safeguarding supervision documentation

Practitioners should ensure that records are available to the supervisor when they seek supervision relating to individual patients. At the introductory session between the supervisor and supervisee, appropriate safeguarding supervision documentation is agreed and explained.

Where follow-up supervision sessions are arranged, documentation from the previous session should be made available for further discussion or closure. The record of supervision attendance should be available to the practitioner's line manager on request.

Key decisions reached regarding individual children, pregnant women or adult patients should be recorded in their health record. Appendices 7 – 12 are useful tools which may support reflective discussion and to evidence the thinking process during safeguarding supervision.

DBTH operates multiple electronic patient record systems in addition to paper records that remain in use in some areas of the Trust. Safeguarding supervision discussions relating to a specific patient should be recorded using the 'Signs of Safety' tool (appendix 6) as a guide. The essence of the Signs of Safety tool is to consider indicators of risk and harm alongside strengths and safety factors.

Supervision discussions that are not patient related or that are retrospective should be recorded using the Supervision discussion template (appendix 4) and a copy saved securely by both supervisor and supervisee.

4.7 Ad-Hoc Safeguarding supervision

It is recognised that colleagues will often require advice or support in relation to safeguarding outside of formal supervision sessions. In the first instance they should approach their line manager or safeguarding supervisor in their department or contact a DBTH safeguarding professional. The Safeguarding professionals are available for advice regarding any safeguarding issues that practitioners wish to discuss. Please contact the Safeguarding Secretary for contact numbers, or to arrange ad-hoc supervision on 01302 642437.

4.8 Medical colleagues – Safeguarding children supervision

Consultant Paediatricians have established safeguarding supervision arrangements that include peer supervision via bi-monthly Peer Review Meetings and ad hoc 1:1 supervision provided by Named / Designated Consultants where required. The Royal College of Paediatrics and Child Health (RCPCH) sets out good practice recommendations regarding frequency of peer review meetings and participation; RCPCH recommend that Paediatricians attend a minimum of four Peer Review meetings per year, or 50% of the meetings held, whichever is the greater. The requirement set out for DBTH safeguarding supervision compliance in relation to Consultant Paediatricians, is a minimum of 6 monthly. All other medical colleagues who work with children and families as part of their clinical role, are required to access supervision on an Ad-Hoc basis when required.

4.9 Patients lacking capacity

PATIENTS LACKING CAPACITY

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the Extranet.

There is no single definition of Best Interest. *Best Interest is determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

4 TRAINING/SUPPORT

DBTH will ensure that those practitioner's providing safeguarding supervision will be trained in safeguarding supervision skills. Supervision training, including mandatory updates will be provided through internal or external training providers depending on availability.

DBTH provides regular mandatory safeguarding training to all employees that is role specific are per the Intercollegiate Document (2019). It is the supervisor and supervisee's responsibility to ensure they have an up to date knowledge of safeguarding frameworks, legislation, policy and procedures. Practitioners can access further information about safeguarding procedures by accessing the following online:

Doncaster Safeguarding Children's Partnership Doncaster Safeguarding Children Partnership (dscp.org.uk)

Doncaster Safeguarding Adults Board Doncaster Safeguarding Adults Board (DSAB) - City of Doncaster Council

Nottinghamshire Safeguarding Children's Partnership Nottinghamshire Safeguarding Children Partnership

Nottinghamshire Safeguarding Adults Board Nottinghamshire Safeguarding Adults Board

5 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Audit of the supervision process and adherence to this policy within the Trust is required to demonstrate compliance with Section 11 of the Children Act 2004 and in reporting of safeguarding performance and compliance to Local Safeguarding Partnerships and Integrated Care Boards. An annual safeguarding declaration is also completed.

Monitoring Arrangements

Line Managers must be able to evidence their arrangements for safeguarding supervision and records should be retained to demonstrate this.

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Adherence to policy	DBTH Safeguarding Team.	Quarterly	Review of compliance returns. Reported to Strategic Safeguarding Group.

6 DEFINITIONS AND ABBREVIATIONS

Supervision: For the purpose of this policy, supervision can be defined as 'an accountable process which supports assures and develops the knowledge, skills and values of an individual, group or team. The purpose is to improve the quality of their work in order to achieve agreed outcomes'. Working Together to Safeguard Children (2023).

Group supervision: Group supervision is a negotiated process whereby members come together in an agreed format, to reflect on their work by pooling their skills, experience and knowledge in order to improve both individual and group capacities. Morrison (2005).

CIN	Child in Need
CO	Care Order
CPP	Child Protection Plan
CSPR	Childrens Safeguarding Practice Review
CQC	Care Quality Commission
DBTH	Doncaster & Bassetlaw Teaching Hospitals
DfE	Department for Education
DOH	Department of Health
EPO	Emergency Protection Order
ESR	Electronic Staff Record
ICO	Interim Care Order
ICB	Integrated Care Board
LAC	Looked after Child
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conferences
MCA	Mental Capacity Act
NHS	National Health Service
NSPCC	National Society Prevention Cruelty to Children
PPO	Police Protection Order
RCN	Royal College of Nursing

7 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified (appendix 13).

8 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Safeguarding Children Policy - PAT/PS 10
Safeguarding Adults Policy PAT/PS 8
Mental Capacity Act 2005 Policy and Procedures including deprivation of liberty safeguards (DoLS) PAT/PA 19
Equality Analysis Policy - CORP/EMP 27
Fair Treatment for All Policy - CORP/EMP 4
Was Not Brought Policy PAT/T79
Prevent Policy CORP/RISK 25
Domestic Abuse Policy PAT/PS 12
Female Genital Mutilation Identification, Reporting and Management PAT/T 64

9 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

10 REFERENCES

Bunker D, Wijnberg I (1988) Supervision and Performance: Managing professional work in human service organisations. San Francisco. Josey Bass.

CQC (2009) Safeguarding Children. A review of arrangements in the NHS for safeguarding children.

Department of Health (1989) Children Act. Available at: Children Act 1989 (legislation.gov.uk) (Accessed: 27 August 2024)

Department of Health (2004) Children Act. Available at: Children Act 2004 (legislation.gov.uk) (Accessed: 27 August 2024)

HM Government (2023) Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children. Available at: Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk) (Accessed: 27 August 2024)

Jarvis P (1995) *Adult and Continuing Education.* London. Routledge.

Laming, Lord (2009) The protection of Children in England: A Progress Report. London, HMSO

Mental Capacity Act 2005 Available at: Mental Capacity Act 2005 (legislation.gov.uk) (Accessed: 27 August 2024)

Morrison T (2005) Staff Supervision in Social Care: Making a Real Difference for Staffand Service Users. London. Pavillion.

Royal College of Nursing (2014) Safeguarding Children and young people- every nurse’s responsibility. London. RCN.

RCPCH (2024) Peer Review in child protection. Available at: Peer Review in child protection - RCPCH Child Protection Portal (Accessed: 27 August 2024)

APPENDIX 1 – SAFEGUARDING CHILDREN SUPERVISION FREQUENCY TOOL

Supervision in line with staff role

Staff Role	Recommended Supervision Frequency (minimum)	Individual	Group	Suitable Supervisors
Safeguarding Professionals	3 Monthly	Yes	No	Designated Nurses or Named Nurses/Safeguarding professionals who are /internal or external to the Trust
Safeguarding Supervisors	6 Monthly	On an ad hoc basis as and when required	Yes	Safeguarding Professional within the Trust SG Team
Practitioners working predominantly with children & families	6 Monthly	On an ad hoc basis as and when required	Yes	Safeguarding supervisors within the Trust
Consultant Paediatricians	6 monthly	On an ad hoc basis as and when required	Yes (via attendance at the Paediatric Peer review group)	Named Doctors for Safeguarding / Designated Doctor
Other Medical colleagues working with children and families	On an ad hoc basis and when required	On an ad hoc basis and when required	No	Supervising Consultant / Named / Designated Doctor for Safeguarding / Trust Safeguarding Team
Acute/Community based practitioners predominantly working with children & families	6 Monthly	On an ad hoc basis as and when required	Yes	Safeguarding supervisors within the Trust
Role involves working with adults and those who may see children/young	On an ad hoc basis as and when required	On an ad hoc basis as and when required	On an ad hoc basis as and when required	Safeguarding Supervisors within the Trust / Safeguarding professionals in the Trust SG Team

people intermittently				
Non Clinical colleagues Will **NOT** be monitored through compliance reporting.	On an ad hoc basis as and when required	On an ad hoc basis as and when required	On an ad hoc basis as and when required	Line Manager or Safeguarding Supervisor within the Trust

It is recognised that colleagues will often require advice or support in relation to safeguarding outside of formal supervision sessions.

APPENDIX 2 - COMPETENCE INDICATORS FOR SUPERVISOR CHECKLIST

Competence indicators for supervisor – check list

INDICATOR	YES/NO	COMMENTS
Understands purpose and key task of supervision		
Understands and can explain DBTH's supervision policy		
Understands and can explain the boundaries of supervision (as outlined in the supervision contract)		
Understands and can explain the 4 functions of supervision (management/support/development/mediation)		
Understands and can explain the purpose of supervision to supervisees		
Understands and can escalate persistent non-engagement by the supervisee		
Understands an appropriate environment conducive to a positive supervision session		
Understands and can support accurate recording of supervision		
Understands that the supervision process is child focussed		
Understands and can enable the supervisee to identify and explain evidence, risks, needs strengths, values, attitudes, feelings policies, and professional knowledge underpinning their practice and decision making		

Effective Supervision

INDICATOR	YES/NO	COMMENTS
Understands and can identify/analyse poor or blocked behaviour and establish a strategy to address the issues		
Understands and can professionally challenge concerns, discriminatory attitudes and behaviour		

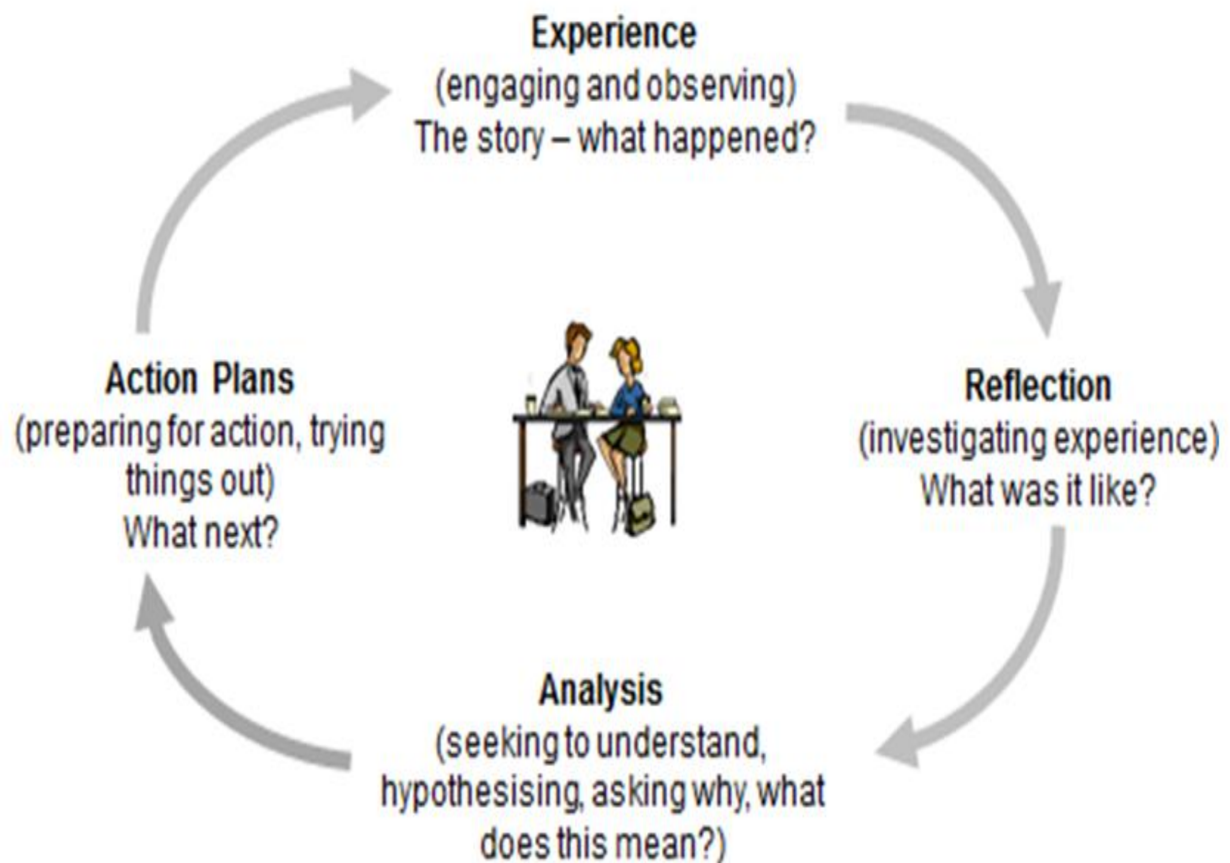
Demonstrates understanding of practice resolution and support within DBTH		
Demonstrates an awareness of the benefits of effective supervision for the key stakeholders (child/practitioner/organisation/partner organisations		

	Name/Designation	Date
Self-Assessment		
Assessor		

Comments

Signed Safe and Effective	Designation	Date

APPENDIX 3 – KOLB SUPERVISION CYCLE



Kolb – Style Questions to support Supervision

General questions

- What would you like to happen/what do you want?
- How will you know if this piece of supervision has been helpful to you?
- What do I need to know about…?
- What do you see as the main issues/your chief dilemma?
- What do you think are the main contexts influencing this situation?
- How do you understand…?
- What explanations do you have?
- How would you describe…?
- How would xxxxx view you/what is going on?
- What would xxxxxx say?
- Has there been a situation like this before?
- When xxxxx does this what does y do/how would you react?
- What you have said made me curious about…
- How would a manager/the NMC/regard this?
- If you looked at this from a 'patient safety' perspective what thoughts would you have?
- What are the differences in beliefs/understandings/approaches between…?
- What do you think would need to happen?
- What would happen if you tried…?
- Where do you think things will be in…(time)?
- What will happen if nothing changes?

Focus on Experience

Here the emphasis is on facilitating an accurate and detailed recall of events. A partial description of the situation will undermine the rest of the cycle. We can be assisted to recall more than we think if the right questions are asked.

How are you today- what's your day been like so far?

- What happened before the visit/meeting?
- What was your role?
- What was your aim? What planning did you do?
- What did you expect to happen?
- What happened?
- What did you say and do? What methods or interventions did you try?
- What did the baby and/or client say or show?
- What reactions did you notice to what you said/did?
- What surprised or puzzled you?
- What struck you? What were the key moments?
- What words, nonverbal communications, smells, sounds, images struck you?
- What did you notice about yourself/ the users/ other worker?
- What didn't you notice? What was hard to observe?
- What observations or concerns do other agencies have?
- What went according to plan? What didn't happen?
- What changes or choices did you make?
- What did you say, notice or do immediately after the session/appointment?

Focus on Reflection

Here the emphasis is on eliciting feelings, partly because they bring out further information, or may reveal out underlying attitudes. They may also give clues to other personal factors complicating/blocking the workers experience. Reflection helps the worker make links between the current situation and his/her prior experiences, skills and knowledge.

- What did you feel at the start of this visit? What feelings did you bring into the visit?
- Describe the range of feelings you had in this visit?
- What did the visit/your feelings remind you of?
- What previous work, processes, skills, knowledge are relevant?
- What patterns did you see in the visit? Are these familiar?
- Where have you encountered similar processes?
- Describe a time when you last experienced that – what happened?
- Who/What does the client remind you of?
- What did you think the client was thinking? Based on your evidence?
- What feelings might you or other workers be carrying on behalf of the client? For example what transference of projection might have been occurring?
- What other factors might influence how you, the client, co-worker felt or reacted? For example, race, age, gender, sexuality?
- Where or when did you feel most or least comfortable?
- Who seemed least or most comfortable – at what points?
- What thoughts went through your mind during the session?
- What ideas came to you during the session?
- What did you tell yourself about what was happening, or about your feelings?
- What feelings were you left with – does this always happen after seeing these kinds of cases?
- What metaphor or analogy would you describe your experiences of working with this situation?
- What was left unfinished?

Other methods to assist reflection include role play, genogram, eco maps to draw out context, roles and patterns.

Focus on Analysis

Here the emphasis is on analysis, probing the meanings that the supervisee and the user attribute to the situation, consideration of other explanations, the identification of what is known or understood, and the areas for further assessment.

- List three assumptions you brought into this visit?
- How do you explain or understand what happened in the visit?
- How did this visit fit/or not fit into the overall aims of your work with this client?
- What aims/outcomes were/were not achieved?
- What went well, or not well and why?
- What other, possibly unexpected outcomes, did the visit produce?
- How else could you explain what was happening in that visit?
- How far did this visit confirm or challenge your previous understanding or hypothesis/
- What new information emerged? What was the critical moment?
- What theory, training, research, policy, values might help you make sense of what happened in this session?
- How else might you have managed the visit?
- What are the current needs, risks, strengths for the user/s?
- What is unknown?
- What conclusions are you drawing from this work so far?
- How would you define your role in this situation?
- How would other key agencies define your role?
- How would the client define your role?
- What expectations does your agency have of your role?
- What family or community behaviours are acceptable to you?

Other methods to assist analysis include: What do you know tool, Signs of safety framework, sharing articles, references, case presentations, external speakers, attending training, group supervision

Focus on Action Plans

The focus here is on translating the analysis into planning, preparation and action. This includes the identification of outcomes and success criteria as well as consideration of potential complications and contingency plans.

- In light of the reflection and analysis we have done, what is your overall summary of where things are at, and what needs to be done next?
- Can you identify what you are not and what you are responsible for in managing this case?
- What training, supervisory, co-work and support needs have been raised for you?
- What information needs to be obtained before proceeding?
- What are your aims in the next phase of the work?
- What is urgent and essential?
- What would be desirable?
- What is negotiable and non-negotiable in this situation?
- What would be a successful outcome to the next session from your perspective/service users/other agencies?
- What might be your strategy for the next session?
- What are the possible best or worse responses from the client?
- How can the client be engaged- what does s/he need from you?
- What contingency plans do you need – what is the bottom line?
- Who else needs to be involved?
- What would you like from them?
- How well equipped do you feel to undertake this?
- Where do you feel more or less confident?
- How can you prepare for this – mental rehearsal, flip charts, reading, co-worker discussion?
- What can I do that will be helpful at this stage?
- When does feedback and debrief need to take place?
- Are there any safety issues for you/others?
- What can we do to minimise the dangers/risk?

Other methods may include role play, co-work planning, case planning, contacting other agencies involved, use of the Signs of safety framework/What do you know tool.

APPENDIX 4 - SUPERVISION DISCUSSION TEMPLATE

Doncaster and Bassetlaw Teaching Hospitals NHS Trust

Supervision Session/Discussion

Date of Session: ………………………………….. **Date of Last Session: …………………………………………………**

Supervisor: …………………………………………. **Supervisee: ……………………………………………………………..**

Issues Discussed	Actions	Who and when
Agenda AOB		

Issues Discussed	Actions	Who and when

APPENDIX 5 - SAFEGUARDING SUPERVISION CONTRACT

Safeguarding Supervision Contract

1. Ground Rules

Punctuality – time keeping important.

Uninterrupted time – not exceeding 2 hours.

Commitment – must be given high priority and should only be cancelled in exceptional and unforeseen circumstances. Every effort will be made to reconvene a cancelled meeting within 2 weeks.

Reciprocity and Respect – mutual interaction and respect are important. If disagreements occur that cannot be resolved within the supervision meeting to both parties satisfaction, it will be referred to the supervisors line Manager for consideration.

2. Frequency of supervision

Supervision will be accessed a **minimum** of once every 6 months. At each supervision session a mutual agreeable date will be made for the next supervision session.

3. Agenda Preparation

Whilst not an exhaustive list the following should be considered in safeguarding supervision:

- Any cases where a family member is subject to MARAC (victim or perpetrator) and where areas of concern remain
- Any cases where a colleague has not been able to complete an action on a child protection plan/strategy meeting/safeguarding investigation
- Any cases where there is concern that the current safeguarding plan or actions may not meet the child or adult's needs (including unborn)
- Any cases where there are professional differences of opinion regarding protection planning and how this was resolved
- Any cases that are particularly traumatic and colleagues may need further support
- Any cases where the practitioner has concerns they wish to discuss
- Mental capacity concerns (parents and children 16 and over apply MCA). Under 16, Gillick competency principles' apply
- Any significant learning disabilities or barriers to communication
- At cases 'where was not brought' is a concern
- Any case identified for discussion by either the supervisor or supervisee

4. Issues of Confidentiality

Supervision records made during a session which are not related to a child/adult will be recorded on the supervision session/discussion sheet and a copy retained securely by the supervisor, A copy can be provided to the supervisee where requested with the expectation of this being securely stored.

All employees are responsible for maintaining confidentiality in respect of colleagues and service users.

5. Date to Review Agreement

Annually.

6. Recording Method

Discussions about individual children, adults and families will be recorded directly into the relevant patient record system during the supervision session as per Supervision Policy.

Any personal information will be treated as confidential unless such disclosures directly affect the work of the supervisee or implementation of DBTH policies and procedure.

Signed ………………………………………….Date………..

Signed ………………………………………….Date………..
Copy for supervisor and supervisee

APPENDIX 6 – SIGNS OF SAFETY TOOL

Signs of Safety tool

<table>
<tr><td><u>What's Working well?</u></td><td><u>What are we worried about?</u></td><td rowspan="2"><u>What needs to change?</u></td></tr>
<tr><td><u>Child/Adult's Voice</u></td><td><u>Child/Adult's Eco Map (Family and Support)</u></td></tr>
</table>

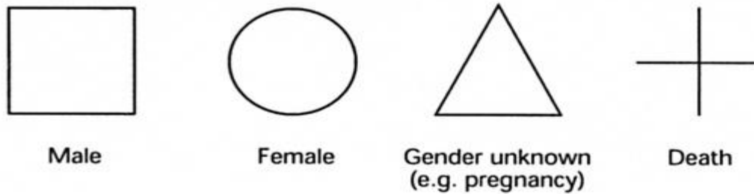
APPENDIX 7 – WHAT DO YOU KNOW?

Useful tool - What Do You Know?

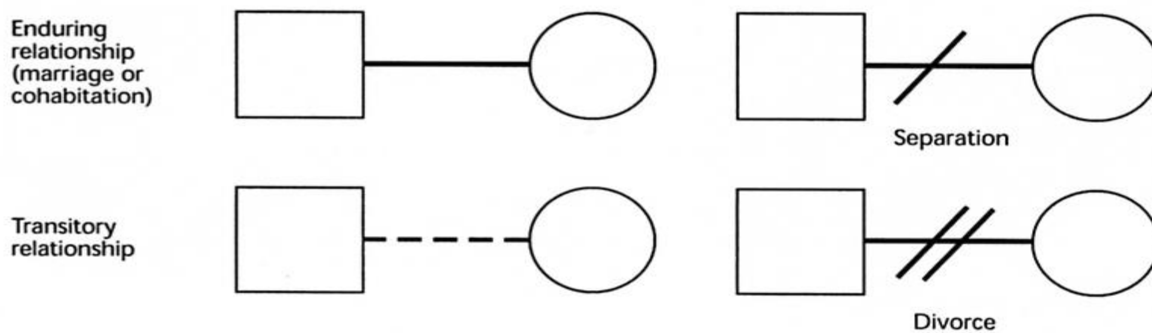
WHAT DO YOU KNOW?	WHAT DO YOU 'THINK' YOU KNOW?
WHAT DO YOU NEED TO KNOW?	**WHAT ACTIONS ARE NEEDED?**

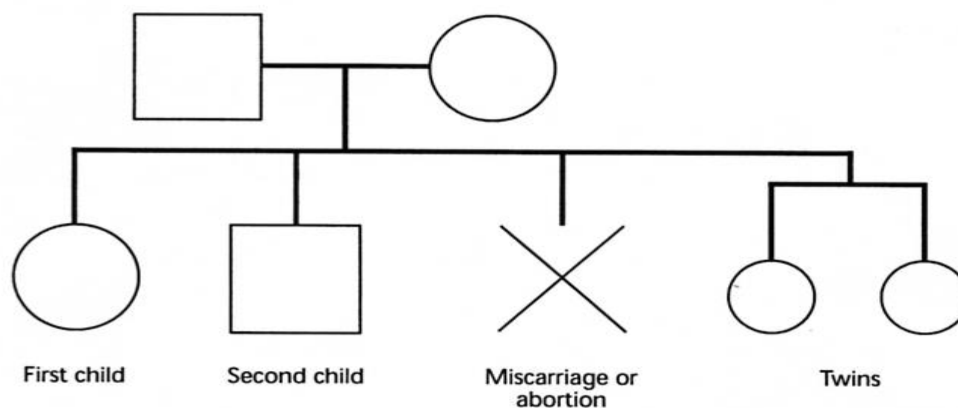
APPENDIX 8 – GENOGRAM SYMBOLS

Genogram symbols



Genogram symbols



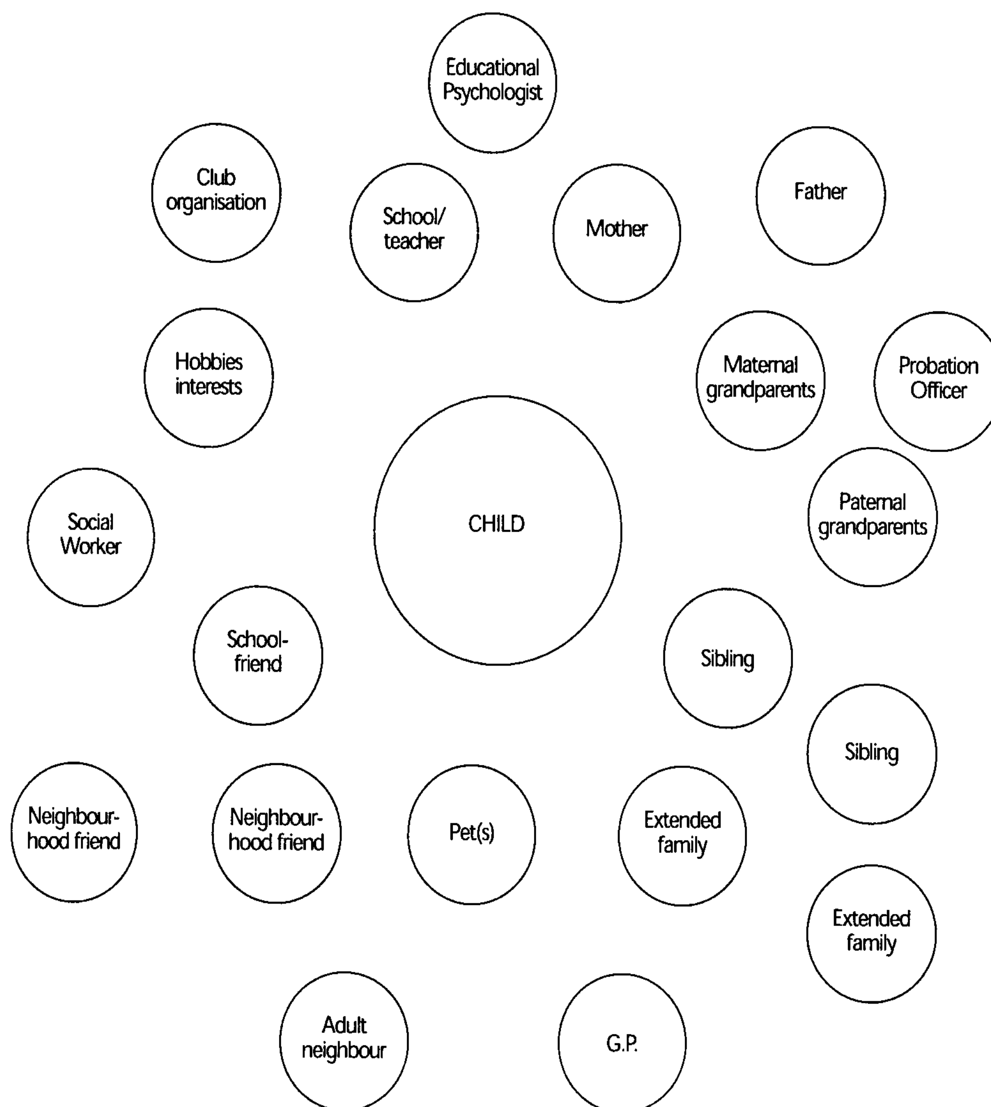


A dotted line should be drawn around the people who currently live in the same house.

Compiling a genogram

A genogram of family tree covering three or more generations may be compiled using these symbols. Other relatives in addition to parents and children can be involved in compiling the genogram. More than one session may be needed if the exercise is used to discuss the family's history in detail and to enter significant dates and other information. Working on a genogram also provides the practitioner with an opportunity to observe family relationships, for example how open family members are with each other, how well they respond to each other's needs, how flexible they are and how much they know about each other.

APPENDIX 9 – ECO MAP



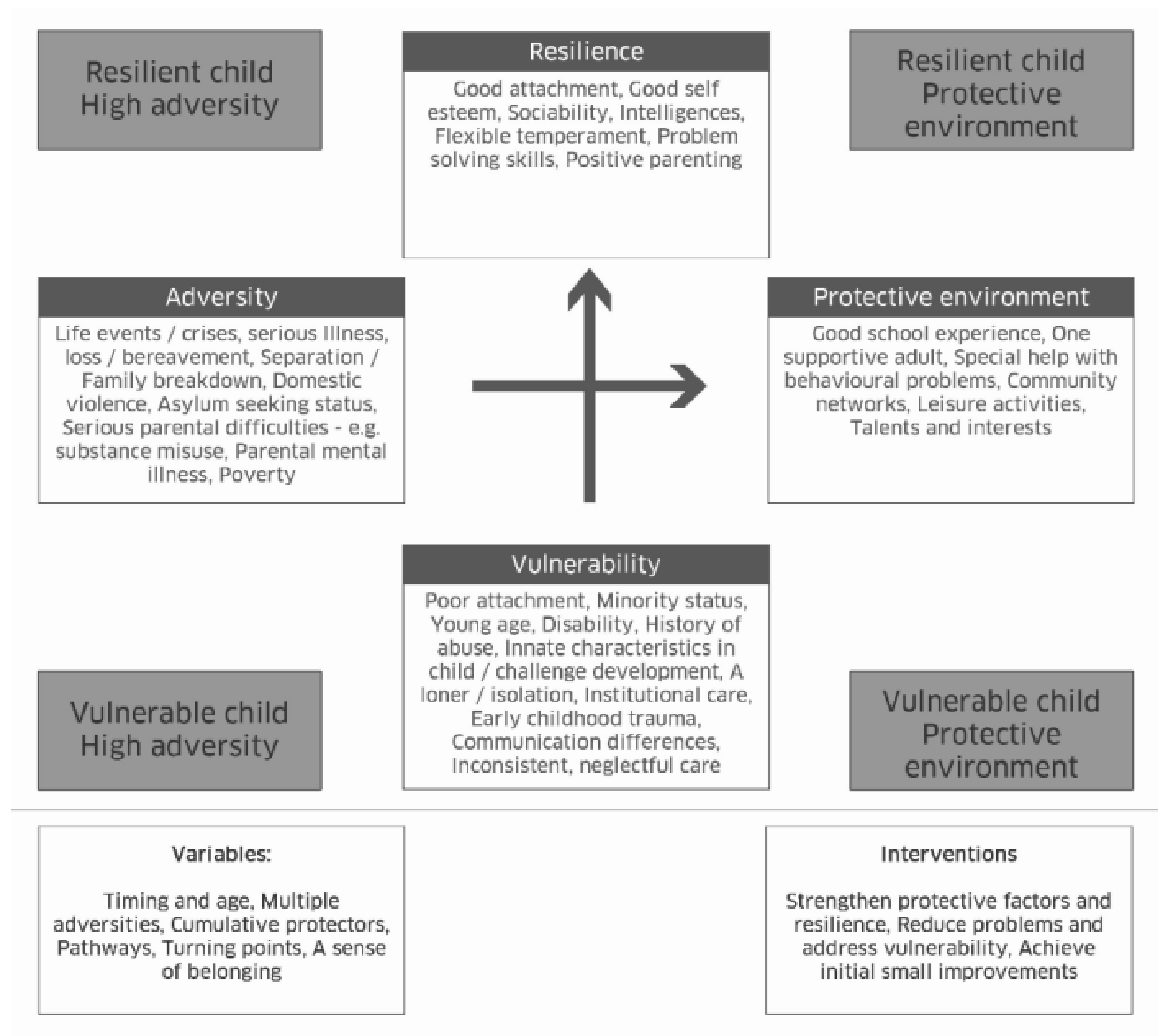
- Place child or couple or family in central circle.
- Identify important people or organisations and draw circles as needed
- Draw lines between circles where connections exist
- Use different types of lines to indicate the nature of the link or relationship

——— = strong

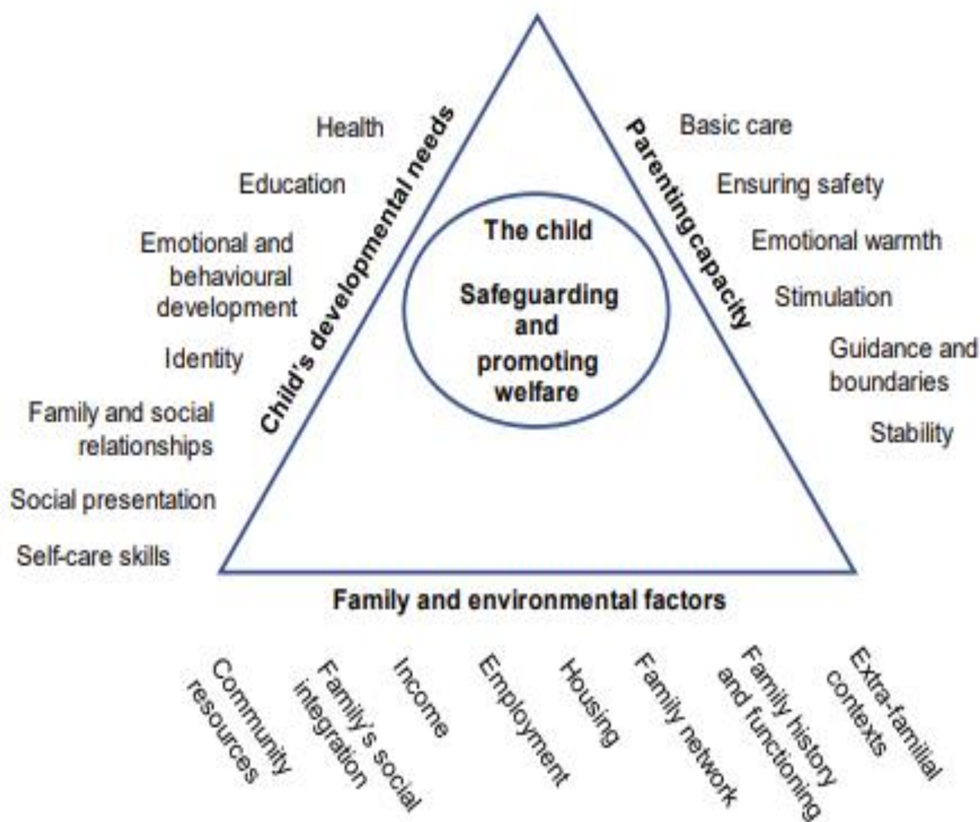
- - - - = weak

· · · · · = stressful

APPENDIX 10 – RESILIENCE AND VULNERABILITY MATRIX



APPENDIX 11 – ASSESSMENT FRAMEWORK



Working Together to Safeguard Children (2023).

APPENDIX 12 – SUPERVISION COMPLIANCE TEMPLATE

Safeguarding Supervision compliance template

Completed by:	Division:	Date:	Quarter:

Department	Number of people requiring supervision	Number of people compliant	Number of people non-compliant	Overall compliance percentage

APPENDIX 13 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Safeguarding Supervision Policy	Safeguarding	Vicki Baker	Existing policy - update	5.9.2024

1) **Who is responsible for this policy?** Name of Division/Directorate: Safeguarding team - DBTH

2) **Describe the purpose of the service / function / policy / project/ strategy?** Who is it intended to benefit? What are the intended outcomes? To provide guidance for colleagues on safeguarding supervision and requirements for role.

3) **Are there any associated objectives?** Legislation, targets national expectation, standards: Working Together 2023, Children Act 2004.

4) **What factors contribute or detract from achieving intended outcomes?** – Adherence to policy

5) **Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief?** Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) **Is there any scope for new measures which would promote equality?** [any actions to be taken] – N/A

7) **Are any of the following groups adversely affected by the policy?**

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) **Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box**

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: **August 2024**

Checked by: [signature] **Date: 5.9.2024**