Safeguarding Supervision Policy

Solent NHS Trust policies can only be considered to be valid and up-to-date if viewed on Solnet. Please visit Solnet for the latest version.

Purpose of Agreement	This policy outlines the expectations in relation to safeguarding supervision across the Trust. It outlines the arrangements for safeguarding supervision and how this is recorded and monitored.
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Amendments Summary:

Please fill the table below:

Amend No	Issued	Page	Subject	Action Date
1	3.16	8	Including responsibility to activate escalation procedure	
2	4.3	9	Staff to be familiar with new guidance appendix D	
3	4.3	9	Detail of the amount of cases required	
4	4.4	9	Expectations for supervisors if a supervisee has not discussed the minimum cases	
5	Appendix B	13	Changes added to the supervisors contract to reflect the above (2)	
6	Appendix B	13	Changes added to the supervisees contract to reflect the above (1)	
7	Appendix D	16-17	Incorporate Appendix D at the end of the policy.	
8	1.3	6	Requirements for adult services and think family approach made more explicit	30/06/20
9	2.2	6	Requirements for adult services made more explicit	30/06/20
10	3.16	8	Escalation process added	30/06/20
11	4.3	9	Additional requirements added	30/06/20
12	Appendix B	14	Additional requirements added	30/06/20
13	Appendix D	16	Appendix added	30/06/20
14	Append D	17	Omitted 'Safeguarding Adults' section added	02/03/2021

Review Log:

Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
V1	New policy – ratified May 2018	Angela Anderson	PSG, Assurance Committee	
V2	August 2020	Fiona Holder	SSG, PSG, Management Meeting	
V3	March 2021	Fiona Holder	Approved via Policy Steering Group Chair's action	Add the omitted content to Appendix D relating to Safeguarding Adults

SUMMARY OF POLICY - SAFEGUARDING SUPERVISION: GUIDE FOR CLINICIANS

This policy applies to active clinical staff, specific admin staff working in clinical areas, clinical agency staff, employed within the Trust, student, or volunteer. Every active clinician delivering care to patients/clients in Solent NHS Trust is expected to undertake safeguarding supervision.

What it is

Safeguarding Supervision is the framework for staff to safeguard patients, providing high quality, safe care. It is an opportunity to:

- Reflect and review their practice
- Discuss individual cases in depth
- Change or modify their practice and identify training and continuing development needs

What it isn't

Safeguarding supervision is different to clinical, management or educational supervision, however, safeguarding cases may be discussed as part of a clinical supervision session, please see section 3.6 for more detail. It is different to the everyday practice of discussing urgent clinical or safeguarding cases with peers/seniors in the moment.

There are different models of supervision and in Solent NHS Trust clinicians are expected to access at least one option for safeguarding supervision every 12 weeks. The options available in the Trust are:

Each service/team needs to decide on the most appropriate model for their area and agree this with the clinical director (CD)/ Professional Lead Quality, Standards & Quality for that service.

1. One to one- meetings with your clinical supervisor, safeguarding lead or member of the safeguarding team - this may include reflecting on a specific case, or a caseload review,
2. Group sessions- a larger number of individuals meeting perhaps as part of an educational session, or as part of an MDT
3. Case review- a smaller number of individuals meeting regularly to work through issues of mutual interest
4. Specialist safeguarding supervision either as a group or one to one but facilitated by safeguarding specialist nurse/Named Nurse or Named Doctor e.g. Family Nurse Partnership (FNP)

Essential elements which need to be included in the model are:

- A formal arrangement with a named supervisor, learning set or peer group
- Confidential if 1-1 or group
- Protected time for both supervisor and supervisee
- Used to discuss issues relevant to clinical practice and safeguarding practice
- Structured reflection
- Facilitates learning and quality improvement
- Could include risk management and case review
- Could address safeguarding issues
- Recorded on the template on SystmOne and logged on SolNet

Monitoring

- Individual staff are expected to upload confirmation of their safeguarding supervision shortly after it takes place
- Supervisors are expected to ensure all staff they supervise upload as required
- Summary of discussion and agreed action points to be held by the supervisor and/or supervisee
- Managers are expected to monitor compliance by receiving reports from team leaders
- Clinical Directors are expected to review compliance at local clinical governance meetings
- Compliance is reported quarterly at Performance review meetings with Chief Operating Officers.
- Compliance should be measured annually

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1. INTRODUCTION & PURPOSE

1.1 Safeguarding Supervision offers a formal process of professional support and learning for practitioners. Safeguarding Supervision is about the 'how' of safeguarding practice; it provides a framework for examining and reflecting on a case from different perspectives. It also facilitates the analysis of the risk and protective (resilience) factors involved (Her Majesty's Government, 2015).

1.2 Solent NHS Trust recognises the importance of safeguarding supervision in professional development and that it helps the supervisee develop confidence in decision making.

1.3 The purpose of the policy is to outline expectations on ALL clinicians and managers from all service lines, in relation to safeguarding supervision across the Trust. It confirms the arrangements for safeguarding supervision and how this is recorded and monitored. Safeguarding supervision encompasses the "Think Family" approach to safeguarding, acknowledging that staff from adult services may require safeguarding supervision on child concerns and vice a versa.

1.4 The policy acknowledges that for some key staff, for example clinicians working in the field of safeguarding, looked after children, adult mental health, Family Nurse Partnership (FNP) additional safeguarding supervision will be required. See details below.

2. SCOPE & DEFINITIONS

2.1 Safeguarding supervision is an accountable process which supports, assures and develops the knowledge, skills and values of an individual group or team. (Skills for Care, 2007). It provides the opportunity for staff to:

- Reflect and review their practice
- Discuss individual cases in depth
- Change or modify their practice and identify training and continuing development needs

2.2 This document applies to ALL active clinical staff from all service lines, including agency staff, bank staff, employed within the trust, whether paid, unpaid, student or volunteer.

3. PROCESS/REQUIREMENTS

3.1 Safeguarding Supervision is the framework for safeguarding patients and is different from clinical supervision (Please see Clinical Supervision policy for more details).

3.2 Safeguarding Supervision is a requirement for all clinical staff working directly with adults and children.

3.3 Consideration needs to be given to non-clinical staff regarding access to safeguarding supervision as and when appropriate dependent on exposure e.g. Safeguarding administrator, Looked after children administrators, FNP administrators, Patient Advice and Liaison Service (PALS) and complaints team.

3.4 All clinicians and those who facilitate safeguarding supervision are expected to access safeguarding supervision a minimum of every 12 weeks. This must be recorded on the Trust system.

3.5 There are a number of different models of supervision available which include:

- One to one- meetings with your clinical supervisor or safeguarding lead or a member of the safeguarding team - this may include reflecting on a specific case, or a caseload review.
- Group sessions- a larger number of individuals meeting perhaps as part of an educational session, or as part of an MDT.
- Case review- a smaller number of individuals meeting regularly to work through issues of mutual interest.
- Specialist safeguarding supervision facilitated by safeguarding specialist nurses/named Nurse/Named Doctor e.g. FNP.

3.6 Safeguarding Supervision is separate from but complimentary to other forms of management and clinical supervision. If safeguarding supervision is to be discussed within protected clinical and management supervision time then evidence of this needs to be maintained and available for reporting purposes.

3.7 The minimum requirements for the participation in Safeguarding Supervision by clinicians will be reinforced during the appraisal process and participants will be expected to demonstrate compliance of the requirements at subsequent appraisals.

3.8 Adequate protected time must be allowed for effective supervision to take place and interruptions only allowed for urgent situations. Each session will last minimum of 1 hour maximum 2 hours.

3.9 Each service/team will decide with their line manager on the most appropriate model for their area and agree this with the clinical director/ professional lead quality, standards & governance for the service.

3.10 The clinician or group will have a formal agreement with a named supervisor and this can be recorded on a form such as the one provided in appendix B.

3.11 One to one supervision will be confidential. A summary of discussion and agreed action points should be recorded and retained by the supervisee/s and appendix C provides a suggested template.

3.12 Following a supervision session, individuals will upload confirmation of their supervision as soon as possible after it has taken place using the Trust recording database.

3.13 Following the supervision session individuals will ensure the client record is also completed with a record of supervision and action plan agreed.

3.14 Family Nurse Partnership (FNP)

- Safeguarding supervision for the Family Nurses is provided by the FNP supervisor and is integrated within the wider supervisory role of the FNP supervisor. The Family Nurses receive one to one weekly supervision from the supervisor and this is sufficient to address

most safeguarding issues relating to children, young people and adults without the need for additional safeguarding supervision. Weekly supervision is a licensing requirement.

- FNP Supervisors will keep a record of clients discussed at supervision using the FNP national unit supervision template.
- The Family Nurses and their supervisors will receive 6 weekly group supervision with their supervisors and by a senior safeguarding specialist, e.g. Safeguarding programme lead, NHS England.
- The Named Nurse for Safeguarding Children will provide safeguarding supervision for the FNP supervisor's clinical work on a monthly basis and will be available for advice and support on safeguarding issues for the Family Nurses.

3.15 Community Paediatricians, Dental, Podiatry and GP's

- Community Paediatricians, Dentists and GP's will access safeguarding supervision as agreed with Clinical Director and will provide evidence of their safeguarding supervision.

3.16 Escalation

- Both Supervisor and supervisee have a responsibility within safeguarding supervision to consider if there is a requirement to activate the Hampshire, IOW, Portsmouth and Southampton Escalation Protocol, which is available on Solnet or via the safeguarding team.

4. ROLES & RESPONSIBILITIES

4.1 Directors, Clinical Directors, Operational Directors are responsible for:

- Ensuring appropriate models of safeguarding supervision are in place for all active clinical staff.
- Ensuring that there are systems in place to monitor their services compliance with safeguarding supervision.
- Clinical Directors to review compliance at local governance meetings.
- Chief Operating Officers to receive quarterly reports on compliance from Clinical Directors at performance review meetings.

4.2 Managers and service leads are responsible for:

- Agreeing the appropriate model of safeguarding supervision for their team.
- Ensuring all active clinical staff are aware of the expectation to attend a minimum of 12 weekly safeguarding supervision as agreed with Clinical Director and Professional Lead and are facilitated to attend.
- Ensuring all active clinical staff are aware of the requirement to record their safeguarding supervision on the Trust database and that they have access to the system.
- Identify the admin staff who require safeguarding supervision, facilitate and monitor their attendance.
- Monitoring their staffs attendance at safeguarding supervision and report compliance through the appropriate governance systems.
- Ensuring that there are sufficient numbers of trained supervisors available within their team/service to deliver high quality supervision.
- Having oversight of clinicians safeguarding caseload and ensuring appropriate recording is maintained.

4.3 Clinical staff (Supervisees) are responsible for:

- Ensuring they identify with the support of their manager a suitable supervisor and agree the dates for their supervision sessions.
- Be familiar with the attached Appendix D '*A Practitioner Guide on when to Consider a Case Discussion within Safeguarding Supervision'* to support with prioritising case selection.
- Preparing for supervision sessions, including identifying issues from their practice for discussion.
- Taking responsibility for the outcomes and actions taken as a result of the supervision.
- Keeping a written record of their supervision sessions.
- Recording their supervision sessions on the Trust database.
- Where appropriate record any decisions or outcomes of supervision discussions in the patients clinical records.
- There is an expectation that clinical staff will discuss a minimum of 4 cases per year at safeguarding supervision.

4.4 Supervisors are responsible for:

- Ensuring they attend supervisor training provided by the Trust and have 3 yearly updates.
- Being supportive and facilitating the supervisee to identify issues, manage their response to their practice and identify personal and professional development needs.
- Supervisors undertaking the 1:1 model of supervision should expect to discuss a minimum of 4 cases per year with each clinical staff member. If that has not occurred, then there is an expectation that the supervisor facilitates this with random case load selection with guidance from Appendix D.
- Ensuring there is a supervision contract in place so that supervisor and supervisee are clear about roles, responsibilities and boundaries.
- Keeping a record of supervision sessions.
- Ensuring they appropriately share information where there are serious concerns regarding the conduct, competence or health of a clinician.
- Supporting the supervisee to access specialist safeguarding supervision where this is appropriate.
- Discuss any recurrent non-attendance at supervision with the relevant line manager or following the agreed local processes.

5. TRAINING

5.1 Safeguarding and clinical supervision training will be provided by the Learning & Development team with support from the safeguarding specialist nurses.

5.2 All new supervisors will complete this training prior to undertaking supervision and will be registered on a central database.

5.3 All existing supervisors will complete 3 yearly updates.

5.4 For the purpose of quality assurance an annual peer review system will be implemented.

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 A thorough and systematic assessment of this policy has been undertaken in accordance with the organisations Policy on Equality and Human Rights.

The assessment found that the implementation of and compliance with this policy has no impact on any employee on the grounds of age, disability, gender, race, faith, or sexual orientation. See Appendix A.

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 Services will report compliance with supervision to the Clinical Director through local governance meetings.

7.2 The Clinical Director will report compliance to the Chief Operating Officer on a quarterly basis through performance committee.

7.3 The professional leads, Quality, standards and governance will facilitate an annual review of impact of supervision on practice, using a range of methods, and report through governance structures.

7.4 Services will escalate to the Chief Nurse, through governance structures, any barriers to implementation of the clinical supervision policy.

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

This policy must be read in conjunction with the below policies that are available on Solnet: http://intranet.solent.nhs.uk/DocumentCentre/Pages/Policies,-Clinical,-SOPS-and-Clinical-Guidelines.aspx

- CLS18 Clinical supervision Policy
- AP01: Safeguarding Adults policy
- CP01: Safeguarding children and young people policy
- HR43: Performance management policy
- LD03: Supporting learning in practice
- HR17: Policy for managing performance of medical and dental staff
- GO18: Freedom to Speak Up
- HR19: Medical Appraisal and revalidation policy

In addition, this should be read in conjunction with the following guidance:

- Care Quality Commission: Regulation 18: Staffing (2014)
- Skills for Care: Providing effective supervision (2007)
- Care Act 2014
- Working Together 2015

10. GLOSSARY

10.1 MDT: Multidisciplinary team
FNP: Family Nurse Partnership
HMG: Her Majesty's Government
PALS: Patient Advice and Liaison Service

Appendix A:

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims

Service Line / Department	Safeguarding	
Title of Change:	Safeguarding Supervision Policy	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	To set out the expectations regarding access to safeguarding supervision for clinical staff who are actively involved in delivering care.	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			*	
Gender reassignment			*	
Disability			*	
Age			*	
Sexual Orientation			*	
Pregnancy and maternity			*	
Marriage and civil partnership			*	
Religion or belief			*	
Race			*	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	No	Updates made have no impact on supervision provision
Have you taken into consideration any regulations, professional standards?	Yes	In line with Legislation, National and Local Guidance

Step 3: Review, Risk and Action Plans

How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	■	☐	☐
What action needs to be taken to reduce or eliminate the negative impact?	N/A		
Who will be responsible for monitoring and regular review of the document / policy?	Head of Safeguarding		

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	*Fiona Holder*	*Date:*	*17/08/20*

Appendix B Supervision Contract Template

The contract for agreeing supervision is intended to ensure all active clinical staff access regular safeguarding supervision.

Safeguarding Supervision should be undertaken a minimum of every 12 weeks for all active clinical staff.

Supervisor's Responsibilities and Expectations

- The supervisor will meet with the supervisee a minimum of every 12 weeks, these will commence on *(enter date here)……. …….* & will be located in a confidential space which is appropriate and free from distraction.
- To undertake an open and honest discussion re cases that staff are working with.
- Support and professional challenge will be given and supervision will be recorded.
- Discussion around team work and training will be included.
- Expect to discuss a minimum of 4 cases per year with each clinical staff member. If that has not occurred, then there is an expectation that supervisor facilitates this with random case load selection.
- Ensure supervision is recorded on Trust database.
- Seek specialist safeguarding supervision for the supervisee where this may be indicated as an outcome of supervision.

Supervisee's Responsibilities

- Organising their safeguarding supervision
- Open and honest discussion re cases that the staff are working with and have responsibility for.
- To discuss at a minimum 4 cases per year.
- Implement actions to be taken as an outcome of supervision.
- Agree to inform other professionals where they are involved with patients of any information that may impact on a patient's safety. Discuss the appropriate referral to other agencies where this is indicated.
- To ensure all relevant information is recorded on client record.
- Record supervision on Trust database.
- Save records of supervision for audit purposes and as evidence for revalidation where required.
- Escalate or seek specialist supervision for complex safeguarding cases.

Supervisee signed: Date:

Supervisor signed: Date:

This contract should be reviewed on annual basis

Date of review of contract:

Appendix C

Safeguarding Supervision Record of Attendance

Date ……

Name	Signed	Name & DOB of focus child

Key Issues/Topics Discussed

Facilitator (Name) Signed …… Date……

Appendix D

A Practitioner Guide on when to Consider a Case Discussion within Safeguarding Supervision

This appendix provides additional guidance for clinical staff when considering cases to discuss within any model of safeguarding supervision. This is not an inclusive list but guided by legislation and evidence to support decision making. There is an expectation any children/ cases identified from the list below will be considered for a minimum of yearly discussion at safeguarding supervision. This does not mean that the case has to be discussed yearly, only that it has been considered and this should be then be recorded within the child's electronic health records.

Children with complex/multiple physical and or mental health needs including learning differences, (whether or not they have a statutory Education, Health and Care Plan).

This may not be achievable for certain clinicians that case hold large numbers of children who fit the above (example: community paediatricians) however discussion or consideration of discussion would be expected if there are any concerns in relation to:

- Concerns in relation to potential abuse or neglect including extra-familial harm
- Poor engagement / non-attendance by parent or young person
- Concerns re compliance
- Concerns re adherence to medical advice, use of equipment, medications and treatment
- Educational neglect
- No change/ improvement in the outcomes of the child
- Perplexing presentations
- A drift in the case
- Children who are young carers
- Children showing signs of being drawn into anti-social or criminal behaviour, including gang involvement and association with organised crime groups
- Children who frequently go missing from home or Care
- Children at risk of modern slavery, trafficking or exploitation
- Children at risk of being radicalised
- Family circumstances present challenges for the child especially in relation to parental mental health, substance use and alcohol, parental learning differences or crime.
- Children living with or in contact a potential perpetrator or victim of Domestic abuse
- Children living in poverty
- Children who are using drugs or alcohol
- Children who have significant changes in their presentation and/ or behaviour that causes concerns
- Children who are privately fostered without CSC assessment or those children that frequently move addresses or being cared for by a variety of people

- Children who have recently been placed back into parental care and /or recently closed from children social
- Children at risk from harmful traditions such as Female Genital Mutilation, Honour Based Violence, Breast Ironing, Forced Marriage, etc.
- A child where there are perplexing presentations i.e. the child's clinical presentation is not adequately explained by any genuine illness or evidence, and this is impacting upon the child's health and social wellbeing

As with complex needs it may not be realistic to consider all children who meet the criteria above for safeguarding supervision however again if there are any concerns in relation to the points below, the cases should be considered for discussion:

- Concerns in relation to potential abuse or neglect including extra-familial harm
- Poor engagement / non-attendance by parent or young person
- Concerns re compliance
- Concerns re adherence to medical advice, use of equipment, medications and treatment
- Health, Social or Educational neglect
- No change/ improvement in the outcomes of the child
- A drift in the case, for example where no progress is being made or actions taken

Safeguarding Adults

Adults with a learning disability or who have an impairment of, or disturbance in the functioning of the person's mind or brain which could have an impact on their decision making are at increased risk of abuse and neglect from others. Indicators of concern which may prompt need for safeguarding supervision may include:

- Not being taken to health appointments, lack of access to appropriate health care
- Carers not adhering to health advice and treatment for the adult
- Family/ relationship circumstances presenting challenges for the adult, such as mental health concerns, domestic abuse, substance misuse, financial abuse
- Significant changes in presentation and behaviour
- Delay or problems with diagnosis or treatment - unresolved health concerns which may be attributed to their disability
- Problems with identifying needs and providing appropriate care in response to changing need
- Adults at risk of being radicalised