

## CLINICAL SUPERVISION IN CHILD PROTECTION CASE WORK POLICY

**(To be read in conjunction with the Trust  
 Safeguarding and Protection of Children Policy and Procedures)**

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Relevant Staff Groups:	Children and Young People's Services Staff Somerset Talking Therapies Staff

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## DOCUMENT CONTROL

<b>Reference Number</b> SA/July 15/CSCPCWP	<b>Version</b> 3	<b>Status</b> Final	<b>Author</b> Named Nurse Safeguarding Children
<p><b>Amendments</b> include:</p> <ul style="list-style-type: none"> <li>• Child sexual exploitation</li> <li>• Documentation on RiO and impact of increasing numbers of staff groups having full access to RiO</li> <li>• Responsibilities linked to preparation for supervision Updated Clinical Supervision Contract</li> </ul>			
<p><b>Document objectives:</b> The aim of this policy is to provide detailed guidance on the provision of specialist clinical supervision in relation to the child protection work undertaken by Somerset Partnership staff. The policy outlines the reasons for child protection clinical supervision and details the processes involved in it. Child protection supervision is provided to practitioners who are working directly with children and families, where there are concerns for the welfare of the child. This applies primarily to Health Visitors and School Nurses. CAMHS professionals are another staff group able to identify safeguarding and child protection concerns on a regular basis. The ultimate aim is to provide safer care for children through the scrutiny of practitioners' interventions. The scrutiny and resulting decision-making about practice imperatives and plans also reduces potential risk to the Trust.</p>			
<p><b>Intended recipients:</b> Children and Young People's Service Staff Talking Therapies Staff</p>			
<p><b>Committee/Group Consulted:</b> Safeguarding Children Best Practice Group, Safeguarding Steering Group, Health Visitor Best Practice Group, School Nurse Best Practice Group, Integrated Therapy Service Managers, CAMHS Service Managers, Talking Therapies Managers</p>			
<p><b>Monitoring arrangements and indicators:</b> Clinical Audit</p>			
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## **1. INTRODUCTION**

- 1.1 The Nursing and Midwifery Council, (NMC, 2008) advice sheet on clinical supervision states: "Clinical supervision should be available to registered nurses throughout their careers so they can constantly evaluate and improve their contribution to the care of people". Other professional bodies, such as the Royal College of Speech and Language Therapists (2011 P 10), include clinical supervision in their guidance.
- 1.2 However, certain features of child protection work necessitate the inclusion of specific features in the supervision process. Professionals are often required to make difficult and complex professional judgements, in managing multi-disciplinary, inter-agency and cross-cultural issues. It is demanding work that can be distressing and stressful. Lord Laming, in his review following the death of Victoria Climbié observed, "One of the most striking features of Victoria's case...was the sheer number of occasions when the most minor and basic intervention on the part of the staff concerned could have made a material difference to the eventual outcome. In some cases nothing more than a manager reading a file, or asking a straightforward question about whether standard practice had been followed, may have changed the course of these terrible events" (DoH, 2003).
- 1.3 All Somerset Partnership NHS Foundation Trust staff in the front line of practice must be well supported in this work and have access to advice from peers, Managers, Named and Designated staff, (Working Together to Safeguard Children, 2015, Section 48.). A robust clinical supervision service, specific to child protection casework, must also be provided.
- 1.4 The Trust will support the process by enabling the RiO electronic record system to capture evidence of supervision in child protection work and the ongoing impact of this process on children's outcomes. This will support the CQC process of inspecting Somerset Partnership as a safe organisation.

## **2. PURPOSE & SCOPE**

- 2.1 The purpose of this policy is to clarify child protection clinical supervision processes within the Trust to ensure the following outcomes:
- safe and consistent clinical practice in relation to work with vulnerable children and their families
  - increased knowledge, confidence and competence in practitioners, supporting Continuing Professional Development, (CPD)
  - development of greater clinical proficiency and creative professional development
  - development of an environment and culture where reflection on clinical practice is encouraged and supported
  - shared expertise through gaining access to new ideas
  - improved clinical standards which contribute to clinical effectiveness and the Trust's Strategy for Clinical Governance
  - safe management of identified stress factors in clinical practice
  - a culture of challenge to professional practice to drive up standards

- 2.2 This Policy primarily applies to staff working within the Children and Young People's Directorate, and who work directly with children and their families. However it is also relevant to other health practitioners working within child protection processes, such as Contraceptive and Sexual Health staff, Minor Injury Unit staff and Adult Mental Health Services staff, who must also be able to access skilled advice and support. Where appropriate, formal supervision with respect to their child protection activity will be made available.
- 2.3 This Policy also covers the responsibility of the Trust in providing ad hoc supervision to all Trust staff requesting support and advice on child protection matters. The Safeguarding Team acts corporately to ensure all children's safeguarding and child protection needs are considered regardless, of the service providing care.

### 3. DUTIES AND RESPONSIBILITIES

- 3.1 **The Trust Board** has a duty to ensure that it fulfils its statutory responsibilities to safeguard and promote the welfare of children.
- 3.2 **The Designated Non-Executive Director** supports the Executive Lead and the safeguarding team in all aspects of the Safeguarding Children agenda, monitors activity and outcomes, and provides additional assurance to the Board in this area.
- 3.3 **The Director of Nursing and Patient Safety** is the Executive Lead for Safeguarding Children with the Trust.
- 3.4 **All Trust staff** who are concerned about the welfare of a child must tell someone about their concern and follow the Trust Child Protection Policy.
- 3.5 **All Trust staff** working with children and their families must access regular planned child protection clinical supervision with a member of the Trust Safeguarding Children Team.
- 3.6 **All Trust Managers and Heads of Service** are required to support the application of this Policy within their relevant services.
- 3.7 **The Named Nurse for Safeguarding Children** will be responsible for reviewing this policy at least every two years.
- 3.8 **The Trust's Safeguarding Children Team** will be responsible for providing both planned and ad hoc child protection clinical supervision to all Trust staff who work with children and their families and any member of staff who is concerned about the welfare of a child.
- 3.9 **The Trust's Safeguarding Children Team** will adhere to the Trust's clinical supervision Competency Framework when carrying out planned child protection clinical supervision with staff.
- 3.10 **The Trust's Learning and Development Service** will ensure adequate training opportunities are available to equip the Named Nurse and Locality Safeguarding Children Nurses with the appropriate knowledge and skills to deliver a high quality and effective clinical supervision service.

## 4. EXPLANATION OF TERMS USED

- 4.1 **A child:** a child is anyone aged between 0 and their eighteenth birthday. For the purposes of child protection, this policy also applies to unborn babies.
- 4.2 **The age of a child:** There is no single law that defines the age of a child across the UK. The UN Convention on the Rights of the Child, ratified by the UK government in 1991, states that a child “means every human being below the age of eighteen years, unless, under the law applicable to the child, majority is attained earlier.”  
(Article 1, *Convention on the Rights of the Child*, 1989).
- 4.3 **Clinical supervision:** clinical supervision is a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance patient/client protection and safety of care in complex clinical situations.
- 4.3.1 The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice (CQC, 2008).
- 4.3.2 Clinical 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 to achieve agreed outcomes” (Skills for Care and CWDC, 2007, page 5).
- 4.3.3 Assessing children and families (NSPCC, 2014) states: To be able to analyse assessment information effectively, practitioners need to be equipped with the knowledge and skills to think analytically, critically and reflectively. They also need to be able to inform their judgement through multi-disciplinary liaison and knowledge of current research and evidence. Good, regular supervision will enable them to review their understanding of a case and if necessary revise their conclusions in the light of new information, shifting circumstances or challenges to their thinking (DHSSPS, 2011a; Turney et al, 2011).
- 4.3.4 For many practitioners involved in day-to-day work with children and families, effective supervision is important in order to promote good standards of practice and to support individual staff members. Supervision should help to ensure that:
- practice helps to keep children safe from harm and identifies risk to children
  - practice is soundly evidence-based
  - practitioners develop skills in reflection on professional practice to ensure a positive engagement with supervision
  - local processes are consistent with LSCB and organisational policies and procedures
  - practitioners fully understand their roles, responsibilities and the scope of their professional discretion and authority

- the training and development needs of practitioners and supervisors are identified, so that each has the skills to provide an effective service, (Working Together to Safeguard Children, 2015)
- The “Voice of the Child” is central to Trust work planned, with children and families

4.3.5 **Professional Curiosity:** (also described as "respectful uncertainty") is mentioned in both *Understanding Serious Case Reviews and their Impact A biennial analysis of serious case reviews 2005-2007* and *Building on the Learning from Serious Case Reviews: A two year analysis of child protection database 2007-9*. Lord Laming in his report into the death of Victoria Climbié stated that professionals should not be too trusting or over optimistic in their work with children and families. Staff should:

- Use all sources of information in relation to a child/family
- Corroborate information shared by children/families with other involved professionals
- Seek advice if unsure of the relevance / accuracy of information shared by children/families
- Respectfully challenge information provided by parents / carers if necessary
- Recognise the importance of information about the father and/or the male carer in the home, (or if absent), and record accordingly
- Be aware of your own agency’s historical information and seek historical information from other agencies
- Review and act on families lack of engagement with appointments and services
- Keep an “open mind” during assessment processes and always consider that people can and do tell lies.

This process of supporting professional curiosity through high quality child protection supervision is intended to develop a clear voice of the child as above. The Trust template and supervision process will support the reflective process and challenge to practice required to develop an objective perspective to a child’s situation.

## 5. PROCEDURES FOR CLINICAL SUPERVISION OF CHILD PROTECTION CASEWORK

### 5.1 Access to Child Protection Clinical Supervision by Staff Group

5.1.1 Child Protection Clinical Supervision will be accessed at defined intervals dependant on the role of the specific staff group involved. The staff groups and supervision intervals are identified at Appendix A below.

5.1.2 All Mental Health Service staff including the Child and Adolescent Mental Health Service, (CAMHS), will access the line management and clinical supervision structure which is already in place as set out in the Trust’s Clinical Supervision and Coaching Policy and the Staff Appraisal and Management Supervision Policy. This includes a specific standing item to ensure that safeguarding and child protection issues are raised and discussed in supervision. This is scheduled to occur monthly for full time staff and on a pro rata basis for part time staff. Multi-Disciplinary Team Meetings will continue to

include “Safeguarding Children” as a standing agenda item. As in section 5.7.2 below, dedicated safeguarding and child protection supervision time is available to CAMHS professionals on a regular basis. When unavailable for ad hoc supervision, the Safeguarding Children Team provides alternative access to supervision.

- 5.1.3 Trust Medical Staff working in both Adult and Children’s Services must access clinical supervision in accordance with the Trust’s Appraisal for Medical Staff Policy. Individual cases involving child welfare concerns should always be discussed with the Named Doctor or in her absence with the Named Nurse or a Locality Safeguarding Children Nurse. All cases discussed as part of a clinical supervision process must be documented in the relevant clinical record and must include a clear action plan with a documented rationale for each action described.
- 5.1.4 All other Trust staff must access child protection clinical supervision on an ad hoc basis from a member of the Trust Safeguarding Children Team, (or a manager or colleague out of office hours), when they have identified a concern about a specific child, a broader safeguarding children issue, or require de-brief following a child protection incident. All Trust staff must follow the Trust Child Protection Policy at all times following identification of a concern about a child.
- 5.1.5 Practitioners will also have access to clinical supervision using an agreed model, either individual or peer group, to allow for reflection on practice issues other than those related to child protection. This should be prioritised by Managers and practitioners in line with the Trust Clinical Supervision and Coaching Policy.

## **5.2 Structure of Planned Child Protection Clinical Supervision Sessions**

- 5.2.1 Planned child protection clinical supervision delivered by the Trust Safeguarding Children Team will be in a group format wherever possible. Group clinical supervision will be the Trust method of choice as it offers staff the opportunity to share information with team members about clinical cases allowing useful discussion and debate of the issues raised with staff contributing their knowledge, skills and experience to the case discussion. This is particularly beneficial in circumstances where teams are working corporately, sharing complicated cases between several practitioners and where the team consists of part-time practitioners who need to cover each other’s workload.
- 5.2.2 Child protection clinical supervision will involve the detailed, structured discussion of all cases where there are significant concerns about the welfare of a child, (see 5.3 below). The discussion will include:
  - information sharing
  - monitoring of professional records
  - discussion of the supervisee’s ongoing involvement with the family
  - review of previous care plans
  - the voice of the child as best it can be determined
  - identification of risks and protective factors for each child discussed
  - formulation of future care plans

- an opportunity for the supervisee to reflect upon their skills, knowledge and value base as well as the impact on them of working with families where children are at risk or have been abused
- any additional practice or supervision issue identified which requires further action
- how information will be shared with other involved professionals and agencies, including GPs

### **5.3 Criteria for Cases That Should Be Discussed At Child Protection Clinical Supervision**

5.3.1 The below criteria illustrate which cases should be discussed at planned child protection clinical supervision. Those practitioners who, due to their professional role, are not required to access planned child protection clinical supervision should access ad hoc supervision if they have any concerns about the welfare of a child, (see also the Trust Child Protection Policy).

**Please note that this list is not exhaustive and any concerns about a child's welfare can be discussed at planned clinical supervision sessions.**

- All families on the practitioner's caseload where children are subject to a Child Protection Plan
- All families with an allocated Social Worker from Children's Social Care
- Families where there have been reported incidents of domestic abuse, either formally through established information-sharing processes or from disclosures from victims or third parties
- Families in which adult behaviour, is believed to have an impact on the welfare of the child(ren), such as through substance misuse or mental illness
- Families where social exclusion impacts on the welfare of the child(ren)
- Families who are not compliant with health services and care for either adults or children, which will negatively affect the child(ren)
- Families where Fabricated or Induced Illness is suspected
- Cases where there have been several low grade concerns over a short period of time, (including Domestic Abuse notifications, attendance at A and E or MIU, poor attendance at routine health appointments, or lack of access by a health professional)
- Cases where child sexual exploitation is suspected or disclosed
- Families in which a child is 'Looked After' (in the care of the Local Authority or within a private fostering arrangement)
- Families where the practitioner has been subject to any perceived or actual violence or intimidation by any family member

- Any other child / family where the child(ren) are causing the practitioner concern with respect to their welfare for any reason
- Any family where formal Common Requests for Involvement have been declined, and where other means of risk reduction are failing to have an impact on the child(ren)'s well-being

5.3.2 Particular attention should be given by both the clinical supervisor and the supervisee to the management of cases where staff and/or members of their families, or other professionals are involved. This process should involve ensuring the most appropriate member of staff is allocated to the case, to avoid conflicts of interest. The allocated staff member must have access to the clinical supervisor on an ad hoc basis to discuss the case as it develops; and must be able to discuss any concerns in relation to the member of staff involved with the family. These concerns may need to be reported to the member of staff's line manager for consideration against risk assessment processes.

5.3.3 A significant gain from group supervision sessions with mixed experience amongst the professionals is the enhanced learning opportunities for the less experienced professionals. In particular, students exposed to learning opportunities through supported practice and supervision are more likely to feel engaged and valued in the role they have chosen. They are also more likely to respond appropriately to situations they experience, if they have been exposed to supervision experiences containing similar situations to those in their practice.

5.3.4 Clinical supervision in child protection contains elements from numerous models of clinical supervision, used flexibly to meet the needs of professionals and situations. Supervision must contain challenge to practice to enable professionals to develop expert skills in practice in safeguarding children and child protection work. The supervisor must ensure that the manner of challenge and support meets the needs of the professional affected.

## **5.4 Documentation**

5.4.1 Health Visiting and School Nursing staff will ensure that RiO electronic clinical records for each family are up-to-date before each planned Child Protection Clinical Supervision session.

5.4.2 The appropriate RiO template for child protection clinical supervision should also be updated prior to each supervision session as thoroughly as possible to inform the supervision discussion. The template may be updated further in collaboration with the supervisor during the supervision session.

5.4.3 A progress note needs to be added to each family member's RiO record, identifying that the session has taken place, on whose RiO record the supervision template is stored and to include any specific action determined during the session, for that family member.

5.4.4 Professional groups who use the RiO electronic record have access to all records produced for record-keeping in the Trust. Communication between

professionals where there is safeguarding and child protection supervision is essential for joined up working and appropriate information-sharing. .Where professional groups involved in work with the family and/or children use alternative record systems, a means of communication between involved professionals must be found. Any communication is to ensure that the safeguarding and child protection work is coordinated and adds to the safeguarding and child protection of each child.

- 5.4.5 The Integrated Therapy Service will have an overview of their group supervision discussions recorded as part of the Team meeting Minutes. Any detailed action plans resulting from these sessions will be prepared separately by collaboration between the individual supervisor and supervisee and recorded in the supervisees' professional record for the child(ren).
- 5.4.6 Ad hoc clinical supervision will be documented in the relevant professional record by the practitioner. Entries may be added to the RiO electronic record system by members of the Safeguarding Children Team as and when the Team member finds it appropriate to do so. The Team member will alert any other involved professional to the entry as relevant to the work. Communication with professionals not using the RiO system may take various formats such as telephone conversations or secure emailing. Documentation of relevant information should include telephone conversations and other forms of communication, including texting where relevant to the ongoing supervision and care provided.

## **5.5 Clinical Supervision Process for Practitioners Working Solely With Children and Families and Carrying Out Key Child Protection Work, (Health Visitor and School Nursing Teams)**

- 5.5.1 Planned child protection clinical supervision sessions will take place in a quiet and confidential setting, away from such distractions as telephones, members of the public, or colleagues not involved in the process. Both the supervisor and supervisee will ensure adequate time is allocated to the supervision session.
- 5.5.2 Cases to be discussed should be presented concisely and succinctly by the supervisee, providing an update of progress and changes in circumstances since the previous session. Practitioners must avoid repeating unnecessary historic information about families at review clinical supervision sessions unless such history is relevant to the family's current situation and likely action plan.
- 5.5.3 At each child protection clinical supervision session the supervisor and supervisee will together identify specific issues that have been discussed during the clinical supervision session, to identify any that require management intervention or escalation, or that highlight a specific training or development need for the practitioner or wider professional group.
- 5.5.4 School nurses who have caseloads which include children who are the subject of a Child Protection Plan but who have no outstanding health needs are not required to bring these cases to be discussed at supervision sessions. However, should any health need be identified during the Child Protection Plan process, the School Nurse Team will respond to the identified need by considering how the identified need might best be met, and by whom. The

appropriate member of the School Nurse Team will take up the action or refer as required after a suitable assessment of the identified need. This may trigger a need for the child/ren to be brought to a supervision session or discussed on an ad hoc basis with a member of the Trust Safeguarding Children Team. This process will apply equally to children subject to other multi agency safeguarding and child protection processes e.g. Child in Need, Team Around the Child, Signs of Safety etc.

- 5.5.5 Children Looked After may have health needs identified at any point in their care experience. The relevant professional who identifies the health need will act to ensure that the health need can be met. Supervision is required for those children looked after who have ongoing health needs.
- 5.5.6 In most instances, the Child Protection RiO template will be the record for review at each supervision session. Should the supervisor consider it necessary, the main record for the relevant child(ren) can be accessed and reviewed.
- 5.5.7 Domestic Abuse notifications shared by the Police, are currently reviewed by the Safeguarding Children Nurse working from the safeguarding office of the Multi-Agency Safeguarding Hub (MASH) prior to being sent to the relevant professional or Team. Significant incidents will be shared with the professional or Team through an alerting email or telephone contact. The Safeguarding Children Nurse in the MASH will also alert the relevant Safeguarding Children Nurse for the geographical area receiving the incident for assessment and to consider whether further discussion is required during the next planned supervision session or as an ad hoc conversation to evaluate the appropriateness of the course of action taken by the practitioner.
- 5.5.8 Cases where there have been several low grade concerns over a short period of time, (including Domestic Abuse notifications, attendance at A and E or MIU, poor attendance at routine health appointments, or lack of access by a health professional), must also be subject to an action plan to ensure the concerns are assessed and discussed with the family, including when, where and how the children should be seen and assessed and consideration for possible referral to Children's Social Care.
- 5.5.9 If a circumstance should arise where the practitioner considers that their caseload does not contain any children/families who meet the criteria at point 5.3 above, two alternative cases will be selected by the supervisor from the practitioner's caseload. The supervisor will use the Family Health Needs Assessment RAG tool to identify families assessed as requiring Universal Partnership or Universal Partnership Plus health services and use the session for review and reflection.
- 5.5.10 The supervision process will take place on a three monthly basis, (see Appendix A below), although this will be flexible to reflect each individual practitioner's need and the perceived "heaviness" of the child protection cases to be discussed. Intervals between supervision sessions should be no more than three months for Health Visitors and School Nurses.

- 5.5.11 Responsibility for arranging the supervision session will be shared between the Supervisor and Supervisee(s). A future date will be set at the end of each supervision session and this will be adhered to as a priority.
- 5.5.12 Should a supervision session be cancelled due to staff sickness a new session must be arranged within the following month ensuring no interval between supervision sessions is longer than three months.
- 5.5.13 If a supervision session has been postponed for more than three months this must be reported by the Supervisor to both the relevant Line Manager and the Named Nurse, who will agree an urgent action plan with both Supervisor and supervisee(s) to ensure the postponed supervision session takes place as soon as possible.
- 5.5.14 Where professionals are absent from practice for extended periods of time, planned or unplanned, they must arrange supervision within a month of return to practice if at all possible. During their absence, cases for supervision will be allocated to other members of the Team to avoid gaps in assessment and service input.
- 5.5.15 The supervisor will collate aggregated information from supervision sessions about the types of issue discussed and any ongoing concerns expressed by practitioners. This information will be fed into the training needs analysis for practitioners.
- 5.5.16 The Designated Nurse for Safeguarding Children will observe at least one child protection clinical supervision session undertaken by each member of the Safeguarding Children Team on an annual basis, to monitor the standard of the supervision provided. The standard is measured against the available recommendations such as those cited in section 4 above.
- 5.5.17 The Designated Nurse will communicate their assessment of the quality of the supervision and any recommendations for change and/or improvement through the Trust Named Nurse and Trust Head of Safeguarding.

## **5.6 Communication of Clinical Supervision Outcomes to GP Colleagues by Health Visitor and School Nursing staff**

- 5.6.1 Health visiting and school nursing staff must ensure that the outcomes of clinical supervision are communicated to the child's GP to aid good communication processes and raise GP awareness of ongoing child protection concerns, and health visitor/school nurse involvement with children and families.
- 5.6.2 Information-sharing should ideally take place during regular face-to-face meetings with members of the Primary Healthcare Team, including GPs. If this is not possible, an electronic template is available for completion, (Appendix B), which details both demographic information, a brief summary of the child's current situation and the proposed action plan.
- 5.6.3 Forwarding of electronic clinical supervision records to GPs should not take the place of regular face to face meetings with members of the Primary Healthcare Team including GP colleagues.

5.6.4 Specific supervision action plans requiring collaboration with any member of the Primary Healthcare Team will be recorded in the clinical supervision action plan in the usual way.

## **5.7 Supervision Processes for Trust Staff Working within the Child and Adolescent Mental Health Service and Having Some Involvement in Key Child Protection Processes**

5.7.1 In line with the Trust's Clinical Supervision (and Coaching) Policy, all CAMHS staff have individual monthly line management supervision (pro-rata for part-time staff). Child protection and Safeguarding issues are a standing item on the supervision agenda. Issues will be discussed and documented in the supervision notes, as well as transferred to the relevant RiO progress notes. Any issues discussed with the Safeguarding Leads will also be documented on RiO, and verified by the relevant Safeguarding Lead.

5.7.2 Regular safeguarding and child protection supervision is offered by a dedicated professional from the Trust Safeguarding Children Team. Ad hoc supervision is available at all times from this professional when available, or from any member of the Trust Safeguarding Children Team when unavailable.

## **5.8 Supervision Processes for Trust Staff working with Children and Families or with Adult Survivors of Abuse and Neglect but having little involvement in key child protection processes**

5.8.1 Staff working within the Integrated Therapy may be working with some of the most vulnerable children in the community or with adult survivors of child abuse and neglect. Consequently these staff groups also require access to regular clinical supervision.

5.8.2 Staff will be offered group supervision during planned team meetings at quarterly intervals, (Appendix A). Integrated Therapy Service staff will be supervised by the specific Named Nurse or Locality Safeguarding Children Nurse who has clinical responsibility for the geographical area in which the team operates.

5.8.3 At these group clinical supervision sessions, staff may bring individual cases for reflection, guidance and support or request discussion on broader safeguarding and child protection issues. These may include clinical processes, interpretation of local and national policy training queries and updates on child protection practice. Appropriate supervision will also be provided for Talking Therapies staff.

5.8.4 The content of the group supervision and any outcomes from it will be recorded in the minutes of the meeting.

## **5.9 Supervision Processes for Members of the Safeguarding Children Team**

5.9.1 The Named Nurse Safeguarding Children will provide six-weekly clinical supervision for the Locality Safeguarding Children Nurses. Operational support will be provided by the line management structure. Criteria for cases brought

for clinical supervision will reflect the criteria listed at point 5.3 above. However, emphasis should be placed on the following circumstances:

- clinical supervision cases that require escalation
- clinical supervision cases where there are concerns about a practitioner's performance
- clinical supervision cases where there are concerns about the multi-agency response to a particular case
- complex clinical supervision cases
- cases involving members of staff
- cases of suspected or actual Fabricated and Induced Illness
- clinical supervision cases where a child has been significantly harmed
- clinical supervision cases that are likely to attract media attention
- cases which highlight a gap in services to meet need, increasing risk of harm

5.9.2 The Named Nurse Safeguarding Children will provide the Looked after Children Specialist Nurse with two-monthly clinical supervision. The Children Looked After Nurses will access two-monthly clinical supervision with a Locality Safeguarding Children Nurse. Operational support will be provided by the line management structure. Criteria for cases brought for clinical supervision will reflect the criteria listed at point 5.3 above.

5.9.3 The Named Nurse will access monthly clinical supervision with the Designated Nurse for Safeguarding Children and operational support from the Head of Division for Children, Young People and Families.

5.9.4 The Named Doctor will access clinical supervision from the Designated Doctor for Safeguarding Children.

## **5.10 Outcomes of Child Protection Clinical Supervision**

5.10.1 Both clinical supervisor and supervisee must ensure the following outcomes are achieved through facilitation of the clinical supervision process:

- clarity regarding the issues presented by the case, including risk and protective factors, and an understanding of how effectively professionals are working together
- an accurate assessment of the child(ren)'s current health status including a detailed account of any unmet health needs and what actions are planned to ensure those needs are met
- an accurate assessment of the parent(s)/carer(s) health needs, including a detailed account of any unmet health needs and what actions are planned, with consent, to ensure those needs are met
- assurance that the most appropriate professional is working with the family, taking into account:
  - the specific needs of the child/ren and parents/carers,
  - the individual professional's particular area/s of expertise

- any likely conflict of interest, (such as where staff members and/or their families, or other professionals, are involved)
- a written action plan is agreed for the health professional, detailing ongoing work with the child, family or carers, and relevant other agencies, always ensuring that the child's needs are central
- the clinical supervision action plan is documented in the relevant clinical record
- individual/team/professional group training needs are identified
- a review clinical supervision date is set
- the whole process is supportive, educational and protective of both professionals and the child(ren) discussed.

## **6. TRAINING REQUIREMENTS**

- 6.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Mandatory Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.
- 6.2 The Trust will ensure that adequate provision of initial and update training in clinical supervision is available to members of the Trust Safeguarding Children Team.
- 6.3 All members of the Safeguarding Children Team must hold a recognised clinical supervision qualification or have supervision experience that is commensurate. They must also attend the Somerset Local Safeguarding Children Board Child Protection Clinical Supervision course within three months of taking up a post within the Team.
- 6.4 Newly appointed health visiting and school nursing staff must meet with the Named Nurse or Locality Safeguarding Children Nurse within their first three months of employment to discuss Trust expectations in terms of their participation in child protection clinical supervision. The Safeguarding Children Nurse will ensure that the newly appointed staff member is familiar with both the process and documentation required for the planned supervision.
- 6.5 Mental Health Services staff providing child protection clinical supervision will complete the Somerset Local Safeguarding Children Board *Child Protection Clinical Supervision* one day training course.
- 6.6 The Named Nurse will provide bespoke training sessions for each student health visiting and school nursing cohort which will include responsibilities for child protection clinical supervision. Delegation of this training to a member of the Trust Safeguarding Children Team will be considered to avoid undue delay to the training for such students.
- 6.7 The *Clinical Supervision in Child Protection Case Work Policy* will be referenced in all Trust safeguarding and child protection training.

## **7. EQUALITY IMPACT ASSESSMENT**

- 7.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If any individual or group, believes they are disadvantaged by anything contained in this document please would they contact the Equality and Diversity Lead. They will then actively respond to the enquiry.

## **8. MONITORING COMPLIANCE AND EFFECTIVENESS**

- 8.1 The effectiveness of this policy and procedure is subject to scrutiny and review by the Local Safeguarding Children Board (LSCB), Somerset Clinical Commissioning Group and the Trust's Safeguarding Steering Group.
- 8.2 Compliance will be reported in the Safeguarding Children Annual Report to the Board.
- 8.3 The Trust regularly reviews its safeguarding children arrangements. The Director with Board responsibility for Safeguarding Children is accountable for ensuring the compliance against the South West Child Protection procedures.
- 8.4 The Named Nurse and Named Doctor are responsible for ensuring any recommended changes are implemented.
- 8.5 All Trust staff should be aware of this policy. It is referred to at every child protection training session at all levels.
- 8.6 The Named Nurse will facilitate monitoring, local audits and investigations to ensure staff are aware of, and are following the policy, and to assess whether there are any barriers in place which prevent or discourage staff from using it.
- 8.7 Where there is evidence that a staff member has not followed the policy properly, the Named professionals will follow this up accordingly, and where appropriate, use the DATIX reporting system. Such events will be reported to the Trust Safeguarding Steering Group, **from** where, as appropriate, actions will be recommended and monitored. Any high scoring risks will be placed on the appropriate Risk Register and monitored until the risk is reduced.
- 8.8 **Monitoring arrangements for compliance and effectiveness**
- The Trust Safeguarding Steering Group will be responsible for the monitoring arrangements.
- 8.9 **Responsibilities for conducting the monitoring**
- The Named Nurse will lead internal monitoring, audit and investigation processes to ensure compliance with this policy and related guidance.

## 8.10 Methodology to be used for monitoring

- Review of child protection clinical supervision documentation as part of any future Children and Young People's Service documentation audit
- Review of clinical supervision documentation as part of any Serious Case Review or Internal Case Review
- Review of any complaints regarding child safeguarding and child protection will include investigation into staff compliance with this policy
- Review of any child protection clinical supervision incidents reported via DATIX incidents

## 8.11 Frequency of monitoring

The Named Nurse will provide annual update reports to the Trust Board to reflect progress on the above measures. A quarterly report to both the Trust Clinical Governance Group and Trust Safeguarding Children Steering Group will include the outcomes of any audits, case reviews and incidents.

## 8.12 Process for reviewing results and ensuring improvements in performance occur

Monitoring, audit reports and investigation reports will be presented to the **Trust Safeguarding Children Steering Group** for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This Group will be responsible for ensuring improvements, where necessary, are implemented and actions monitored.

Any lessons learnt will be shared with the relevant Best Practice Group and added to the 'What's On @ Sompar' electronic newsletter, (when applicable).

## 9 COUNTER FRAUD

- 9.1 The Trust is committed to the NHS Protect Counter Fraud – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

## 10. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

- 10.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the fundamental standards, last updated **24<sup>th</sup> June 2015**, which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 14:	Meeting nutritional and hydration needs
Regulation 15:	Premises and equipment

Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

10.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 16:	Notification of death of service user
Regulation 17:	Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18:	Notification of other incidents
Regulation 19:	Fees

10.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

### Relevant National Requirements

*Department of Health initiatives  
NICE and other clinical guidance*

## 11. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

### 11.1 References

Department of Health. The Victoria Climbiè Inquiry: Report of an enquiry by Lord Laming, (2003)

Nursing and Midwifery Council. Clinical supervision for registered nurses, (2008)

CQC Supporting information and guidance: Supporting effective clinical supervision July 2013 CQC

Benner's taxonomy: Develop skills across novice to expert practitioners (Benner, 1984)

M Government. Working Together to Safeguard Children, (2015).

Royal College of Speech and Language Therapists. Royal College of Speech and Language Therapists Professional Standards, (2009)

NHS IAPT Supervision Guidance (Turpin and Wheeler, 2011).

NSPCC Assessing children and families (NSPCC 2014)

Skills for Care and Children's Workforce Development Council. Providing Effective Supervision, (2007)

<http://www.skillsforcare.org.uk/publications/ProvidingEffectiveSupervision.aspx>

NHS IAPT Supervision Guidance (Turpin and Wheeler, 2011).

### 11.2 Cross reference to other procedural documents

Appraisal Policy for Medical Staff

Child Protection Training Strategy

Clinical Supervision (and Coaching) Policy

Learning, Development and Mandatory Training Policy

Risk Management Policy and Strategy

Safeguarding and Protection of Children Policy and Procedure  
Safeguarding Vulnerable Adults At Risk Policy  
Staff Appraisal and Management Supervision Policy  
Staff Mandatory Training Matrix (Training Needs Analysis)  
Untoward Events Reporting Policy

All current policies and procedures are accessible in the policy and guidelines section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

## **12. APPENDICES**

12.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A Child Protection Clinical Supervision by Staff Group  
Appendix B Template to Share Clinical Supervision Outcomes with GPs where face to face meetings have not been possible  
Appendix C Contract of Expectations for Clinical Supervision with Health Visitors and School Nurses

### Child Protection Clinical Supervision by Staff Group

<b>Staff Group/Service *</b> Supervision provided by the Named Nurse or Locality Safeguarding Children Nurses	<b>Type of supervision</b>	<b>Interval</b>
Health Visitor teams	Group or individual	Three monthly
School Nurse teams	Group or individual	Three monthly
Integrated Therapy Service Locality teams	Group	Four monthly
Children Looked After Nurses	Individual	Two monthly
Paediatric Continence Nurses	Individual	Two monthly
CAMHS	Individual or Group	Two Monthly
<b>Staff Group/Service *</b> Supervision provided by the Named Nurse	<b>Type of supervision</b>	<b>Interval</b>
Locality Safeguarding Children Nurses	Individual	Six weekly
CAMHS Safeguarding Professional	Individual	Two monthly
Children Looked After Specialist Nurse	Individual	Two monthly
<b>Staff Group/Service *</b> Supervision provided by the Designated Nurse	<b>Type of supervision</b>	<b>Interval</b>
Named Nurse	Individual	Two monthly
<b>Staff Group/Service *</b> Supervision provided by the Designated Doctor	<b>Type of supervision</b>	<b>Interval</b>
Named Doctor	Individual	Ad hoc

**\* All other staff groups will access ad hoc child protection clinical supervision from the Trust Safeguarding Children Team as and when safeguarding and child protection concerns arise.**



**Contract of Expectations for Child Protection Supervision Version 2014****Clinical Supervision in Child Protection: Contract of Expectations**

In line with the current Somerset Partnership Clinical Supervision in Child Protection Policy, both supervisor and supervisee will be subject to the following expectations:

**The supervisor will:**

- be appropriately trained and prepared for their supervisory role
- receive monthly supervision themselves from the Named Nurse Safeguarding Children, who will in turn receive regular supervision from the Designated Nurse for Safeguarding Children
- create a safe, quiet and private environment for the clinical supervision process where:
  - safe reflection on practice can occur
  - the impact of the child protection work on the individual practitioner can be assessed standards of safeguarding practice can be assessed and developed
- facilitate case discussion which facilitates best practice in safeguarding children activities, as defined in Working Together documentation
- identify areas of concern such as poor practice, leading to liaison with the supervisees' line manager to instigate a programme of support and development.
- ensure the supervision process is completed on a three monthly basis. Any cancellations to planned sessions will be re-scheduled as a high priority, within one month of the cancelled date
- ensure any learning points identified, including examples of good practice and innovative ways of working, are disseminated across the Trust, to promote improved clinical practice

**The supervisee will:**

- attend the supervision session adequately prepared
- ensure their preparation includes a clear assessment of the current situation of each child/family to be discussed. This is to highlight:
  - the nature of the concerns/ presenting issues
  - a thorough risk assessment
  - the identification of protective factors
  - a clear analysis of the known or potential impact of the risk and protective factors on the children's well-being
  - a clear action plan
  - the identification of any stress factors for the individual practitioner and a plan for minimising any such factors
- ensure that the above preparation is followed by the completion of a clear plan on the main carer's RiO Child Protection Clinical Supervision template, **ahead of the planned supervision session**

- take a full and active role in the supervision process, responding honestly and with clarity about the issues discussed, expecting the process to challenge practice and pre-conceived professional opinions at times
- ensure that the agreed supervision actions are completed before the next planned session is due to take place

***I agree to comply with the above Contract of Expectations***

***Signed (supervisor)..... Print Name..... Date.....***

***Signed (supervisee)..... Print Name..... Date.....***