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AN ROINN
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MÀNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

Regional Nursing Reform Implementation Team

Safeguarding Children Nursing Supervision Pilot

Project Document

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1. CONTENTS

2. INTRODUCTION

The need for structures and systems that support effective safeguarding children practice have been repeatedly emphasized in child death inquiry reports, case management reviews and in the DHSSPS Inspection Report (2006), Our Children and Young People – Our Shared Responsibility. As part of the Regional Reform Implementation Project, the DHSSPS issued a draft Nursing Safeguarding Supervision Policy and Standards Template (2008) with the intention of promoting best nursing practice in safeguarding children. Key benefits include:

- Regional approach to safeguarding children supervision for nurses*
- Improved supervision process that will result in a more efficient, competent and confident nursing workforce
- Increased focus on the potential contribution of all nurses to safeguarding children
- Framework that will support Trusts with their safeguarding responsibilities and preparation for RQIA children's services inspection

NIPEC (2007) defined nursing supervision as:
'A process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service and user protection, quality and safety'.

Safeguarding children nursing supervision is complementary, but additional, to nursing supervision as described by NIPEC (2007).

For the purpose of this report the term **'nurses' refers to all registered nurses, midwives, and public health practitioners. The term **'safeguarding children nurse specialist'** (SCNS) is used to describe those nurses who provide specialist advice and supervision to nurses regarding child protection, children in need, Looked After Children and when nurses have child care concerns.*

Safeguarding nursing supervision provides specialist professional safeguarding advice and support that promotes best safeguarding practice through reflection, information, learning, confidence, competence and accountability. It involves quality assurance to ensure compliance with best practice guidelines and addresses professional development needs and opportunities in relation to safeguarding children and families.

Safeguarding nursing supervision is facilitated by nurses who have specialist knowledge and experience of child protection and specifically relates to:

- Children and young people in need of protection
- Children in need as defined by Children (NI) Order
- Children subject of domestic and inter-country adoption procedures
- Looked after children and families where there are child care concerns

The frequency of safeguarding children supervision varies in accordance with the nurse's role and responsibilities with children and potential to safeguard children.

This report describes a DHSSPS regional safeguarding children nursing supervision pilot that commenced in October 2008 and was completed in September 2009. The pilot is an integral part of both the Reform Implementation Project Safeguarding Supervision Work-stream, and, the Strategic Review and Development of Health Visiting and School Nursing Practice. A Project Board and Steering Group with representatives from the 5 Health and Social Care Trusts (See Appendix 1) were set up to oversee the implementation of an agreed Pilot plan (See Appendix 2).

Extensive consultation has highlighted the commitment of nurses to safeguarding children. However, there is a need to improve safeguarding nursing supervision arrangements on a regional basis in order to maximise the contribution of nurses to safeguarding children. Nurses need access to effective supervision arrangements at levels that reflect their involvement and responsibilities for children and families.

Nurses have identified the benefits of safeguarding children nursing supervision. They have also highlighted challenges in relation to the application of consistent supervision standards, documentation, and training. Recommendations from this pilot focus on the

need for Trusts to have a safeguarding children nursing supervision system that includes increased levels of supervision, resources and training for key nursing groups.

The pilot focuses on the needs of five key nursing groups: health visiting; school nursing; community mental health; community paediatrics, and community children's and adolescent mental health services (CAMHS). Fifteen nursing teams, (approximately 90 nurses) participated in the Pilot (see Table 1) using a pilot procedure and documentation developed by the pilot steering group (see Appendix 3).

Table 1. Nursing Teams involved in DHSSPS Safeguarding Children Nursing Supervision Pilot

Area of Nursing Practice	Trust	Number of Pilot Teams	Supervision Method
Health Visiting	All five Trusts	5	Individual
School Nursing	Four Trusts	4	Individual
CAMHS	Southern Trust	1	Individual and Group
CAMHS	Belfast Trust	3	Individual and Group
Community Mental Health	South Eastern Trust	1	Individual and Group
Community Children's' Nursing	Northern Trust	1	Individual
TOTAL		**15**	

3. Aim

The aim of the safeguarding nursing supervision pilot project was to develop an effective and supportive regional safeguarding nursing supervision process for endorsement by DHSSPS in October 2009.

4. Objectives

The objectives of the safeguarding nursing supervision project were to:

- Review existing arrangements for safeguarding supervision for nurses
- Consult with nurses and their managers regarding proposed supervision principles, methods and documentation
- Develop pilot procedures and documentation
- Plan and provide training required for implementation of pilot procedures
- Conduct a supervision pilot with health visitors and school nurses in each of the five Trusts based on consultation
- Conduct a supervision pilot with Community children's nurses (NHSCT), Community psychiatric nurses (BHSCT) and CAMHS Nurses (SEHSCT and SHSCT)
- Produce a supervision process that is purposeful, effective and supportive to nurses and Trusts
- Ensure that quality is a theme throughout the project

5. Quality

Throughout the project, advice was sought from experts and specialists including experienced safeguarding supervisors, designated and named nurses for child protection, training consultants, specialist practitioners, strategic and operational managers as well as senior members of governance and information technology teams. Contact was also made with supervisors from other regions.

6. Project Assumptions

The following assumptions were adopted throughout the pilot:

1. Nurses have a duty to safeguard and promote the welfare of children (NMC 2008).
2. Safeguarding children is a complex aspect of practice. Nurses require support through effective supervision.
3. Safeguarding supervision should be available to nurses at a level that reflects their involvement with children and families, and their level of responsibility.
4. Nurses have the right to receive quality supervision from competent supervisors.
5. The quality of supervision has a direct bearing on the quality of service delivery and outcomes for children and families.
6. The principles and guidance outlined in Safeguarding Children and Young People: Roles and Competences for Health Care Staff Intercollegiate Document (Royal College of Paediatrics and Child Health, April 2006) should be embraced.
7. The principles and guidance outlined in Competencies for Nurses Specialising in Safeguarding Children (NSCAN 2004) should be embraced.
8. Safeguarding supervision enables nurses to:

    - Feel supported
    - Improve standards of care
    - Increase understanding of professional issues
    - Further develop skills and knowledge
    - Identify training needs and opportunities
    - Enhance understanding of multi-disciplinary and multi-agency practice and processes

9. All those involved in the Project will fully engage with the pilot process in an open and constructive manner so that the project's objectives are realised.

7. CONSULTATION METHODS

Consultation with nurses was pivotal to the successful completion and outcomes of this pilot. Nurses were supportive of the pilot and engaged constructively throughout the consultation process.

Consultation Workshops

Five information and consultation workshops were held in December 2008. These were attended by 150 nurses and managers from the 5 key professional pilot areas (see Appendix 4). Participants included a representative from NIPEC.

DHSSPS Regional Newsletter

A regional newsletter was circulated by the DHSSPS to inform nurses and midwives of the pilot and to request their participation, comments and support.

Meetings with nursing groups

The project manager met with named nurses for child protection, SCNSs, nursing managers and teams involved in the pilot. The focus of these meetings was to review existing supervision arrangements and processes and to seek views regarding how improvements in safeguarding nursing supervision could be achieved.

Evaluation questionnaires following supervision sessions

Supervisors and supervisees were asked to complete an evaluation questionnaire after each individual and group supervision session.

Regional evaluation workshop

An evaluation workshop, facilitated by the Beeches Management Centre, was held on 29th June 2009 at Antrim Civic centre. This was attended by thirty five nurses with representation from each of the five pilot nursing groups, nurse managers and safeguarding children nurse specialists.

8. REVIEW OF EXISTING SAFEGUARDING ARRANGEMENTS

The findings from consultation with nursing groups regarding existing safeguarding children supervision arrangements can be divided into eight themes:

8.1 Key Benefits of Safeguarding Children Nursing Supervision

Nurses identified the benefits of safeguarding supervision (see Table 2). Nurses unanimously supported the introduction of a regional approach to policy, procedure and documentation for safeguarding nursing supervision.

Table 2. Key Benefits of Safeguarding Supervision

Key Benefits of Safeguarding Supervision

- Opportunity to reflect, consider options, evaluate and plan
- Practitioners able to share concerns
- Opportunity to get an objective view from supervisor
- Reassurance, guidance and constructive advice
- Support with risk management and decisions regarding thresholds
- Increased confidence, assertiveness and ability to appropriately challenge
- Role clarification
- Written record of supervision in client record
- Opportunity to consider professional development needs

8.2 Key Barriers to Effective Safeguarding Children Nurse Supervision

Key barriers to effective supervision have been divided into three key areas: resources, organisational culture and the supervision process (See Table 3). Nurses were clear that if effective safeguarding children nursing supervision is to be available, each of the three areas need to be regionally addressed.

Table 3. Key Barriers to Effective Safeguarding Nurse Supervision

Resources	Organisational Culture	Supervision Process
Nursing capacity and caseload pressures *Inadequate SCNS capacity resulting in inaccessibility of SCNS to non health visitors* *SCNS not available outside of 9am - 5pm Monday - Friday* *Training required to ensure competency of safeguarding supervisors including those required for group supervision* *Competing pressures and insufficient protected supervision time* *Lack of opportunity to access supervision from a specialist in another practice area* *Poor physical environment* *Lack of computer records* *Electronic records not user friendly*	*Supervision experienced as scrutiny rather than supportive* *Supervisee feels vulnerable if they disclose limitations or lack of competence* *Low priority given to safeguarding nursing supervision and frequently cancelled at short notice* *Stressful working environments accepted as normal*	*Inconsistent policy and procedures within and across Trusts* *Some documentation does not lend itself to risk management* *Quantity required rather than quality* *Personality/relationship problems with either supervisor or other group member* *Interruptions accepted as unavoidable for example supervisors' / supervisees' mobile phones remain switched on* *Poor planning and preparation* *Care Plans / client notes not available*

8.3 Access to Safeguarding Children Nurse Specialists

SCNSs in Trusts are expected to provide advice and support within office hours to all nurses employed by the Trusts. This is done through telephone conversations or arranged face to face supervision sessions.

'Open access' to a SCNS was considered to be essential and highly valued by all nursing groups. However, the SCNS service is perceived as a service that is primarily for health visitors. Two reasons were given for this. Firstly, health visitors are considered to be the key nursing professional in safeguarding children as described in ACPC policy and *procedures (ACPC Policy and Procedures, 2005, parg 3.48).* Secondly, funding for initial SCNS posts following introduction of Children (NI) Order Guidance and Regulations came from health visitor budgets.

Two Trusts have funded additional SCNS hours to support nurses working in mental health services. Additional funding was allocated to Trusts to provide a part-time SCNS service to nurses working in acute hospitals (0.5 WTE to each of the 5 major hospitals).

8.4 Documentation and Record keeping

Trusts were at various stages in the process of developing and introducing amended safeguarding supervision recording formats. This was useful in the development of pilot documentation, particularly as the principles and language of UNOCINI were being adopted.

There was variation in documentation and recording practices relating to 'open door' advice and agreed further actions. Some SCNSs were making records and forwarding these for inclusion in case files. A copy was kept for the SCNS file. Other SCNSs were relying on practitioners to make records of SCNS advice given.

Recording and filing of planned case supervision also varied. In some Trusts, safeguarding nursing supervision records were filed in the nurse's personal supervision files rather than case files.

8.5 Current Supervision Arrangements and Issues for Five Nursing Pilot Groups

8.5.1 Health Visitors

Health visitors are a key health professional in child protection cases and their safeguarding supervision needs have been prioritised over other nursing groups.
Health visitors are the only group of nurses who reported planned individual safeguarding supervision with a SCNS. The frequency of health visiting supervision varied considerably within and across Trusts. For example, in one Trust, all health visitors were having three-monthly supervision regarding all families where there were child protection concerns. This was placing huge demand on scant SCNS resources. Band 8 SCNSs had little or no time to participate in key aspects of their job, including leadership, practice development, audit and strategy. In another Trust, some health visitors had planned supervision regarding individual cases annually, with the additional opportunity for planned group supervision facilitated by the SCNS.

There was variation in and across Trusts in relation to the criteria for safeguarding nursing supervision. Some health visitors reported having had supervision regarding children and families subject of child protection, children in need, 'looked after' and adoption procedures. Other health visitors reported planned supervision regarding children and families subject of child protection procedures only. In one Trust, a group of health visitors were required to choose three cases for consideration at safeguarding supervision but had the additional option of group supervision.

8.5.2 School Nurses

The role of school nurses in safeguarding children differs within and across Trusts. Nursing responsibility for school aged children who are subject of child protection procedures is usually transferred from school nurses to health visitors. However, a small number of school nurses have developed their safeguarding competencies and retain family nursing responsibility for school children who are subject of child protection procedures. The number of cases retained by school nurses is linked with

resources available in school nursing teams and competing demands including the introduction of additional vaccination programmes. School nurses who retain case responsibility receive safeguarding supervision from a SCNS in line with that provided to health visitors working within the same Trusts. It is anticipated that school nurses will have an increasing role in safeguarding children following implementation of the Review of Health Visiting and School Nursing (see DHSSPS consultation document issued September 2009). This will have implications for SCNS resources as school nurses will required higher levels of safeguarding supervision.

8.5.3 Community Psychiatric Nurses

Opportunities for community psychiatric nurses to avail of safeguarding supervision vary within and across Trusts. There were no formal arrangements identified in any Trust for regular, planned individual safeguarding nursing supervision, by a SCNS, for nurses working in adult mental health services. Two Trusts provide group safeguarding children supervision to nurses working in addiction services. Some line managers record families where there are identified child protection concerns during line management supervision (line managers may or may not be nurses). They offer advice and support regarding child protection matters and encourage contact with the SCNS if this is deemed to be appropriate.

SCNSs have indicated an increase in their level of contact with community psychiatric nurses following recent highly publicised child death inquiries where mental health practice has been scrutinized. However, significant issues need to be addressed:

- The current level of SCNS resources does not lend itself to proactive involvement with nurses working with mental health services
- There are a significant number of community psychiatric nurses who do not avail of SCNS support and advice
- Some community psychiatric nurses feel apprehensive about sharing sensitive mental health information due to the fear concern about breaching client confidentiality. They feel that they are an advocate for their client/patient and their role in safeguarding children may be in conflict with this

8.5.4 CAMHS

Nurses working in CAMHS services have regular planned multidisciplinary supervision. Whilst the focus of this is on issues specific to their sphere of practice, child protection issues may be discussed and actions agreed. Nurses working in CAMHS identified their lack of contact with an identified SCNS as a significant concern for them given that children who present with emotional difficulties are often in need of safeguarding.

8.5.5 Community Children's Nurses

Community children's nurses reported that they do not have planned supervision with a SCNS but discuss child protection concerns during supervision provided by line managers. This lack of regular planned safeguarding supervision was identified as a significant gap during the consultation. Community children's nurses felt strongly that they need regular one to one supervision. This is due to the number of vulnerable children with increasingly complex needs being supported at home.

8.6 Does safeguarding children nursing supervision always need to be carried out by a safeguarding children nurse specialist?

Nurses were divided into 18 groups during consultation workshops. 10 of 18 (56%) groups consulted stated that safeguarding supervision should only be carried out by a SCNS. Their reasons were that:

- Safeguarding practice is complex and involves risk management decisions in relation to child protection. Nurses require safeguarding supervision from those with a high level of expertise in this area;
- SCNSs have specialist knowledge, skills and experience to provide this type of supervision competently;
- SCNSs are involved in safeguarding supervision across teams and directorates. They have a broader knowledge of the child protection process, issues needing to be considered, and, thresholds applied;

- SCNS provide an objective opinion if required as they are not involved in direct nursing care or management;
- Role confusion is likely to occur if more than one person is responsible for safeguarding supervision.

5 out of 18 groups (28%) stated that safeguarding supervision could be carried out by someone other that a SCNS, provided that these supervisors had specialist knowledge, skill and training. Two of the five groups (both mental health) suggested that safeguarding supervision should be provided by someone who is from the same professional group. Community psychiatric nurses were of the opinion that the support of a SCNS specifically working with their services was necessary in all Trusts.

3 of the 18 groups (17 %) were undecided.

8.7 Pilot Process and Documentation

Consultations regarding existing safeguarding supervision documentation highlighted issues for consideration during the pilot. These included the need to:

- Define the role of line managers and supervisors
- Agree what information should be evident in case records
- Provide confidential personal supervision regarding practice and training
- Develop a regional approach to frequency, methods and documentation for each nursing group involved in the pilot
- Ensure that safeguarding children supervision arrangements allow the supervisee and the supervisor to raise issues or barriers that cannot be resolved within the supervisee / supervisor relationship
- Set clear boundaries that reflect the emotional demands of safeguarding supervision on staff

8.8 Suggestions and further comments outside the scope of the pilot

Nurses raised issues that were related to, but outside the scope of the pilot (see Appendix 5). These include:

- The relevance of the safeguarding supervision pilot to other key nursing groups (midwives and learning disability nurses were considered as important key groups requiring safeguarding supervision)
- Investment required if additional and improved supervision processes are to be introduced for nurses
- Pre registration and post registration education
- Implications for multi-disciplinary practice and supervision particularly where nurses provide supervision to or receive supervision from disciplines other than nurses

9. SAFEGUARDING CHILDREN NURSING SUPERVISION - TRAINING FOR SUPERVISORS AND MANAGERS

Two three day courses, facilitated by the Beeches Management Centre, were provided for safeguarding nursing supervisors (see Appendix 6). Priority was given to safeguarding children nurse specialists (SCNS), managers and senior practitioners from pilot site areas. A total of 59 nurses attended. This included 22 SCNSs.

The course content was developed using information submitted by course participants using a pilot training needs questionnaire (see Appendix 7). Analysis of the information identified illustrated that:

- A number of SCNSs had not had formal training in relation to supervision principles or methods, or their role in safeguarding nursing supervision
- Participants required updating on the principles and methods of supervision
- Supervisors felt confident in their ability to provide individual supervision but needed training in group supervision methods and skills
- SCNSs 'definitely' wanted risk assessment frameworks included in the training

Course Evaluation

General comments received regarding the course and facilities were very positive (See Appendix 8). Participants enjoyed the opportunity to get away from their stressful workplaces to reflect upon practice and professional needs. They valued the opportunity to network, share and learn with colleagues in other Trust areas. Many supervisors stated that they were so preoccupied with the needs of others and achieving quantitative supervision goals that they do have not have time to consider their own professional needs.

Evaluations of the course content were positive with the exception of those received from community psychiatric nurses who felt that the course was too detailed for their needs.

Risk assessment frameworks including Barnardo's Risk Assessment Matrix and the Graded Care Profile were shared during the courses. Some course participants were familiar with these. Participants felt that supervisors need further opportunities to consider how these frameworks could be applied regionally to nursing practice and safeguarding children nursing supervision, within the multi-agency context of safeguarding children.

Participants found the session on group supervision to be a necessary component of the course. Application of the proposed model to safeguarding children supervision stimulated considerable debate. An experiential learning session for all participants was an effective way to demonstrate how group supervision could be applied in a structured and meaningful way. Participants agreed that the proposed model may not be the best model to consider a complex case history.

10. EVALUATION OF SAFEGUARDING CHILDREN NURSING SUPERVISION PILOT IMPLEMENTATION PHASE

Thirty-five nurses and nurse managers, including representatives from each of the five nursing pilot groups attended an evaluation workshop on 29th June 2009. The workshop was used to reflect upon:

- The nurses' experience of the safeguarding supervision process used during the pilot implementation phase
- How best to achieve an effective regional safeguarding supervision system for the nursing groups involved in the pilot

Sixty-one evaluation forms, completed following supervision sessions, were received from supervisees. 30 evaluation forms were received from supervisors.

10.1 Individual Safeguarding Children Supervision

Individual supervision sessions were supportive and focused, with clear outcomes regarding nursing practice and case management. Documentation was underpinned by UNOCINI and this was found to be useful by supervisees and supervisors. Sessions were most effective when an agenda was used, time was protected and staff had prepared. The process ensured evidence of safeguarding supervision in children's records.

The supervision process was challenging for some, particularly those who had not previously used a structured approach. Difficulties included sessions being too long; staff not prepared; protected time not adhered to, and limited or no administration support available. 23 out of 61 supervisees found preparation problematic due to competing demands, interruptions, and inexperience of pilot documentation (see Appendix 9).

10.2 Issues addressed during Individual Safeguarding Nursing Supervision

The supervision sessions addressed a range of challenging client and practice issues (see Table 4).

Table 4. Client and Practice Issues considered during Individual Safeguarding Supervision

Client Issues	Practice Issues
Children subject of LAC Reviews *Disability* *Bullying* *Attachment disorder* *Adolescence* *Child's development delay* *Emotional abuse* *Physical abuse* *Sexual abuse* *Inappropriate sexualized behaviour* *Adult sexual abuse* *Domestic Violence* *Pregnancy and violence* *Alcohol abuse* *Parenting issues* *Parental Mental health* *Housing and Home conditions* *Vulnerable family with health concerns*	*Thresholds for referral* *Care Planning* *Documentation* *Visiting patterns* *Gaining information on new family and how to arrange support* *Current caseload weighting* *Caseload pressure, vacant caseloads, extra child protection allocation* *Increase of paperwork* *Caseload change – rural community / ethnic minority groups* *Risk assessment* *No access visits* *Role of nurse in child protection cases* *Role of school nurse / social worker and joint visits* *Report writing* *UNOCINI referrals* *Communication with social services difficulties in gaining information* *overdue meetings i.e. LAC, Case Conference, etc* *Record storage / filing system* *Working in partnership with vulnerable clients* *Parental co-operation* *Routine enquiry (domestic violence)* *HV role with teenagers* *Multi-disciplinary approach* *Confidentiality*

10.3 Evaluation of the Individual Pilot Safeguarding Supervision Process

The pilot safeguarding supervision process used a logical process. Only one person felt that the process had inhibited discussions about 'other' cases.

Twelve out of 61 supervisees reported interruptions during their supervision session. These were due to telephone calls and shared office accommodation.

All nurses felt that they had sufficient opportunity to participate in the supervision process.

Only eight supervisors indicated that they used risk assessment frameworks during supervision. These were identified as the UNOCINI threshold matrix, Barnardo's risk assessment model for domestic violence, Zero tolerance staff safety risk assessment, and the Graded Care Profile. Supervisors used frameworks that they were previously familiar with indicating the need for additional training and support in the use of these.

10.4 Learning Outcomes following Individual Safeguarding Children Nursing Supervision

Forty-seven of the 61 supervisees identified learning outcomes as a consequence of their supervision experience. These can be divided into three categories: personal, caseload and professional support available (see Table 5). Three nurses felt that they had not learned anything new.

10.5 Practice and Development Needs identified following Safeguarding Children Nursing Supervision

Practice and development needs identified during the pilot supervision included training; understanding and experience of UNOCINI; protection of children and the internet; health needs assessment; domestic violence risk assessment; care plans; communication with teenagers; support services available to families; time management; looked after children; ethnic minority groups; risk assessment frameworks and report writing skills and court reports.

Table 5. Learning Outcomes identified by Supervisees following safeguarding Children nursing supervision

Personal	Caseload	Professional Support
Helped me reflect on practice.	*More clarity with cases now and have a better action plan.*	*Awareness of changes following Maternity Leave*
More insight into my training needs.	*Confidence to reduce monthly contacts and provide evidence to support decision.*	*Knowledge of Domestic Violence Risk Assessment*
Some recording issues highlighted	*Gave me a broader insight into concerns about client*	*Very helpful to have support*
Improved record keeping and insight into, importance of proofing.	*Importance of care planning for each child in family.*	*Confirmed my concerns for the child.*
The need to protect myself and have clear documentation.	*Focus on specific needs*	*Reassurance that I carried out protocol.*
Preparation is beneficial	*Correct management of child protection and risk management of each family*	*Gave me support with my decisions*
Learnt to be honest and more upfront	*Importance of multi-agency communication*	*Very informative re the use of Assessment Framework*
To be more analytical	*Helped me structure caseload*	*Good direction and support*
To be more organised	*Structure required for care plans*	*Increased awareness of role of child protection nurse and importance of liaison / communication*
To approach issues from different perspectives	*Importance of partnership with families*	*Felt session was excellent to address my concerns*
I will be more self assured when completing reports and clearer about my remit	*Systems in place to access information from other trusts*	
Be more receptive to others views and opinions	*To contact SS more when case conference, care groups, LACs overdue*	

10.6 Evaluation of Group Supervision

Group supervision was unanimously evaluated as a particularly effective and useful learning experience that should be available to key nursing groups (see Appendix 10). The group supervision model used during the pilot was recommended by the Beeches Management Centre. Each group member had 15 minutes to be supervised. This promoted focus on particular aspects of practice or issues. Adequate preparation by supervisees and strict adherence to timescales by supervisors was deemed to be critical to successful group supervision.

Supervisees suggested that Trusts need to be creative in facilitating mixed nursing group supervision sessions as this would facilitate transfer of learning from one team or directorate to another. This approach would promote mutual learning and improved multidisciplinary team work.

10.7 Safeguarding Issues addressed during Group Supervision

A range of safeguarding issues was addressed during group supervision (see Table 6).

Table 6. Issues addressed during Group Safeguarding Children Nursing supervision

Safeguarding Issues	Practice Issues
Frequent accident and emergency attendances *Alcohol abuse* *Neglect* *Children's behaviour* *Impact of attachment difficulties* *Parental mental health* *Impact of parental relationships on children* *Domestic violence*	*Guidelines regarding child protection workloads* *Threshold decisions* *Management of conflicting opinion* *The role of nurses in families when parents refuse services* *Threshold of 'significant harm'* *Storage of records* *UNOCINI processes including communication and referral.*

10.8 Evaluation of Group Pilot Safeguarding Supervision Process

Some supervisors highlighted their lack of experience and confidence in facilitating group supervision. This was not evident from the evaluations provided by supervisees. The need for further training opportunities was suggested.

Participants agreed that:

- Group sessions need to be facilitated by a SCNS;
- Six people is the ideal number for a supportive learning environment;
- Complex cases need to be discussed at individual supervision sessions if all supervisees are to have opportunity to submit a topic for group supervision.

10.9 Pilot Documentation

Views were sought regarding how the pilot safeguarding children supervision process could be improved. Two key issues were identified:

- The level of information required in documentation is too detailed and time consuming
- Two hours is not sufficient to carry out safeguarding nursing supervision for some health visitors if all child protection, LAC, children in need and families are discussed

The consensus of opinion was firstly, that the documentation needed to be reduced. It was suggested that this could be achieved if client records were available during individual supervision sessions. Secondly, that there needed to be a fairer and more equitable allocation of safeguarding cases and it was hoped that this would be addressed through the implementation of the regional caseload weighting system that is also being piloted.

10.10 Health Visitor Safeguarding Children Record Audit

Some supervisees and supervisors did not have time to complete the record audit due to time constraints. One health visitor had 23 cases to discuss and another had 25. Case supervision was prioritised over record audit. It is impossible to establish from the questionnaires if these health visitors have an unusually high level of childcare issues as part of their caseload work, or, as suggested by some workshop participants,

that the SCNS might be providing 'line management' supervision because team managers were not available.

Eighteen out of 30 supervisors identified caseload practice issues during supervision that required further action. These related to growth monitoring, record keeping, following up on case conference minutes, communication and information sharing. Two supervisors reported that performance issues were identified which required further discussion with team managers so that performance action plans could be implemented.

The record audit was deemed to be appropriate for health visiting and school nursing but not suitable for other nursing groups, particularly community psychiatric nurses whose clients are adults.

10.11 SCNS Staff Contact Sheets

Staff contact sheets completed by the SCNS when contacted by a nurse were deemed to be useful, succinct and important if supervisors are to adhere to NMC guidelines on record keeping. However, their implementation proved challenging in Trusts where SCNSs have not previously recorded their discussions with staff. SCNSs described situations when they were outside of their offices and did not have access to the relevant documentation.

10.12 Evaluation forms

Evaluation forms were completed by both supervisors and supervisees following individual supervision sessions. The consensus view was that evaluation forms do not need to be used following every individual supervision session. However, there should be an annual evaluation process that includes staff questionnaires. The outcome of this should be reported to the appropriate Trust governance fora.

Evaluation of each group supervision session was considered to be necessary and appropriate. Nurses were of the view that information required on this form, like all forms, needs to be kept to what is essential.

Agenda for Individual Supervision

Nurses identified advantages of the safeguarding nursing supervision agenda:

- Provides useful information when setting priorities for discussion at safeguarding supervision
- Previous agendas can be referred to ascertain outcomes for cases previously discussed at safeguarding supervision
- Allows line managers to see which cases are presented at supervision
- Supports fair and equitable case allocation
- Informs caseload profiling

Nurses identified issues relating to the safeguarding nursing supervision agenda:

- Complexity of cases or proposed length of supervision time required not identified
- Guidance required regarding filing of agendas
- Too detailed for some groups of nurses for example CAMHS

10.14 Personal Supervision Form

The personal supervision form was considered to be useful. The consensus view of nurses and nurse managers was that personal supervision forms should be copied to line managers who are best placed to ensure that ongoing support is provided for staff.

Nurses and nurse managers were of the opinion that the personal supervision form is not required in all supervisions but should be used when practice, competence or training issues have been identified.

10.15 Supervision by Line Manager - Guidance

Nurses and nurse managers felt that it was useful to define the distinct responsibilities of line managers in relation to safeguarding supervision. However, they stressed that should be guidance and not a form for completion.

10.16 Overall Evaluation Ratings from Supervisees

Supervisees were asked to rate their overall satisfaction with their safeguarding supervision experience. Results illustrate a high level of satisfaction with the pilot process (see Table 7). 74% described their supervision experience as excellent or very good.

Table 7. Supervisee's Overall Rating of Pilot Supervision Process

Excellent	Very Good	Good	Satisfactory	Poor	Total
18 (30%)	27 (44%)	12 (20%)	4 (7%)	0	61

11. PROPOSED STANDARDS REGARDING THE LEVELS OF SAFEGUARDING CHILDREN NURSING SUPERVISION FOLLOWING PILOT

The following proposed standards have been informed by the outcomes of the safeguarding children nursing supervision pilot.

Standard 1

All nurses may request and will be provided with individual safeguarding advice, support and supervision regarding any child or family where the nurse has safeguarding concerns.

Standard 2

All nurses will be provided with information regarding the name and contact details of a SCNS.

Standard 3

Nurses will have a level of safeguarding children nursing supervision that reflects their knowledge, competence, experience and caseload demands.

Standard 4

Trust policy will outline the level of planned safeguarding children nursing supervision provided to each nursing group.

Standard 5

Table 8 outlines the minimum levels of safeguarding children nursing supervision required by nursing groups involved in the pilot.

Table 8. Proposed Levels of Safeguarding Children Supervision for Nurses

Minimum levels of safeguarding children supervision

Nursing Group	Individual	Group	Comments
Health Visitors, School Nurses and CCN's	4 monthly by SCNS	Yearly	Required for those school nurses and CCN's taking a lead nursing role in safeguarding cases
Health Visitor, School Nurse and CCN Managers		6 monthly by SCNS	
CAMHS and Community Psychiatric Nurses (CPN)	To be arranged with SCNS as and when the nurse is involved in a child protection case. Managers to provide safeguarding children supervision at managerial supervision sessions.	6 monthly by SCNS	A named SCNS is required to work specifically within mental health services.
CAMHS and CPN Managers	6 monthly by SCNS		
SCNS	Monthly by named nurse for child protection	4 monthly by named nurse	
Named Nurse for Child Protection	As and when required by Public Health Agency Nurse for Child Protection	4 monthly by Public Health Agency Nurse for Child Protection	Named Nurses may require supervision by senior staff from other nursing disciplines depending on issues arising.

NB Nurses will have open door access to additional safeguarding children supervision as and when required

12 . SAFEGUARDING CHILDREN NURSE SPECIALIST CAPACITY TO PROVIDE SAFEGUARDING NURSING SUPERVISION

At March 2008, there were 2,071 children on the child protection register in Northern Ireland. This was an increase of 463 (29%) from the same date in 2003 (DHSSPS Children Order Statistical Bulletin 2008). Neglect was the most common category of abuse, with 49% assessed to be at risk of neglect. This is particularly relevant to nursing given the impact of neglect on health outcomes.

Between 2002/2003 and 2007/2008, child protection registrations increased by 36% from 1,102 to 1,147. Between 2007 and 2008, the number of Looked After Children in Northern Ireland increased by 3% from 2,356 to 2,429. There has been no increase in SCNSs to cope with this increasing workload.

During 07/08 there were 28,088 referrals to children's social services relating to 21,109 children. Over 7000 children did not receive a service. Nurses, as members of the primary health care team require support and supervision from team managers and SCNSs so that they can continue to support these families appropriately.

Nurses, managers and safeguarding children nurse specialists have repeatedly expressed concerns about the limited number of specialist nurses available in Trusts to provide the range of safeguarding supervision opportunities required by nurses. There are 24 WTE specialist nurses employed by the five Trusts. 2.5 WTE of these are employed within the acute sector (See Table 9). In addition to providing advice, support and safeguarding supervision, the SCNS role includes:

- Development of Trust nursing policy, procedure and guidance
- Training including facilitation of uni and multi-disciplinary training programmes
- Training needs analysis
- Facilitation and provision of induction
- Attendance at case conferences
- Participation in regional and Trust governance fora
- Research and audit

- Membership or individual agency review and case management review panels

It is essential that the nursing infrastructure supports nurses to carry out their safeguarding role and responsibilities effectively. If SCNSs are to support nurses with their role and responsibilities with this vulnerable client group, it is imperative that a review of the SCNS workforce is undertaken as a matter of urgency.

	Qualified Nursing & Midwifery Workforce	**Number of Children on Child Protection Register 31 March 2008**	**Number of children in need referrals/ allocated service / not allocated service ***31 March 2008**	**Number of Looked After Children**** **31March 2008**
NHSCT	2938 HC* 2,473.8 WTE**	331	4,333/2,493/1840	506
SHSCT	2669 HC 2193.8 WTE	314	4,343/3,225/1118	356

Table 9 Number of Safeguarding Children Nurse Specialists per Trust

SHSCT	2669 HC 2193.8 WTE	314	4,343/3,225/1118	356
WHSCT	2731 HC 2455.5 WTE	406	3,383/3,186/197	426
SEHSCT	2314 HC 1944.9 WTE	417	4,076/2,181/1895	553
BHSCT	5629 HC 4839.6 WTE	603	4,842/2,815//2027	592
Total	**16281 HC 13907.6 WTE**	**2,071**	**20,977/13,900/7077**	**2,433**

* HC Head Count

** WTE Whole Time Equivalent

*** Children and families who are referred to, but not allocated a social service, can continue to require a high level of nursing and primary care intervention. These children and families often cause nurses most concern and are subject of nursing safeguarding supervision.

**** Looked After Children may be placed in other Trust areas and nurses employed by the 'placement' Trust assumes responsibility for nursing care.

13. Estimated SCNS Hours required to Deliver Proposed Levels of Safeguarding Children Nursing Supervision.

Estimation of SCNS hours required for each of the pilot nursing groups has been made if the proposed levels of supervision are to be introduced. The following groups of staff have been used for this purpose:

1. Health Visitors and School Nurses in Western Trust
2. Community Psychiatric Nurses in South Eastern Trust
3. Children and Adolescent Mental Health Nurses in Belfast Trust
4. Children and Adolescent Mental Health Nurses in Southern Trust
5. Community Children's Nurses in Northern Trust

The estimation is based on the following:

- Group supervision sessions will last a minimum of 3 ½ hours allowing for 15 minutes per person involved (maximum 8) plus 15 minutes to open and 15 minutes to close the session. One hour has been added for preparation, evaluation, liaison with line managers and administration.
- Individual safeguarding supervision take an average of 2 ½ hours allowing for 2 hours in supervision and 30 minutes for preparation, evaluation, administration and liaison with line mangers.
- Nurses working in the key pilot groups require at least three additional one hour safeguarding supervision sessions, outside of planned safeguarding supervision arrangements, regarding a child/family where child protection concerns or practice issues arise and supervision is needed sooner than planned.
- 25% is added to reflect goods and services associated with the cost of delivering the service.

13.1 Estimated SCNS Hours for Health Visitors and School Nurses in WHSCT

Health visitors provide a developmental surveillance programme to families with children aged up to 4 years old. 612 of the 1497 (41%) child protection registrations during the year 07/08 involved children aged up to 4 years (Children Order Statistical Bulletin, DHSSPS 2008). Health visitors and school nurses provide an additional targeted service to families with identified needs. They are involved in multidisciplinary and multi-agency care plans to meet the needs of these children and families.

The Western Trust has a total of 90 health visitors and 24 school nurses as of September 2009. In addition, there are 4 team managers. If the proposed level of planned safeguarding supervision outlined in Table 9 is to be adopted, there are:

- 90 health visitors and 12 school nurses in the Western Trust who require individual safeguarding supervision every four months with additional group supervision once per year
- 11 school nurses require group supervision every 6 months
- Health visitors and school nurses (Band 6) require three additional safeguarding supervision sessions in cases where child protection procedures arise and need to be discussed outside of planned safeguarding supervision arrangements
- 4 nurse managers require three monthly individual supervision

Based on the above staff numbers and level of proposed supervision, the Western Trust requires a minimum of 1463 SCNS hours per year for safeguarding nursing supervision health visitors and school nurses (see Table 10).

Table 10. SCNS capacity required for health visitor and school nurse safeguarding children supervision

Nurses	Number	Supervision Method	SCNS Hours per year
Health Visitors	90	3 individual x 2 ½ hrs x 90 11 groups x 3 ½ hrs	hours 38.5 hours
Nurse Managers	4	4 individual x 2 ½ hrs x 4	40 hours
School Nurses Band 5	11	2 groups x 3 ½ hrs x 2 per year	14 hours
School Nurses Band 6	12	3 individual x 2 ½ hrs x 12 2 groups x 3 ½ hrs	hours 7 hours
Health Visitors and Band 6 School Nurses	102	306 x 1hr additional supervision regarding cases where safeguarding supervision is required outside of planned 3 monthly	306 hours
Sub Total			**1170.5 hours**
25% Goods&Service			292.6
Total			**1463 hours**

13.2 Estimated SCNS Hours for Community Psychiatric Nurses in SEHSCT

Studies indicate that a significant proportion of children who come into the child protection system are from families where mental health problems are present (Messages from Research, DoH 1995). A review of child deaths and serious injury through abuse and neglect indicates that risk is increased where mental health problems coexist with other factors including drug or alcohol abuse and learning disability (Department for Children, Schools and Families, 2008).

The South Eastern Trust has 60 community psychiatric nurses as of September 2009. In addition, there are 4 team managers. If the proposed level of planned safeguarding supervision outlined in Table 9 is to be adopted, there are:

- 60 community psychiatric nurses who require group supervision every six months by an SCNS
- 4 community mental health nurse managers require individual safeguarding supervision every three months
- 64 community psychiatric nurses require approximately 3 additional safeguarding supervision in cases where child protection procedures arise and need to be discussed outside of planned safeguarding supervision arrangements.

Based on the above staff numbers and level of proposed supervision, the South Eastern Trust requires a minimum of 380 SCNS hours per year for the purpose of safeguarding nursing supervision (see Table 11).

Table 11. SCNS capacity required for community psychiatric nurses at SEHSCT.

Nurses	**Number**	**Supervision Method**	**SCNS Hours per year**
Nurse Managers	4	individual x 2 ½ hrs x 4 per year	40 hours
Community Psychiatric Nurses	60	9 groups x 3hrs x 2 per year	72 hours
Nurse Managers & Community Psychiatric Nurses	64	3 x 1hr additional supervision regarding cases where safeguarding supervision is required outside of planned safeguarding supervision	192hours
Sub Total			**304 hours per year**
25% Goods and Services			76 hours
Total			**380 hours per year**

13.3 Estimated SCNS Hours for CAMHS in BHSCT

The Belfast Trust has a total of 74 nurses working in CAMHS as of October 2009. This includes 18 nurse managers. The Belfast Trust provides regional Tier 4 in-patient services and the number of nurses employed reflects this.

There are 56 nurses who require group supervision every three months and 18 who require individual safeguarding supervision every three months. In addition, CAMHS nurses require 3 safeguarding supervision in cases where child protection procedures arise and need to be discussed outside of planned safeguarding supervision arrangements.

If the proposed level of planned safeguarding supervision outlined in Table 9 is to be adopted, the Belfast Trust requires approximately 973 SCNS hours to provide safeguarding nursing supervision for CAMHS staff (See Table 12).

Table 12 Estimated SCNS hours required for CAMHS in BHSCT

Nurses	**Number**	**Supervision Method**	**SCNS Hours per year**
CAMHS nurses	56	7 groups x 3 ½ hrs x 4 per year	98
Nurse Leads/Managers	18	18 individual x 2 ½ hrs x 4 per year	180
CAMHS nurses	74	74 individual case supervision x 1 hr x 3 per year	500
Sub Total			**778 hours per year**
25% Goods and Services			195
TOTAL			**973 Hours per year**

13.4 Estimated SCNS Hours for CAMHS in SHSCT

The Southern Trust has a total of 22 nurses working in CAMHS as of October 2009. This includes two Lead Nurses who also provide a service to clients. In addition, the team includes 7 nurses who work with children who have learning disabilities and 2 nurses who are linked to the child development clinics.

If the proposed level of planned safeguarding supervision outlined in Table 9 is to be adopted, there are 29 nurses who require group supervision every three months and 2 who require individual safeguarding supervision every three months. In addition, CAMHS nurses require safeguarding supervision in cases where child protection procedures arise and need to be discussed outside of planned safeguarding supervision arrangements and need to be discussed outside of planned safeguarding supervision arrangements. This has been estimated at three per year. Based on the above estimations, the Southern Trust requires a minimum of 211 SCNS hours per year for the CAMHS team (See Table 13).

Table 13. Estimated SCNS hours required for the CAMHS team at Southern Trust.

Nurses	Number	Supervision Method	SCNS Hours per year
CAMHS nurses	29	4 groups x 3 ½ hrs x 4 per year	56 hours
Nurse Leads	2	2 individual x 2 ½ hrs x 4 per year	20 hours
CAMHS nurses	31	31 individual case supervision x 1 hr x 3 per year	93 hours
Sub Total			**169 hours per year**
25% Goods and Services			42 hours
Total			**211 hours per year**

13.5 Estimated SCNS Hours for Community Children's Nurses in NHSCT

The Northern Trust has a total of 24 community children's nurses (CCNs) as of October 2009. This includes 2 lead nurses, 9 Band 7 CCNs and 13 Band 5 CCNs. If the proposed level of planned safeguarding supervision outlined in Table 9 is to be adopted, there are 7 CCNs who require 6 monthly individual supervision by a SCNS plus 6 monthly group supervision. 2 CCN lead nurses require 3 monthly individual safeguarding supervision by a SCNS. In addition, 11 CCNs require additional safeguarding supervision in cases where child protection procedures arise and need to be discussed outside of planned safeguarding supervision arrangements. This has been estimated at three per year. Based on the above estimations, the Northern Trust requires a minimum of 131 SCNS supervision hours per year for the CCN service.

Table 14 Estimated SCNS hours required for the Community Children's Nurses Team at Northern Trust (not including as and when required advice and support).

Nurses	Number	Supervision Method	SCNS Hours per year
Community children's nurses Band 7	9	9 individual x 2 ½ hrs x 2 per year 2 x 3 ½ hrs group supervisions per year	45 hours 7 hours
CCN Nurse Managers	2	2 individual x 2 ½ hrs x 4 per year	20 hours
Community children's nurses/managers	11	11 individual case supervision x 1 hr x 3 per year	33 hours
Sub Total			**105 hours per year**
25% Goods and Services			26
Total			**131 hours per year**

14. Conclusion

'Nurses working with children and young people have an absolute duty to safeguard and protect children and young people from harm, and this can mean breaking confidences by sharing information in order to protect, and dealing with the very difficult situations that can arise as a result' NMC (2008).

It is essential that Trusts have an effective safeguarding children nursing supervision system in place for all nurses. This must include access to advice, support and information for all nurses. The levels of planned individual and group safeguarding supervision should reflect the role and responsibilities of key nursing groups. Trust safeguarding nursing supervision policy, standards and procedures must ensure reflection, risk assessment, planned interventions and ongoing quality assurance, through the use of UNOCINI principles and framework. Adequate resources and suitable environments must be available to facilitate an effective safeguarding children nursing supervision system.

Pilot documentation was developed and used by 16 nursing teams across the 5 Health and Social Care Trusts. Evaluation of the documentation used for individual safeguarding nursing supervision was generally positive. The documentation facilitated a structured approach that promoted analysis and risk management. In order to avoid duplication of recording, pilot safeguarding nursing supervision documentation needs to be amended by reducing the amount of information already available in client notes. As a result, individual safeguarding nursing supervision records must be an integral part of client records. Client records must be available during individual supervision sessions and should contain details of the family composition, nursing assessment and care plan.

Evaluation of group safeguarding nursing supervision was very positive. Group supervision offered a mutually supportive learning experience for those involved. It was used to address concerns and issues arising during safeguarding practice. Nurses felt that this approach should be available to all nurses but should not replace individual safeguarding nursing supervision when dealing with complex cases.

This DHSSPS safeguarding nursing supervision pilot has involved extensive consultation with key nursing groups. Nurses unanimously support the introduction of a regionally agreed safeguarding children nursing supervision system that is linked to the UNOCINI assessment framework. They have identified the benefits of safeguarding children nursing supervision when responding to a range of complex safeguarding issues on a uni-disciplinary and multi- disciplinary/agency manner. Nurses have highlighted significant challenges throughout this pilot. These include competing work demands, insufficient SCNSs to provide the levels of safeguarding children nursing supervision required, and, interruptions due to poor working environments. These challenges must be addressed by Trusts if a culture of supportive safeguarding nursing supervision is to be achieved.

15. Recommendations

The DHSSPS will:-

1. Adopt the safeguarding nursing supervision standards, procedure and levels of supervision outlined in this report in the final version of DHSSPS Regional Safeguarding Children Nursing Supervision Policy and Procedure.
2. Link safeguarding children nursing supervision to the ongoing DHSSPS Adult Mental Health Children's Services Regional Project to ensure that safeguarding nursing supervision is embedded into adult mental health nursing services.

The Public Health Agency will:-

3. Identify the safeguarding children nursing supervision needs of other nursing groups who were not included in this pilot. Priority should be given to the needs of midwives, learning disability nurses, acute paediatric nurses and those working in Emergency Departments.
4. Explore the potential to develop and use information technology for the purpose of safeguarding nursing supervision.
5. Lead the implementation of regional safeguarding nursing supervision standards, procedure and levels of supervision.
6. Define the competencies required by supervisors to deliver safeguarding children nurse supervision

Trusts will ensure that:-

7. Final DHSSPS Regional Safeguarding Children Nursing Supervision Policy and Procedure is implemented.
8. SCNS capacity is sufficient to provide the regional safeguarding children nursing supervision as outlined in the final version of DHSSPS Regional Safeguarding Children Nursing Supervision Policy and Procedure.
9. The number of SCNS hours available for each nursing group are identified by Trusts on an annual basis.

10. There is sufficient SCNS time (likely to be 1.0 WTE) in each Trust employed to address the supervision, training and policy development needs of nurses working in mental health as recommended in previous case management reviews. This SCNS should have a mental health background but work as part of the SCNS team.
11. Safeguarding supervisors are competent in providing individual and group supervision and have a recognised safeguarding children supervision course for supervisors with refresher training three yearly.
12. Nurses have access to a suitable environment for the purpose of safeguarding children nursing supervision.
13. Conduct an annual audit of the effectiveness of safeguarding children nursing supervision. This should include staff questionnaires.
14. Triplicate documentation is available for the purpose of recording SCNS contact with staff.
15. Documentation relating to safeguarding children needs or issues is prominent within records used by community psychiatric nurses.
16. Training programmes are commissioned and available to safeguarding children nurse supervisors include the use of evidence based risk assessment frameworks during safeguarding supervision.

16. REFERENCES

DHSSPS (2009) Draft Review of Health Visiting and School Nursing

DHSSPS (2006) Our Children and Young People – Our Shared Responsibility.

NSCAN (2004) Competencies for Nurses Specialising in Safeguarding Children

NIPEC (2007) Report of the Review of Clinical Supervision for Nursing in the HPSS on behalf of the DHSSPS

NMC (2008) Advice for nurses working with children and young people. www.nmc.org

Royal College of Paediatrics and Child Health Staff (April 2006) Safeguarding Children and Young People: Roles and Competences for Health Care Staff

17. APPENDICES

Appendix 1

Project Board Members

Deirdre Webb, EHSSB / Public Health Agency (Chairperson)

Loretta Crumlish, WHSCT Designated Nurse for Child Protection

Gillian Hughes, BHSCT, Child Protection Nurse Specialist

Susan Gault, NHSCT, Head of Public Health Nursing

Carol Murphy, Health Visitor Manager, SHSCT

Jackie McBrinn, Nurse Manager (Health Visiting & School Nursing) Belfast Trust

Mary Frances McManus, SEHSCT, Child Health Sector Manager

Averil Stubbs, WHSCT, Supervisor of Midwives

Dawn Heather White, SEHSCT, Sector Manager Adult Mental Health

Steering Group Members

Una Turbitt, SHSCT, Project Manager, Named Nurse Child Protection
Southern Trust (Craigavon & Banbridge)

Averil Bassett, Education Consultant, Beeches Management Centre

Paula Brannigan, Mental Health, South Eastern Trust

Fiona Brown, Nurse Manager (Community Children's Nursing), Northern Trust

Loretta Crumlish, Named Nurse Child Protection, Western Trust

Karen Elwood, Nurse Manager , Northern Trust

Billie Hughes, Nurse Manager (CAMHS) Belfast Trust

Kathy Jackson, Nurse Manager, Western Trust

Judith Lees, Named Nurse Child Protection, Northern Trust

Jackie McBrinn, Nurse Manager (Health Visiting & School Nursing) Belfast Trust

Joanne McLaughlin, Safeguarding Children Training Consultant,
Beeches Management Centre

Geraldine Sweeney, Safeguarding Children Nurse Advisor (Mental
Health), Belfast Trust

Eileen Woods, Safeguarding Children Nurse Advisor

Appendix 2

PROJECT PLAN – 10 phases

Phase 1
Project Initiation Document: approved by Project Board.

Phase 2
Project Team established: Membership to include a safeguarding children nurse specialist, health visiting manager and school nurse manager from each Trust, and, a nurse manager / senior nurse with expertise in community children's nursing, CAMHS and mental Health.

Phase 3
Stakeholder information and consultation: Seminars in each Trust. News sheet circulation

Phase 4
Review of existing supervision arrangements.

Phase 5
Guidance and documentation regarding the supervision pilot process presented to Project Board for approval.

Phase 6
Training programme for supervisors designed and delivered. Project manager to meet with supervisees at team meetings.

Phase 7
Health visitor and school nurse pilots established initially, followed by pilots in CAHMS, community children's nurses and community psychiatric nurses. Evaluation documentation forwarded to Project Manager for collation throughout Phase 7.

Phase 8
Pilot evaluation report written and presented to the Project Board for approval.

Phase 10
Closure. This will include presentation of the pilot evaluation and project outcomes to the Project Board and other stakeholders.

Appendix 3

Reform Implementation Nursing Team

Safeguarding Children Supervision Policy for Nurses

Information and Consultation Sessions

Health Visitors, School Nurses, Community children's nurses, Child and Adolescent community psychiatric nurses, Community Psychiatric Nurses and their Managers/Supervisors
(Other Nurses are welcome to attend for information)

Trust	Date	Venue	Time
Belfast H&SC	**Thursday 11th December 2008**	**Ramada Hotel, Belfast**	**10am-1pm (Lunch at 1pm)**
Northern Trust H&SC	**Friday 12th December 2008**	**Express by Holiday Inn, Antrim**	**10am-1pm (Lunch at 1pm)**
Southern H&SC	**Monday 15th December 2008**	**Lough Neagh Discovery Centre`**	**10am-1pm (Lunch at 1pm)**
South Eastern H&SC	**Wednesday 17th December 2008**	**Ramada Hotel, Belfast**	**10am-1pm (Lunch at 1pm)**
Western H&SC	**Thursday 18th December 2008**	**Mellon Country Hotel, Omagh**	**10am-1pm (Lunch at 1pm)**

(Those who are unable to attend the workshop for their Trust are welcome to attend one of the others)

Please forward nominations to Helen.Smyth@setrust.hscni.net at least 2 working days prior to the event to allow for catering

Appendix 4: Issues identified outside scope of pilot

Safeguarding Supervision Pilot

- Safeguarding nursing supervision pilot needs extended to include other key nursing groups including midwives and learning disability nurses.
- Major piece of work required urgently regarding safeguarding practice and supervision in the acute sector. Safeguarding supervision needs to be a part of this
- Need regional audit tool, standards and reporting arrangements in relation to implementation including suggested contingency plans when a Trust cannot fulfil the policy.
- Competencies for safeguarding supervisors need to be defined. These should be linked to supervision competencies (NIPEC 2008).

Investment

- Inequity of LAC nurses across Trusts needs to be addressed.
- Administration support is essential to ensure that Band 7 & 8 staff are not spending inappropriate levels of time on administration duties.

Education

- Safeguarding nursing supervision and models of assessment/frameworks need to be included in University programmes.

Multi-disciplinary context

- Consideration needs to be given to how nurse managers who provide supervision to other disciplines, for example social workers in mental health teams, can utilise new or alternative documentation.
- The role of SCNSs and accountability arrangements in the provision of advice, training and supervision to allied health professionals needs to be regionally agreed. Allied health professionals have more frequent contact with some children and families than nurses.
- Consideration needs to be given to if or not it should be mandatory for key professionals involved in case to attend case conference (mental health).

Appendix 5: Training Programme

SAFEGUARDING CHILDREN SUPERVISION

Dates:	**Venue:**
21, 22, 23 Jan 2009	**Corrs Corner, Newtownabbey**
26, 27, 28 Jan 2009	**The Bank Hotel, Dungannon**

Time: 9.15 – 4.30 (attendance at all 3 dates is compulsory)

Day1	Day 2	Day 3
Why do we need a Safeguarding Supervision Policy Course Expectations Principles of Supervision and use of Kolb's Learning Cycle in Risk assessment in Domestic Violence and Abuse - Using the Ontario Model (adapted by Barnardos) in Supervision Impact of Mental Health Illness on Parenting Capacity and application of UNOCINI Application of Graded Care Profile in Neglect Cases	Welcome – Expected Learning Outcomes Includes a theoretical model and chances to apply the model to case material Identifying and reducing risk in Sexual Abuse Gerrilyn Smith Assessing Non abusing parents Models of Supervision Case discussion using the theoretical ideas presented	Welcome – Expectations and Learning Outcomes Introduction to pilot supervision process and documentation Introduction to pilot supervision process and documentation (continued) Group Supervision: Principles & Skills Supervision in Practice – facilitated experiential learning Feedback, Pilot Implementation Action Plans including Beeches Management Centre Support in the Workplace

Appendix 6

DHSSPS SAFEGUARDING SUPERVISION PILOT TRAINING NEEDS

Please answer the following questions. This information will be used to inform a baseline analysis of safeguarding supervision available to nurses in the five HSC Trusts. It will also be used for the development of a three day training programme for nurses who are providing safeguarding supervision. Please complete as fully as possible and add any additional comments as you feel appropriate.

Information contained within this document will be treated as confidential.

NAME JOB TITLE

HSS TRUST

Which nursing groups do you supervise and what is the method and frequency of supervision (please complete the table below)? Please comment if you also have managerial responsibility.

NURSING GROUP e.g. HV, SN, CAMHS, CPN, CCN, others	METHOD e.g. one to one, open door, group or other	Frequency	Number of nurses in this group that you provide supervision	Comments

Further comments regarding the nursing group, method, frequency, numbers and any other issue relating to safeguarding supervision.

If you do not supervise currently, who do you intend to supervise (safeguarding) in the next year?

Have you attended training for supervisors? If yes, Please provide details e.g. approximate **date, number of days, provider and content**. Please comment on the usefulness of this in relation to safeguarding supervision.
Do you receive safeguarding supervision and if so who provides this and by what method and frequency?

Have you attended training for child protection/safeguarding supervision? If yes, please provide details e.g. approximate date**, number of days, provider and content**. Please comment on the usefulness of this in relation to safeguarding supervision.

Do you require training on the following?

SUBJECT	DEFINITELY	UPDATE WOULD BE	NO

		USEFUL	
PRINCIPLES OF SUPERVISION APPLICABLE TO SAFEGUARDING SUPERVISION			
KOLB'S LEARNING CYCLE			
PROVIDING INDIVIDUALS WITH SUPERVISION			
PROVIDING GROUP SUPERVISON			
MANAGING POOR PERFORMANCE			
UNOCINI THRESHOLD FRAMEWORK AND ESCALATING CASES CAUSING CONCERN			
RISK ANALYSIS & NEGLECT e.g. GRADED CARE PROFILE			
RISK ANALYSIS & DOMESTIC VIOLENCE e.g. BARNARDOS			
RISK ANALYSIS & SEXUAL ABUSE e.g. FINKLEHOR			
RISK ANALYSIS & MENTAL HEALTH			
RISK ANALYSIS & PHYSICAL ABUSE.			
RISK ANALYSIS & EMOTIONAL ABUSE			

PLEASE IDENTIFY OTHER TRAINING NEEDS

Thank you for your continued support with this project.

Please forward to una.turbitt@southerntrust.hscni.net

Appendix 7

Safeguarding Children Nursing Supervision Course Evaluation

Comments from Participants

'Overall enjoyable even though there was a lot of information'.

'Excellent variation in first day with use of models for risk assessment'.

'All sessions were excellent, very stimulating and well structured'.

'All speakers on day one were very informative, good use of handouts and information pack that will reinforce learning for me'.

'Day 2 was excellent with information and examples of practice. I would recommend this training to all community nursing staff involved in safeguarding children'.

'Gerillyn Smith was excellent, very informative, thought provoking and easy to listen to'.

'I think the course over delivered on my expectations'.

Not relevant to work (Psychiatric Intensive Care Manager)

Too detailed for our needs. (Mental Health)

'Did not get enough time to use case studies'.

'The information and discussion around supervision process was helpful and gave clarity to purpose Group Supervision'.

'Have reservations about the supervision model presented'.

'Found group supervision exercise daunting to facilitate because this is new'.

'Time spent on group supervision exercise very useful'.

Course Evaluation (continued)

52 out of 59 participants completed evaluation forms. Some forms were incomplete and this accounts for totals not always being 52.

Rating 6 = Excellent ……Rating 1 = Poor

1 (a) How well were the learning outcomes met?

Rating	**6**	**5**	**4**	**3**	**2**	**1**
Course 1	10	13				
Course 2	17	8	4			
Total	27	21	4			

1(b) How relevant was the content to your role in Safeguarding Children Supervision?

Rating	6	5	4	3	2	1
Course 1	11	10		1	1	
Course 2	20	5				
Total	31	15		1	1	

3. Overall Rating of Delivery

Rating	6	5	4	3	2	1
Course 1	10	10				
Course 2	20	9				
Total	30	19				

Day 1 includes speakers Use of case studies and group work

Rating	Good	Satisfactory	Poor
Course 1	22		
Course 2	29		
Total	51		

Day 2 includes speaker and discussion

Rating	Good	Satisfactory	Poor
Course 1	23		
Course 2	29		
Total	52		

Day 3 includes speakers, practice development of group supervision and documentation

Rating	Good	Satisfactory	Poor
Course 1	16	4	
Course 2	29		
Total	45	4	

Appendix 8

Comments from Supervisors and Supervisees regarding Individual Supervision Process and Documentation

- *I look forward to my next supervision using the Pilot Framework to ensure I am better prepared and use the time more effectively*
- *This was a very 'straightforward' supervision, 3 cases of LAC presented, long term settled placements, as HV had completed all Appendix 3*
- *This was excellent as made her think more analytically and improved her preparation. Less time – consuming for SCNS but acknowledge impact on Health Visitor's prep time*
- *More protected time required for Health Visitor preparation and reflection*
- *Very lengthy, 3 hours and did not have time to complete record review. I did not know this HV or her cases and it took considerably longer to extract pertinent issues*
- *Reduce duplication of recording*
- *Found discussion of strengths, needs and weakness a useful tool particularly for writing case conference reports*
- *Paper work easy to use. Gives action and direction to work*
- *As a newly qualified HV I suggest supervision sessions are essential to guide thinking and structure practice.*
- *Documentation should be condensed to 1 page. Really appreciate the value of supervision but this will create yet another paper mountain*
- *Lengthy but helps to come actions required Difficult to score threshold Time consuming but valuable support which don't currently get*
- *Felt that quality of supervision was decreased as we had limited time to discuss each case as forms so lengthy to fill in took 4 hours to cover 4 cases*
- *Layout of paperwork easy to use, good tool for community children's nursing to be more specific and systematic in reviewing cases*
- *Supervision is lengthy process but very worthwhile. I feel it enables you to see the outcomes of your work and also to identify areas for improvement*
- *HV had 25 families to discuss on agenda. SCNS having to complete a proforma like Appendix 3 for caseloads such as this will be unmanageable .*
- *Difficulty meeting timescale for photocopying and returning originals to HV*

- *Session took 3 hours and was unfinished. 7 cases discussed in detail and 3 record reviews completed.*
- *Session lasted 3½ hours, did not have time to discuss high dep. Families as I normally would. Worried about the huge time commitment!*
- *Cannot afford 3 – 4 hours for one supervision every 3/12!*
- *Could we have somewhere on each page to put the family name and if it is review supervision do we need to complete all the information each time?*
- *Summary of current situation not applicable to school nursing*
- *Very similar to existing CP documentation supervision used in our trust. A supportive and informative process. No doubt that allocated time should be given to follow this process and ensure best practice*
- *Lengthy process, requiring preparation and allocated time to complete adequately. However, worthwhile process ensuring good practice*
- *As already stated too much time was spent rewriting information which was already held in UNOCINI or Case Conference reports smaller case load but still took 3 hours to complete*
- *The supervision took the whole day from 9.30 am – 5 pm, this was a very heavy CP caseload and I felt there was far too much writing of material which had already been documented elsewhere. HV felt that she did not get as much out of the sessions as before. By the end both HV and myself were exhausted*

Appendix 9

Comments from Supervisors and Supervisees regarding Safeguarding Children Group Supervision

- *I felt the session was of great value to me. Instead of tunnel vision on certain issues the group helped me see issues from a different point of view*
- *I have forgotten some of what was agreed as learning from other colleague's cases. It would be useful to recap at end of supervision. A very good process overall, does tend itself to shared learning. The documentation is lengthy but focused session – requiring dedicated time.*
- *Too much duplication, group of 6 supervisee worked v well, tedious paperwork*
- *We did not use the 15 minute per person approach as the group did not feel that this was a comfortable way of being supervised. Group were supportive to each other and quieter members were noted and encouraged to participate*
- *Excellent feedback from staff involved but was anxious due to my inexperience as supervisor*
- *Limited experience as group supervisor, found training session to be helpful*
- *'Interesting discussions ensued and all appeared to have a favourable outcome'*
- *'most people adhere to policy, but a small number still need the importance of this to be highlighted'*
- *'sharing experience and knowledge has informed my practice'*
- *'well structured supervision – everyone got an equal opportunity to discuss their case and equal input from colleagues'*
- *Need to prioritise issues in advance to avoid duplication, separate out clinical and managerial issues, keep focused on child protection issues, acknowledged good practice identified in group.*
- *A very useful area to be piloting and developing in order to safeguard children - the pilot has come about at a time when there are changes and training in supervision within the Trust, so there are a number of new things to get a group up at the same time, which can be a challenge. Developments in one area can compliment those in another.*

- *I found process very good. It made me think methodically about my role. Felt we needed more time and didn't complete all records. Also I will be more prepared and aware of process for next meeting*
- *Very time consuming to complete 20 – 30 mins to each case*
- *Helped keep a focus on discussion / plan of discussion*
- *We all got a chance to talk about our individual cases and general concerns*
- *Benefited from group supervision – felt I contributed to supervision – felt part of a team*
- *Feel 1-1 supervision more beneficial but group also supportive*
- *Fairly straight forward, supportive, positive experience*
- *Adequate time*
- *felt easier in smaller group*
- *Very well structured*
- *Absolutely useful*
- *Good partnership approach*
- *Yes, good to share ideas I wonder if Social Work input would also be beneficial at the group sessions*
- *5 people ample in group discussion otherwise would be difficult keep within time restraints*
- *5 members adequate*
- *I found the structure limiting as it didn't allow for my concerns to be accurately reflected*
- *I felt the group supervision much better than the focus group as I felt it much easier to talk with fewer people*
- *Group sharing their experience, highlighted issues of working in rural community, discussion re unmet need and importance of recording same*
- *Time to reflect on case presented and practice complexity of case, reassurance re practice*
- *Knowledge/experience similar to others – reduced anxiety better understanding following discussion with group*
- *Would be very useful for new cases possibly document under headings used in process*
- *Some issues are difficult to discuss with a whole room of your peers – risk of feeling inadequate / stupid, etc*

- *It was extremely helpful and provided good learning opportunities, excellent having small groups*
- *I am unsure how effective it is to send preparation to supervisor prior to group session as each topic was introduced at group session. I thought the purpose of sending preparation was for the supervisor to prioritise discussions at group discussion. Therefore I don't see need to send preparatory notes (at the moment).*