

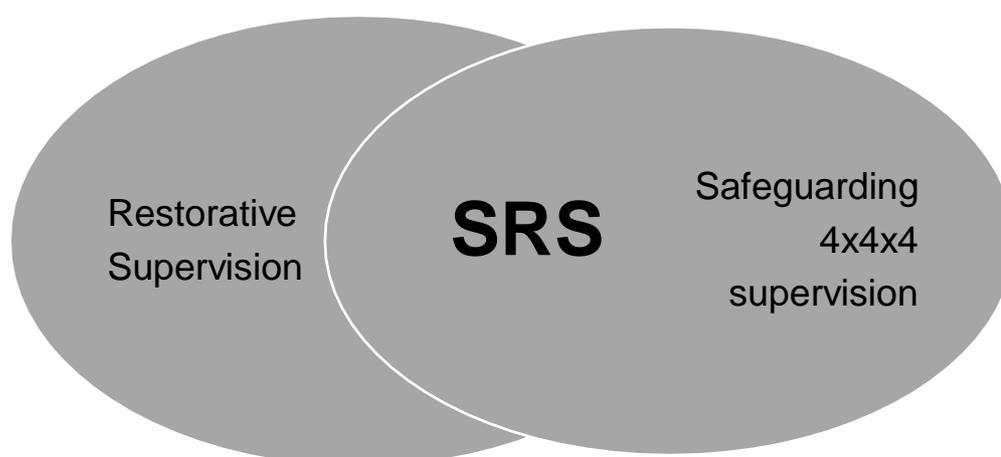
Safeguarding Restorative Supervision – Supporting supervisors to work confidently with emotion and challenge in safeguarding

Introduction

Supervision arrangements for staff working in healthcare settings can at times appear to be a complex and confusing array of different types of supervision (e.g. clinical/managerial/safeguarding/restorative), with little consistency in how these are delivered between organisations. The development of restorative safeguarding is not intended to be yet another model to add to the already confused landscape. Instead the SRS model has been developed out of a desire to reduce confusion and complexity through the recognition that restorative and safeguarding supervision are not mutually exclusive and both are integral to a sound safeguarding system.

Safeguarding Restorative Supervision (SRS) has been developed by Sonya Wallbank and Jane Wonnacott and is supported by a training programme for safeguarding supervisors in a variety of settings. Although initially developed for health organisations, it is anticipated that the model will have relevance in any setting where staff are working day to day with children, adults and families, where assessing and managing the risk of harm is integral to their work.

The underlying premise of this model is that developing resilience within the staff group and enabling practitioners to work positively with emotions is not an optional extra within safeguarding but is a fundamental aspect of the supervisory relationship. SRS utilises the evidence supporting the effectiveness of restorative resilience supervision and combines this with the 4x4x4 model which is a tried and tested approach to safeguarding supervision. This paper outlines the principles of the SRS model and demonstrates how effective safeguarding supervision needs to be underpinned by the supervisor, firstly providing a safe and emotionally contained space to enable critical reflective practice and thinking to take place.



Background: the interface between clinical and safeguarding supervision

Underlying some of the confusions in the supervision landscape within health organisations is the relationship between clinical and other forms of 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 (CQC, 2013).

Literature reviews relating to 'clinical supervision' show that its use as a ubiquitous term may well be problematic as it is often an umbrella statement with little clarity around function and purpose (Berggren et al., 2010). The evidence of the effectiveness within health settings of clinical supervision has been scant and often limited to specialist groups such as mental health nursing. There is little literature dedicated to the use of appropriate and specific strategies to be used within the clinical supervision session (Howard, 2008) leaving managers with a need to improvise as to best practice. Interestingly, managers are often confident with the supervision provided being effective, but less so with the theoretical underpinnings of their supervisory method.

There continues to be confusion regarding models of clinical supervision particularly in health settings. There is little guidance from policy nationally or locally, where 'supervision' is often discussed as being imperative but not described in a way that supports a practitioner to understand what the content or purpose of supervision needs to be in order to be effective. The measures available to practitioners to determine whether their supervisory space is effective have focused wholly on the experience of the supervisee. This misses the aim of supervision to improve or keep safe the care being provided, the experience of the supervisor and the role of the organisation in the function and purpose of supervision. This lack of clarity is reflected in the safeguarding context with child protection or safeguarding supervision (CQC, 2013) either being seen as one form of clinical supervision, or something entirely separate. This is a false dichotomy with evidence suggesting that general clinical supervision is an important aspect of protecting children along with an opportunity to focus on specific cases (Lister & Crisp, 2005).

There is the potential for further lack of clarity and confusion between the terms *safeguarding* and *child protection* supervision. Safeguarding is a term used to describe a wide range of activities related to protecting children from maltreatment, preventing impairment of health and development and promoting their welfare. Child protection is part of safeguarding and promoting welfare; although the supervision activity may be referred to as "safeguarding supervision", the reality is that it is often focused on a narrow group of children who have been identified as in need of a child protection plan. Given that many of the children who die as a result of abuse or neglect are not on a child protection plan this is an unhelpful approach (Davies & Ward, 2012). This paper therefore uses the term "safeguarding supervision" to refer to

supervision activity focused on the needs of children receiving services beyond universal provision.

With the absence of guidance, safeguarding supervision is vulnerable to becoming a space that is solely driven by an organisational demand to be assured that practice is safe. The need for management assurance through checking, challenging, and auditing can overtake the restorative, reflective and learning nature of the session without a strong and skilled supervisor. Given the increase in newly qualified workforces such as Health Visiting the need for this space to remain supportive as well as hold organisational assurance is critical.

The process of conducting safeguarding supervision should not be a punitive one. However in the absence of a common understanding within and between organisations as to how the sessions should be conducted, at times this is how it can be experienced by health professionals.

It is argued that current strategies to manage risk in child protection are, paradoxically, making it harder for professionals to learn how to protect children better.
(Munro, 2010 Page 1135).

One key aim of safeguarding restorative supervision is to mitigate the risk that safeguarding supervision becomes solely a management tool focused on task completion rather than a balanced process focused on supporting and enabling practitioners to use the critical thinking skills that are needed for safe practice.

Restorative supervision overview

Restorative supervision (Wallbank, 2010) was developed as a solution to the emotional demands being placed upon a range of health professionals. It was initially piloted with hospital midwives, gynecology nurses and Doctors in 2009 in response to earlier studies (Wallbank & Robertson 2008), which demonstrated the impact of loss on this group. It has since been used with over 3500 health professionals within the UK and Australia and the evidence that the model supports the professional to think and make decisions continues to grow (Table 1).

The model was designed to focus on the capacity of the individual to deliver complex care in a variety of settings. The dominance of the restorative nature of the model and its emphasis on the wellbeing of the individual, arose from the initial research findings which demonstrated the lack of focus on the professionals' own health and wellbeing and its link to thinking clearly within their role (Wallbank, 2010). The model has subsequently evolved by the original author into one with an emphasis on building resilience in the professional and therefore enabling the most effective restorative function to take place. It also means that the model is sustainable within the individual as they learn new and effective strategies for self-care.

Working within health services regardless of job role, is often hard and challenging work (Point of Care Foundation, 2013) and frequently creates a degree of anxiety or negative emotions that need to be worked through (Wallbank, 2010). We can see from the Francis report into findings at Mid Staffordshire (Francis, 2013) when staff feel overwhelmed by their work, the detrimental impact that has on patient care.

Within children and family services, difficult emotions are often evoked because of the nature and content of the work. Significantly, the often negative context that comes with child protection work means that there is a constant feed of media attention towards the 'failing professionals' and therefore workers experience doubts in their own confidence of being good enough to carry out the role.

The capacity of the professional to remain resilient within their role depends on the support systems, e.g. supervision to manage those negative emotions well and to use emotional responses positively as a tool to understand any issues in the family that may be impacting on the care of the child or vulnerable person. For example where a member of staff is experiencing anxiety or fear, what might this be saying about the experience of the child within that family environment?

Key facets of the restorative model are:

- Providing a safe space which enables the professional to be open about their true sense of self
- Providing a supportive and challenging supervisory environment
- Improving the capacity of the individual to remain resilient in the face of challenging case work through their ability to recognise personal triggers
- Enhancing the ability of professionals to relationship build with fellow professionals to avoid isolation and reduce difficult collegiate behaviours
- Encouraging the professional to focus on the events and/or situations they can change so they experience less helplessness
- Improve the ability of the professional to communicate issues so they can be escalated effectively

Table 1: Impact of restorative supervision sessions on health professionals

Scale Measure	All participants Baseline N=3094	All participants post Supervision N=3084
Compassion Satisfaction	44.20 (4.18)	44.72 (4.17)
Burnout	42.81 (4.23)	24.71 (5.13)
Stress	43.35 (4.12)	16.86 (4.02)

Key: 22 or less Low
 23-31 Average
 31+ High

Results from the programme have shown how individual sessions of restorative supervision followed by group experiences has a significant impact on reducing burnout and stress whilst maintaining compassion satisfaction (the pleasure one derives from their work). Compassion satisfaction remains high across the groups we have worked with, we know that this supports engagement with organisations and keeps people at work even when things are tough. Burnout and stress are reduced from significant clinical levels to a level where the professional would have the capacity to think.

As the use of restorative supervision has grown within health settings an artificial delineation between this as a model of supervision alongside others has become a point of discussion and contention. The immediate need to adopt a restorative model came from the levels of stress and burnout being experienced by professionals. The ability to use restorative skills e.g. the ability to create and develop a supportive space for the professional are also essential skills in the safeguarding supervision space. Developing a model which therefore adopted the best of both models appeared important to support health professionals undertaking safeguarding work.

Safeguarding supervision and the restorative model

Practitioners in health organisations come into contact on a regular basis with vulnerable children and adults and will be making decisions as to whether they are at risk of harm. Some practitioners such as health visitors will have a formal role in safeguarding processes and as a consequence safeguarding supervision will be in place in line with statutory requirements; this may be delivered in a variety of ways.

“..Organisations should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children

...appropriate supervision and support for staff, including undertaking safeguarding training”

Working Together (2013) Pg. 47

Other practitioners who may not be seen as front line safeguarding practitioners, or where supervision is not part of their professional culture, may not have any opportunity to reflect on their safeguarding practice. For these practitioners there is little opportunity to contain the anxiety that so often accompanies managing risk and may affect their capacity to think, learn and develop as safeguarding professionals.

The essence of good safeguarding supervision is supporting the capacity of the practitioner to think, reflect and develop their own solutions around what needs to happen next with families. The restorative nature of the session is therefore paramount to support the professional in their capacity to do this thinking. Alongside this is the need for the organisation to be assured that safeguarding practitioners are competent, any factors that might be inhibiting good practice (both individual and organisational) are identified and acted upon, and there is a clear focus on improving outcomes for people at risk of harm.

The emotional impact of safeguarding work has been recognised for many years (Morrison 1990; Ferguson 2005); one implication of this is that emotions need to be worked with within supervision in order to assist the worker in recognising and working with complexity. Any situation where there are concerns about the safety of a child or adult is unlikely to be simple and will involve making sense of often contradictory information and managing a degree of uncertainty. Where the worker's emotional responses are raising anxiety this may lead to the very opposite approach whereby the worker manages anxiety by striving for simple explanations and solutions.

The supervisor during a safeguarding session needs to work at a number of levels in order to draw out and explore the complexity of the work and support the practitioner in their ability to make sound professional judgments. This focus on the work of the individual practitioner is overlaid by the need to consider their practice within the context of a complex multi-agency environment where the capacity to manage relationships is key. Developing emotionally intelligent safeguarding practice is therefore of fundamental importance and a point where restorative skills are crucial to effective safeguarding supervision.

The organisational importance of the session is critical. Whilst the traditional restorative session emphasised the need to have an open space, the SRS model provides a balanced approach which maintains a focus on the outcomes for the service user whilst supporting and challenging the practitioner. This ensures that both supervisor and supervisee are able to continue to assure the organisation of the safety of the work being undertaken, as well as its effectiveness.

As the integration of accountability within a restorative framework may not have been commonly understood, the role of the supervisory space may be confused and the balance of the session lost. The SRS model ensures that the appropriate degree of restorative efforts take place within the session to support the supervisee whilst the space is sufficiently developed to explore assumptions, complexity and impact of the work.

Given the degree of media scrutiny around safeguarding work it is not surprising that a blame culture arises and organisations are reduced to being unable to recognise the role of safeguarding supervision as being more than a task focused process. The supervisor's role becomes solely one of checking on practice and providing advice and direction. The result is that either practitioners may become disempowered both within supervisory relationships and the whole safeguarding system. It is interesting that serious case reviews frequently identify lack of challenge between professionals as an issue; the capacity to challenge involves practitioners feeling empowered and confident to do so. (Somerset Safeguarding Children Board, 2013). Supervision should play an important role in promoting this aspect of their practice.

The learning from restorative supervision has been the need for professionals to remain in a resilient place themselves to deliver the care, this needs to underpin the safeguarding session not be separate from it. The more the models are artificially separated, the further safeguarding becomes the business of managerial supervision, reducing the effectiveness of the supervision space. This creates the dichotomy of the restorative session being 'good' and the safeguarding session being 'bad'; neither of which is true or helpful in enhancing the ability of the practitioner to think.

Safeguarding Restorative Supervision

Our aim in developing safeguarding restorative supervision was to develop an approach whereby restorative skills could be seen as intrinsic to the safeguarding supervision space rather than separate to it.

One model of supervision that has been used extensively within a child protection context is the integrated (4x4x4) model first developed by Tony Morrison (Morrison 2005; Wonnacott 2014). This model recognises the interdependence of the functions of supervision, their impact on key stakeholders and the four elements of the supervision cycle.

Table 2: The 4x4x4 Model

Four Functions	Four Stakeholders	Four Elements of the Supervision Cycle
Management	People who use services	Experience
Support	Staff	Reflection
Development	The organisation	Analysis
Mediation	Partner organisations	Action planning

This model is useful within safeguarding as it integrates both a focus on accountability through a management process alongside, supporting and developing the supervisee. Linked to this, are the key skills that need to be used for effective child protection of reflection, analysis and action planning.

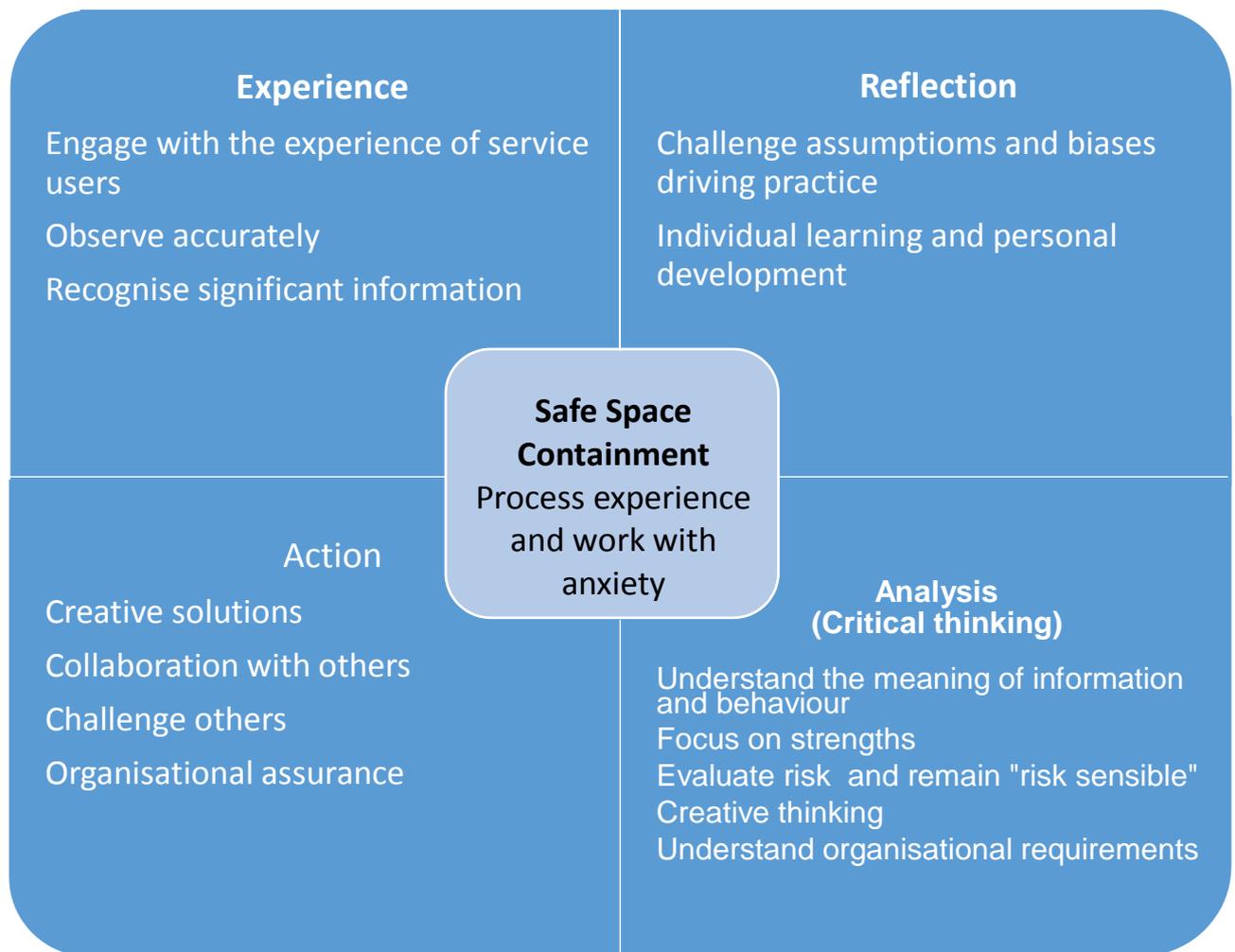
The model has continued to be developed over time drawing on practice knowledge developed from training thousands of supervisors as well as a wide range of professional literature. This literature includes the development of expertise, (Fook et al., 1997), adult learning (Kolb, 2014), reflective practice (Schon, 1983, Ruch, 2000), emotional intelligence, (Goleman, 1996, Morrison, 2007). The model has also continued to be developed in relation to child care practice, taking account of lessons from serious case reviews, the developing literature on influences on decision making (Munro, 2008, Kahneman, 2011), and national guidance (HM Government, 2015).

The model was used as the basis for the national training programme for the supervisors of newly qualified social workers. The final evaluation of the project (Carpenter et al., 2012) found that where supervisees had received their full entitlement to supervision, outcomes in respect of self-efficacy, role clarity, role conflict, job satisfaction and stress were higher than in situations where supervision was only partially implemented. The clearest difference was in relation to stress.

The core of the model is providing the containment that is needed to allow practitioners to think. Here the skills of the supervisor come into play in providing a safe space that nonetheless also allows for the challenge and critical reflection required for safe practice

Utilising restorative skills the model promotes the use of the supervision cycle, which if used effectively, enables an integration of case management with the staff support, critical reflection and critical thinking needed to promote good practice. The model ensures that at all stages of the supervision cycle a restorative approach continually supports practitioners to engage in all these critical aspects of the supervision process.

Fig 1: The Safeguarding Restorative Model: impact on practice



The Supervision Cycle and Safeguarding Restorative Supervision

Telling the story – In order to understand the experience of the professional within safeguarding supervision, the supervisor needs to engage the supervisee to elicit *accurate* observations – this method of telling the story, reflecting on events, thinking about the voice of the service user in the story is compromised if the professional is in a difficult or overwhelmed space. Often the story becomes about the professional’s experience of the family rather than the family itself. Containment of the individual and their capacity to slow down their thinking to reflect appropriately on the family is key. This is a significant skill in restorative supervision, creating a space that feels supportive and enhances learning.

Reflection – *Sharing feelings about the story and previous stories.* In order to be thinking about making connections and recognising patterns, the professional needs to be thinking clearly. The space they are sharing with the supervisor needs to be an open and honest one where thoughts of, *what is this evoking for me and what is this linked to* are able to be shared without judgement. The capacity of the supervisor to listen in a non-judgmental way and know when to challenge and support connection making is again a key

skill in restorative sessions. The supervisor does not remain a sponge, but instead offers a mirror experience, reflecting and identifying patterns in a way that can be heard by the supervisee.

This requires a deeper level of thinking and pattern making by both the supervisor and supervisee. To be reflective in this way, the relationship between the supervisor and supervisee needs to be reciprocal and trusting as the supervisee may need to reveal some vulnerabilities. If the professional is feeling insecure or vulnerable because of workload stress etc. then this process will be slowed down. The professional is likely to be more defensive and unable to see their own contribution in these difficulties.

Analysis – *what does the story mean* – supporting the professional to translate reflective experience into professional evidence. This requires the supervisor to be expert and facilitator at the same time; the supervisor needs to feel that the supervisee is in a place to use the knowledge gained from the reflective process to understand what life is like for the service user. Understanding what life is like, exploring different perspectives and weighing up alternative ideas are key to the supervisory process. Being in a position to analyse rather than adopt a defensive position in favour of one's own practice occurs best when both supervisor and supervisee are able to think clearly. Pattern identification, considering research evidence and own practice experience all take place within a supportive supervisory space. If the supervisee is still overwhelmed by their own experiences because they have not been contained or reciprocal in the session they are unlikely to be able to hear the conversations on the appropriate level. In fact they are more likely still to be focusing on their own experiences.

Plans/Action – The final element of an effective safeguarding session is to agree what plans and actions need to be taken. Whilst a professional who is not in a good enough mode can agree and sign up to these, they are not likely to contribute to a shared understanding of what needs to be done and are more likely to feel that the session has been done unto them rather than being an active participant in the process.

Call for explicit use of supervisory models

Given the difficult nature of the work within safeguarding and the wider organisational and cultural context professionals find themselves operating in, it would be helpful for organisations to understand the benefits of being explicit about the purpose and content of supervision. The directive to engage in 'supervision' is insufficient without specifying the expected outcomes from the activity and using a model grounded in evidence. Organisations need develop a culture within which professionals are able to think and act appropriately and learn from previous experiences, rather than being overwhelmed by them. A restorative and reflective approach to supervision such as the integrated restorative model can provide the foundation for supporting the development of such a culture.

More explicit national guidance relating to the type of model used within safeguarding (especially given the dearth of evidence currently available) would be welcomed and embraced by professionals and safeguarding boards alike. This would also ensure that the space remains an effective one for both supervisor and supervisee.

- Safeguarding supervision needs to support professional's capacity to think and feel restored
- Effective safeguarding supervision combines critical reflective practice and thinking with a restorative approach
- Restorative approaches to supervision need to retain governance and accountability
- The new integrated safeguarding restorative model of supervision ensures that the appropriate degree of restorative efforts are combined with a mature space to explore assumptions, complexity and impact of the work.
- Organisations need specific guidance around the type of supervision being adopted rather than an assumption that any form of supervision is beneficial

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