“Full to the Brim” Taking an ethnographic stance in evaluating the supportive nature of safeguarding supervision in health visiting practice.

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Summary

Safeguarding supervision involves providing specialist support and advice to practitioners who are involved in the safeguarding of the most vulnerable children. Health visitors work with children and their families aged 0-5 years and are regularly involved in safeguarding situations where children have been placed at risk of significant harm by their parent or carer. Health visitors need the opportunity to critically reflect and feel supported in decision-making processes. The aim of this study was to explore and interpret how health visitors are supported within their roles especially when they are involved in the safeguarding practice elements of their practice. This exploration investigated the role safeguarding supervision plays within health visiting practice including, how it was received and delivered.

An ethnographic approach was determined a suitable approach in observing health visitors in practice and observing group supervision processes. Interviews and focus groups with health visitors, interviews with safeguarding supervisors, and safeguarding record keeping reviews were also undertaken. The overall sample size included fifty-four participants across three health boards in Wales.

Results indicated that HVs usually felt supported by peers and supervisors in group supervision situations. Most participants would like access to detailed one to one supervision at least once a year. Health Visitors need to prepare for supervision and Safeguarding supervisors (Safeguarding Nurse Advisors) require supervision training.

Safeguarding supervision provides a structured discussion between supervisee and supervisor to support and advise on specific complexities and challenges within their caseloads. A recommendation for the supervisors was to take a person-centred, restorative approach to safeguarding supervision. Safeguarding supervision training is essential to allow the supervisor to engage authentically and share decision making. For safeguarding supervision to enhance safeguarding practice effectively placing the child at the centre of practice, accountability and responsibility is targeted to the organisation, the supervisor, and the supervisee.

Acknowledgements

“Be strong and courageous! Don’t tremble or be terrified because the Lord your God is with you wherever you go.” Joshua 1v9

I have been on an incredible journey since 2018 when I decided to pursue a PhD. I loved being a health visitor and was well supported by the safeguarding team. So much so I became a safeguarding lead nurse. I was able to draw on my safeguarding experience and had the opportunity to complete safeguarding supervision training with the late Tony Morrison. It impacted me greatly and offered me a new insight into how effective and supportive safeguarding supervision can and should be. I was afforded this training opportunity by Linda Brown, she was inspiring as a safeguarding designated nurse and started me on this journey of curiosity in wanting to dig deeper, explore further and question practice to ensure children and young people remained at the centre of health visiting practice. Heartfelt thanks are given to the Community Practitioner Health Visitor Association Education Trust who have funded this PhD with a MacQueen bursary. There are so many people I need to acknowledge from Linda Brown and Linda Hughes Jones, both Health Board Designated safeguarding leads who lead by example and passion to protect children and young people. Linda Hughes Jones asked me to undertake an evaluation of a move to group supervision in the health board and this is where my PhD journey began. Thank you to all the participants of this study, dedicated health visitors and safeguarding leads doing their absolute best daily. I have been so supported by colleagues (now friends) at Cardiff University, particularly the (old) then primary care and public health nursing team – especially Lorraine Joomun, Amanda Holland, and Kate Phillips, what a journey we have had, champions for each other with lifelong friendships made. I have worked more recently at RCN Wales and the leadership team has been so supportive of my studies. Diane Powles continues to be a constant support, checking in with me and very calming when I have a wobble! To Helen Whyley (RCN Wales Director) and Sandy Harding (Associate Director) thank you, and to the wonderful Nurse Adviser team, a constant support and friendly ear. My supervisors, Professors Daniel Kelly, and Judith Carrier, it is difficult to put in words how inspirational, knowledgeable, supportive (yet firm when needed!) and measured you are. This research carries your names too. My family, my sister Sue, and

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> *"For I know the plans I have for you, declares the Lord, plans to prosper you and not to harm you, plans to give you hope and a future." Jeremiah 29 v11.*

Abbreviations

ACEs:	Adverse Childhood Experiences
APPHNs:	Associate Director Public Health Nursing
ASSIA:	Applied Social Sciences Index and Abstracts
BNI:	British Nursing Index
CAMHS:	Child and Adolescent Mental Health Services
CASP:	Critical Appraisal Skills Programme
CETHV:	Council for the Education and Training of Health Visitors
CINAHL:	Cumulative Index to Nursing and Allied Health Literature
COVID:	Coronavirus Disease
CPD:	Continuing Professional Development
CPHVA	Community Practitioner and Health Visitor Association
CYP:	Children and Young People
DoH:	Department of Health
FG:	Focus Group
g FNP:	Group Family Nurse Partnership
GP:	General Practitioner
HEI:	Higher Education Institution
HRA:	Health Research Authority
HV:	Health Visitor
ICHB:	Inner city /urban area
ICRHB:	Inner city/urban/rural health board
IES:	Impact of Events Scale
iHV:	Institute of Health Visiting
IRHB:	Inner city /urban area health board
MCH:	Maternal Child Health
NHS:	National Health Service
NMC:	Nursing and Midwifery Council
PHW:	Public Health Wales
PNA:	Professional Nurse Advocate
PPE:	Personal Protective Equipment

ProQUOL:	Professional quality of Life
RCS:	Restorative Clinical Supervision
RCT:	Randomised Control Trial
RHB	Rural Health Board
SCIE:	Social Care Institute for Excellence
SCPHN:	Specialist Community Public Health Nurse
SDG:	Sustainable Development Goals
SN:	School Nurse
SNA:	Safeguarding Nurse Advisor
SoS:	Signs of Safety
UK:	United Kingdom
UKCC:	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
UNICEF:	United Nations International Children's Emergency Fund
USA:	United States of America
WHO:	World Health Organisation

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Chapter 1: Introduction and background

There is a lack of research specifically, that relates to safeguarding supervision and the safeguarding practice of health visitors. Health visitors (HVs) are qualified nurses or midwives who have decided to undertake further postgraduate study to attain the title of Specialist Community Public Health Nurse (SCPHN). Specialist Community Public Health Nurses fit into three categories of registration – School Nurse (SN), HV or Occupational Health Nurse (OHN). Health visitors are the focus of this study and work with children and their families aged 0-5 years. They are regularly exposed to a variety of safeguarding issues. For example, children who have been exposed to experiences and behaviours that are categorised as abusive, such as being exposed to physical, psychological, sexual abuse and neglect. Safeguarding refers to the prevention of and protection of children from such abuse/maltreatment. A safeguarding situation arises when individuals have been placed at risk of significant harm and within this research context, the focus is on children aged 0-5 years. Health visitors are experienced professionals who work with all members of society and complex issues that accompany diverse populations on a day-to-day basis.

As a HV and previous Lead Nurse in safeguarding children and young people, I am passionate about HV practice being child centred. To enable HVs, support mechanisms and processes need to be in place to encourage staff well-being, work-life balance, and develop safe, confident, competent practitioners. Health visitors need support, a safe space and protected time to discuss complexities within their caseloads when exposed to significant safeguarding situations. To set a detailed context and offer clarity of the role of the HV, a chapter was developed to state how the role has evolved and how it is delivered across the United Kingdom (UK) in the 21st century. This was felt essential to justify the importance of the role from a wider public health perspective, as well as their importance in the safeguarding of vulnerable children. Professor Dame Sarah Cowley states:

> "*...the health visiting profession has grown and developed.... retaining its commitment to enhancing health and life chances for people facing disadvantage, as well as contributing greatly to the wellbeing of the population. Health visitors are needed now more than ever."* (Cowley 2023, p xii).

The history of health visiting chapter is followed by a chapter defining and explaining the context of safeguarding of vulnerable children and young people and how safeguarding supervision compares with the concept of clinical supervision.

1.1 Background

I undertook a pilot study in 2018 within a local Health Board (HB). The pilot was to evaluate the HVs perceptions in relation to a new group supervision process (Moseley 2020, Appendix 1). The pilot study employed a qualitative/phenomenological design and involved interviews with two safeguarding nurse advisors (SNAs) and 16 HVs (within three focus groups). One of the groups worked within a particularly deprived area of a city. The pilot study raised several practice issues and questions that required further exploration. The results from that evaluation have underpinned this study and generated further curiosity in taking a deeper dive into a broader context geographically and with a larger sample size. The purpose was to explore the efficacy of safeguarding supervision and how supportive it is from the perspective of HVs working with vulnerable children and their families, the safeguarding advisers facilitating the supervision, as well as including insights from ethnographic observations. I was keen to establish HVs' experience of the level of supervision received and whether they felt that it was supportive and relevant to their safeguarding practice, as well as investigating their perceptions of the group supervision process. As a previous lead nurse in safeguarding, I was particularly interested in the education (safeguarding supervision/supervision) training that SNAs had received to inform their facilitation of an efficient safeguarding supervision process. This process is heavily reliant on their safeguarding expertise, but some level of supervision education would also enhance this process. The quality of supervision can have direct impact on outcomes for children and young people (Turbitt 2012) and supervision should remain child focussed. The Institute of Health Visiting reported that it should be delivered by practitioners with expertise in child protection (iHV 2015).

Safeguarding supervision in Wales is expected/embedded in practice and deemed *“mandatory”* in the sense that it is recommended/usual practice rather than enforced by

Public Health Wales (PHW) (PHW 2017) *best practice supervision guidance.* This is subsequently considered at the health board level where safeguarding supervision is checked (attendance) within safeguarding teams and by the HV line manager. There is no formal “mandate” set out from the Welsh Government in relation to safeguarding supervision delivery, or the UK home nation governments. When speaking to safeguarding leads prior to starting my PhD there was debate on the perception of what *mandatory* meant, some felt it was as set out in PHW safeguarding supervision guidance and they felt this was the mandate. Many of the HVs within this study were not familiar with the PHW national guidance.

Safeguarding supervision involves the provision of support, advice and action planning to practitioners who are involved in the safeguarding of children. Moving to group supervision in 2019 was deemed a bold step by the safeguarding team within one health board. Overall, the new process was mostly well received by the HVs and SNAs. In general, they were willing to proceed with the process and my initial evaluation (Moseley 2020) recommended the following to further enhance the safeguarding supervision process at that time in one health board:

- The group supervision to be launched to HVs with a description of a proposed model (group with telephone contact, or one to one if required).
- Facilitators would benefit from specific Safeguarding supervision training/ facilitator training/ or via a post-graduate certificate in education module.
- Smaller supervision groups would allow all HVs to discuss at least one case each if required.
- Planned, structured sessions should be the same for all groups.
- A decision made on how the safeguarding supervision would be recorded.
- Consider use of a model to structure the session. For example, signs of safety. (Turnell and Edwards 1997)
- Consider lengthening the sessions to 3 hours.
- Consider regular re-evaluation of the group supervision process.

As part of this research study, I wanted to build on this initial evaluation of safeguarding supervision practice and enhance the research method to explore the delivery of the

above initial recommendations. The aim was to take this one step further in examining the education and experience of safeguarding supervisors by expanding the sample size and geographical areas involved. My research question was developed with the intention of taking a more structured, revised approach to the methodology used to enhance the initial limited data.

1.2 Research question

Does safeguarding supervision support HVs safeguarding practice when working with vulnerable children and families?

1.3 Aim

To critically explore and interpret how HVs are supported within their safeguarding work, investigating the role of safeguarding supervision and the relationship with the safeguarding supervisor, in developing proficient safeguarding practitioners.

1.4 Objectives

To investigate the following issues with regard to the safeguarding practice of HVs and the supervisory process:

- The everyday work of HVs views about the safeguarding supervision process and whether context influences their individual practice.
- The practice of safeguarding supervisors.
- The perceptions of the safeguarding supervisors.
- The type and variance of supervision delivery.
- The quality of safeguarding documentation.
- To generate new knowledge at the forefront of safeguarding practice in relation to supervision.

The remainder of this thesis will be structured into the following chapters to offer insight into:

- The history of the HV role.
- Safeguarding children and young people.
- Safeguarding supervision and clinical supervision.

- Literature review.
- Research Methods.
- Findings.
- Discussion and recommendations.
- Conclusion.

Chapter 2: The history of the health visitor role

This chapter explores and discusses the history of health visiting incorporating the relevance of the role in public health, health promotion and safeguarding practice. Global comparisons of the HV service will be referred to leading into its history from conception within the UK, to current practice. The definition of the principles of health visiting will be key and the chapter explores how they are relevant from an early intervention and prevention perspective. It is recognised how the role has evolved over the last 150 years with a focus on searching for health needs and the relevance of the early intervention and prevention agenda. The HV role is complex and everchanging, and its delivery is varied across the UK. The aim of this chapter is to offer a history of and insight into the day-to-day role of the HV and to set the context of the complexities experienced within this area of healthcare practice, which includes exposure to safeguarding issues. It is the safeguarding element of the role that is discussed at safeguarding supervision practice. Therefore, the latter half of this chapter sets out to explore safeguarding practice for children young people (CYP), explore the legislative and policy context and consider how risk can be assessed. Safeguarding supervision and clinical supervision will be described to offer further contextual detail. This chapter and chapter three are based on the two published book chapters developed from these thesis chapters (Moseley 2022, 2023).

2.1 Health visiting – a brief global perspective

Health visiting has been in place since the late 1800's within the (UK, although the term health visiting is specific to the UK, Norway, Finland and Denmark, the role exists in various other formats across the world. Sweden uses the term public health nurse; Belgium uses the term social nurse with Pakistan using the terminology of lady HV and lady health worker. In New Zealand, the role is named a Plunket nurse (Plunket Strategy 2016). The aim in New Zealand is to make a difference within the first 1000 days of a child's life, to positively impact future generations, giving children the most positive of start in life to enhance their future potential within society. The Plunket nurse role has been in place for over 100 years. Within the United States of America (USA), public health nurses are named maternal child nurses who work within the remit of

family-nurse partnerships. The role has been in place for over four decades with the aim to support new mothers with an overarching remit of developing trusting relationships to develop extraordinary outcomes (Nurse Family Partnership 2020). The partnership targets new mothers rather than utilising a universal approach to the service. Australia uses the term child health nurse, whilst Russia uses district paediatric nurses (Institute of Health Visiting 2020). Their input/service delivery varies but has a public health focus for children and their families.

In the UK, HVs are qualified nurses or midwives who have undertaken further training at post-graduate diploma/ master's level to reach the qualification of specialist community public health nurses (SCPHN - HV)." The term SCPHN refers to HVs, SNs and OHNs (NMC 2022). The level of training varies across the UK with education providers who are required to be accredited Higher Education Institutions (HEI)/ Universities. The qualification could be attained at level 6 or level 7 (postgraduate diploma or master's level) but since the new Nursing and Midwifery (NMC) standards have been approved education level is now set at level 7 (NMC 2022). The HV primary area of practice is working with children from birth to five years and their families. The term/abbreviation HV and SCPHN will be interchanged based on the evolving, contemporary, literature, policy, and guidance specific to this role.

2.2 The history of health visiting within the United Kingdom

The earliest HVs were members of the Ladies Sanitary Reform Association and evolved within Manchester and Salford. This Association was established in 1852 with records of district nurses and HV type roles being established in 1862. The Association was originally formed to address temperance, which relates to moderating certain indulgences (alcohol, appetite), general health laws and personal and domestic cleanliness (JISC Archives Hub 2019). The Ladies Sanitary Reform Association was a separate committee within the main association and is recorded as an example of one of the first health visiting services (Adams 2012). These early HVs visited families who had poor living conditions and poor sanitation in a time when infant mortality was significantly high. The first HV training programme is recorded as being established in 1892 by Florence Nightingale who was responsible for the role being developed and

used more widely. She recognised the role HVs could play in supporting the population from a public health perspective and recommended the need for formal training for nurses to develop within the public health remit as HVs (Queen's Nursing Institute 2020). This was particularly forward thinking for the time with Nightingale seeing the benefit of home visiting with recognition of the public health. The reputation of Florence Nightingale is well known, deemed as the lady of the lamp, she was a nursing visionary of her time and instrumental in caring for the wounded in the Crimea War, and improving sanitation within the field hospital. In 1860, she established the first school of nursing in St Thomas's Hospital, London (King's College London 2019). The Royal Society for Public Health (previously the Royal Sanitary Institute) established the first recognised education programmes for HVs in 1916. The first statutory qualification is dated from 1919 and was awarded from the Ministry of Health. The programme was equally divided between theory and practice (Adams 2012).

The 1919 programme included,

> *"...elementary physiology, methods of artisan cookery and household management, hygiene, infectious and communicable diseases, maternity and infant child welfare and elementary economics and social problems."* (Adams 2012, Queen's Nursing Institute 2020, p.3).

It seems health visiting in the early 1900's had a firm grasp on the health needs of the populations they served, and they responded to those needs as they changed. The Notification of Birth Acts of 1907 and 1915 and the Maternity and Child Welfare Act of (1918) promoted the development of maternal and child services and this led to the development of the first health visiting education programme. The content of that health visiting programme of 1919 reflected the health needs of the time, including poor sanitation and efforts to reduce the number of deaths from infectious diseases. From 1945, HVs were expected to have a midwifery and/or nursing qualification prior to starting their training. This was governed by the then Ministry of Health (Adams 2012). Health visitor caseloads from 1918 are recorded as one HV to four hundred births; this

was later reduced in the 1930's to one HV per two hundred and fifty births (Dingwall 1977).

The National Health Service (NHS) was established in 1948, and the health visiting role was recognised as essential in relation to collaborating with parents, especially focussing on the health and well-being of mothers and their children. The role of the HV began to broaden and expand. There was some confusion as to where the role of the HV was placed, with General Practitioners (GPs) in primary care settings or with medical officers within the hospital setting (Malone 2000). The Jameson Report (Jameson 1959) referred to the working party who trained and recruited *"visitors"* and the Young Husband Report (Cormack 1959) defined social work practice. To provide further clarity, Jameson (1959) referred to HVs as *"generalist"* case finder's due to how they accessed families within their homes. Social workers were defined as *case workers* as the families they dealt with had particular *problems.* It could be argued that the roles overlap from a social well-being perspective. Today, HVs, social workers and social care teams work in partnership with each other especially from a safeguarding perspective but also within the remit of early intervention and prevention.

As the health visiting role became more established, it became a statutory body with the first principles being established in 1977 by the Council for the Education of Health Visitors (CETHV 1977). The role of the HV was defined in the 1970's as a professional practice which:

> *"…consists of planned activities aimed at the promoting of health and prevention of ill health. It therefore contributes substantially to individual and social well-being, by focussing attention at various times on either an individual, a social group, or a community."* (CETHV 1977, p.7)

The role of the HV has evolved over the past century, as has the definition. Cowley and Frost (2006) refer to health visiting as consisting of planned activities which relate to improving the health and well-being of the population. These activities encompass the individual's physical, mental, emotional, and social well-being with an aim of preventing disease and reducing health inequalities, the main aim of health visiting being to empower families in improving their health and well-being status.

They do this by identifying health needs and working within the remit of their four principles (Cowley and Frost 2006, p.1), which are:

- The search for health needs.
- The stimulation of an awareness of the health needs.
- The influence of policies affecting health.
- The facilitation of an awareness of health needs.

These four principles continue to be as relevant today as they were when there were developed in the 1970's and still underpin HV practice across the UK. They are also relatable to the earlier health visiting practice of the late nineteenth century, where there was a clear search for health needs with interventions being delivered to families within their local areas. Health visitors work collaboratively with families and the community with an aim to improve, enhance children's health, wellbeing, and development. They advise, educate, and empower individuals and families as well as the wider agencies they work with.

Table 1: Key developments in health visiting practice 1970 - 2024.

Year	Key Developments within health visiting 1970 - 2024
1970	CETHV established.
1975	CETHV and Council for the Education and training of social workers separated. All nursing bodies reviewed.
1977	Principles of health visiting defined by CETHV
1979	Nurses, Midwives and Health visitor Act
1983	CETHV abolished. UKCC Midwifery and Health visiting developed.
1984	English and Welsh National nursing boards established
2001	NMC removed health visiting as a distinct profession in statute.
2004	Health visiting register closed. The new register included health visitors as SCPHN.
2004	SCPHN, NMC Proficiency standards published. (NMC 2004)
2006	Principles of health visiting reviewed by Cowley and Frost.
2009	Healthy Child Programme launched (Department of Health 2009). A Vision for Health Visiting in Wales launched (Welsh Government 2009)
2010	UK Government review of health visiting – commitment to increase health visiting numbers by 4,200 in England (Department of Health 2010).
2010	A Framework for the Child Health Promotion Programme in Northern Ireland (Department of Health 2010).

2012	150 years of health visiting celebrations.
2015	Universal Health visiting pathway – Scotland (Scottish Government 2015)
2016	Launch of the Healthy Child (Wales) Programme (Welsh Government 2016).
2019	A review of Health Visiting in England undertaken by the Institute of Health Visiting (iHV 2019).
2020	Health visiting. Good practice case studies. (iHV 2020)
2021	State of health Visiting in England “We need more Health Visitors” (iHV 2021).
2022	NMC Standards of proficiency for SCPHN updated and approved. (NMC 2022)
2024	State of Health Visiting, UK survey report. Millions supported as others miss out. 10th Institute of Health Visiting Annual Health visiting Survey: data year ending November 2023.

Key: CETHV – Council for the education and training of health visitors. UKCC – United Kingdom Central Council for Nursing, Midwifery and Health Visiting. NMC- Nursing and Midwifery Council. SCPHN – Specialist Community Public Health Nursing. UK – United Kingdom. iHV- Institute of Health Visiting.

The health needs of populations are evolving constantly, and health professionals respond to these as governments develop policy, legislation and draw on recommendations from public health bodies such as the World Health Organisation (WHO), Departments of Health and country specific Public Health departments. Pertinent public health, health promotion and safeguarding policy from a macro (global), meso (national- UK) and micro level (home nation or local) perspective, underpin modern HV practice along with the most up to date evidence-based research. The health visiting curriculum from the early 1900’s is somewhat replicated in today’s SCPHN programmes across the UK in line with the SCPHN and NMC standards (NMC 2022). The academic programme is still divided between theory and practice as it was in the early 1900’s. Although, the content of the programme has changed, there are some elements of similarity with a focus of promoting the general health and wellbeing of families. Today’s health visiting curricula varies across higher education institutions (HEIs). All programmes are validated by the NMC and, in general, consist of research skills in health and social care improvement, contemporary approaches to health visiting practice, health promotion and public health, leadership in health visiting and safeguarding children and young people.

The health needs of the twenty first century reflect global and national drivers to reduce the impact of obesity, non- communicable diseases, dental health challenges and poor mental health. Caseload sizes currently vary across the UK and service delivery is vastly different within the UK home nations. The Community Practitioner and Health

Visitor Association (CPHVA) continue to recommend a ratio of one HV per 250 births, but this is exceeded in many areas based on anecdotal evidence. Some areas within the UK report to having caseloads of 800-1000 children. The Institute of Health Visiting (2019) continues to support the recommendation of 250 children per caseload which should be reduced if the caseload is categorised as being high need or deprived. This occurred within Wales when the Flying Start service was introduced. Health visitors working within Flying start areas were allocated 110 families as the service was assessed as requiring enhanced health visiting provision (Welsh Government 2016).

The health visiting role has never been more significant as in the twenty first century with an emphasis on the delivery of necessary early interventions and effective prevention. The recent Marmot review (Marmot 2020) depicts a static life expectancy in England and gross health inequalities that is not dissimilar across all the home nations within the UK. In 2010 within Marmot's Fair Society, Healthy Lives six areas of policy change were recommended (Marmot 2010). They included:

- Providing children with the best start in life.
- Enabling society – children, young people, and adults to reach their potential.
- The creation of fair employment and good work for all.
- Exposure to a healthy standard of living.
- The creation of healthy and sustainable communities

(Marmot 2010)

The key areas identified by Marmot in 2010 are particularly applicable to HV practice and underpinned the drive for more HVs in England at that time. All of the above policy objectives are crucial to improving the health and well-being of future generations and the work of health visitors. The delivery of the principles of health visiting has the potential to offer early intervention and prevention strategies to improve general health and well-being as well as influencing future policies that affect health.

2.3 The need for a health visiting service

Cowley et al. (2015) set out to explore the benefits of a universal HV service and rationalise its positive impact on wider health improvement measures and in the reduction of health inequalities. Their aim was to determine what HV practice entails, and the extent to which their role and purpose is reflected within the Call for Action HV implementation plan in England (Department of Health 2009). Their results, following a systematic, narrative analysis found health visiting practice is "characterized by a particular orientation to practice" (p.465). This characterization refers to HVs' values, skills, and attitudes, which enables them to carry out a universal service. This service relates to a core service provided by HVs including the common thread of working with children and their families from birth to five years. The universal service within the Cowley et al. (2015) paper refers to the importance of the first 1,000 days. This refers to the time from pregnancy up to the child's second birthday (Public Health Wales 2020a). This is a time where effective intervention from a HV can positively influence parenting, attachment, feeding decisions (breast or formula) as well as forming a therapeutic relationship whilst searching for health needs.

Cowley et al. (2015) refer to *salutogenesis*, a concept explored by Antonovsky (1979) which has a vital role within public health and health promotion. Antonovsky explains the origin of the word with *genesis* referring to *the origins of* and *saluto* referring to the *meaning of health.* He attempts to explore, *"*How do we manage to stay healthy?" (Antonovsky 1979, p.vii) and developed a *salutogenic* model based on a sense of coherence at the centre.

Promoting health and working within a public health agenda and policy are two key practice roles undertaken by HVs on a daily basis. Cowley et al. (2015, p.465), refers to salutogenesis as "health creating". The salutogenic approach is thought to be essential in addressing health issues and raising the key public health agenda through promotion of health. Antonovsky's (1979) focus was prioritising the needs of people by working with their strengths and capacity, and within the resources available, to promote health. Therefore, as a concept salutogenesis fits with, and is demonstrated within, HV

practice. In fact, it is also depicted in the application of the four principles of health visiting. Health visitors build therapeutic relationships with parents/carers, assessing their needs, their capacity, and how they can address specific health needs locally with resources available to them. The aim is to promote positive health and well-being, hence, creating positive health experiences and choices and demonstrating a salutogenic approach to their practice.

Cowley et al. (2015) captures how health visiting could function in an ideal world in their paper entitled “Why health visiting?” which refers to problematising health visiting and examines its role in healthcare within British society. Health visiting practice is underpinned by the principles identified above as well as observing and monitoring child development, prevention, detection and supporting in safeguarding children and young people, leadership, and research applicable to its field (Cowley and Frost 2006, Sidebotham 2013). The first three years of a child’s life is known to be critical in building foundations for their future and is well documented (Center on the Developing Child 2019a). The first 1000 days is also a time where attachments to close family members and carers are built; the child starts an exploratory journey, learning and communicating at a fast rate. This includes brain development, where building blocks are set in place for future health and well-being (Center on the Developing Child 2019a). Epigenetics also need to be taken into consideration. This is a new concept within scientific research that purports that gene structure can be altered based on early childhood experiences (Center on the Developing Child 2019b). This supports research undertaken by Bellis et al. (2016) in relation to the impact of adverse childhood experiences (ACEs) in adult life and relates to Antonovsky’s (1979) *sense of coherence* which if present, offers stability and potential within family’s health and wellbeing. Therefore, the need for an HV service which accesses pregnant women and their families as well as during early childhood is essential. The therapeutic relationships established at this time have the potential to support and enhance or *“generate positive epigenetic structures that activate genetic potential.”* (Center on the Developing Child 2019b, online). The HV is very well placed to do this.

During these early years of child development parents/carers require support in various formats. This could be one to one support, group support, or signposting for specific services. For example, from a voluntary agency such as Women's Aid or Barnardo's. These organisations offer specific support based on the service user need. The interventions that HVs offer are vast and it could relate to feeding problems (breast or formula), and assessment of attachment. It can also include support for sleep issues, weaning (commencement of solid food), parental mental health, parental substance misuse, post-natal depression or psychosis, housing difficulties, child development concerns, responses to hospital admissions or accidents and domestic abuse or child protection concerns. A home visiting service utilising the HV role has been deemed an effective and essential one in offering such support (Cowley et al. 2015, Public Health Wales 2020a) and use of a targeted approach is based on the health needs of the family. A targeted approach is used throughout the UK in varying formats. The purpose of this targeted, universal approach is to offer all children and their families equal support and advice and to offer a progressive universal approach which allows all families to be supported. For those with greatest need, this support will be enhanced (Health Service Executive 2019). The number of contacts that health professionals have with families varies across all UK home nations. The aim of these from the antenatal period onwards, is to offer a best start in life allowing individuals to meet their full potential emotionally and physically. The HV has contact within the child's first five years where the aforementioned relationships can be established, and where they can make every contact count in relation to delivering health promotion messages, promoting behaviour change with an aim to reduce the impact of non-communicable disease in later years (Public Health Wales 2020b). This is supported by research relating to early identification of ACEs by HVs (Bellis et al. 2018) and emphasises a need for an increased awareness of epigenetics.

The role of the HV has been shaped by the seminal work of theorists, namely Antonovsky (1987), Rogers (1980) and Bronfenbrenner (1986). This offers further evidence to demonstrate the validity of this role, and its place in society particularly from an early intervention and prevention perspective, linking once again to the potential

enhancement of life chances influenced by behaviour change. Antonovsky' s (1987) work in relation to salutogenesis is linked to the underpinning practice of health visiting and the pro-activeness they demonstrate in identifying need and where they offer a solution focussed approach to their interventions. By applying these core principles of health visiting client needs are established and then acted upon. Health visitors recognise that any intervention must be needs led by the client, (the parent/carer within health visiting practice), Bradshaw (1972) defines this as felt need. Health visitors value the person; they offer a person-centred/client-centred approach to any intervention, hence the link to Rogers (1980).

Rogers (1980) theory of practice refers to empowering individuals, providing support to enhance their full potential. This refers to children here as well as parents/carers. Rogers (1980) considers the personal growth of individuals, hypothesises that every person can grow but they need a certain environment to do this, a positive environment where they can express themselves, be open and honest, and feel accepted. Once goals or wishes are achieved, self-actualisation takes place. This belief in oneself, offers a way forward for individuals especially if a behaviour change is involved or change in lifestyle, change in parenting style, and feeling empowered to leave an abusive relationship. The feelings of self-worth and self-efficacy are powerful in motivating change. Health visitors are key in delivering such interventions in their work with families, based on building therapeutic relationships of respect and mutual trust.

Therefore, the role is demanding in as much as the HV could be exposed to situations where children are at risk of significant harm and in need of protection. Safeguarding of children and young people on a daily basis requires a knowledgeable, confident, and competent HV who has access to necessary support and access to services as required. This chapter has offered some context and background to the history and role of the health visitor. The following chapter concentrates on the safeguarding of children and young people. Safeguarding children and young people theory underpins HV practice, and the chapter progresses the thesis in setting the scene from a contextual

safeguarding perspective, referring to safeguarding principles, key legislation and how risk of significant harm can be assessed within the HV role.

Chapter 3: Safeguarding children and young people

Health visitors require evidence-based knowledge associated with safeguarding principles to enable them to assess safeguarding risk in children and young people CYP. Exposure to risks throughout childhood can be potentially harmful to physical, psychological/emotional, behavioural, and social development. It is often quoted that child protection is everyone's responsibility and safeguarding encompass the prevention of child abuse as well as the protection of CYP. Therefore, HVs must be aware of the impact of risk factors and maintain the child as a focus within their safeguarding practice. Safeguarding practice is underpinned by legislation, policy, and key principles.

3.1 The principles of safeguarding

The six principles of safeguarding were first established by the Department of Health in 2011 and were later embedded in The Care Act (2014). They include;

1. Empowerment – individuals need to be supported to make informed decisions.
2. Prevention - action needs to be taken before any harm occurs.
3. Proportionality – any action needs to be proportionate to the risk.
4. Protection – those with the greatest of need require support, protection, and representation.
5. Partnership – partnership working is essential across all agencies and disciplines when aiming to identify, report and reduce risk.
6. Accountability – all professionals are accountable for their own action/practice within their practice which includes the safeguarding of individuals (Social Care Institute for Excellence 2010).

The above principles are underpinned within legislation and guidance across the UK. They are applicable across all adult and CYP safeguarding agendas. From a CYP perspective, and within HV practice, consent for referral is not necessary if a child is considered to be at risk of significant harm (this applies to section 47 of the Children Act 1989). Consent from a parent/carer is required for a child in need referral in England (Section 17 of the Children Act 1989) or as a result of a care and support plan in Wales (Social Services and Well-being (Wales) Act 2014). Legislation and policy do vary

across the UK home nations, but the principles of safeguarding across are the same. Two key principles in the safeguarding of CYP are that safeguarding and protection of CYP is everyone's responsibility as well as the need to adopt a child-centred / children's rights approach to practice (United Nations Convention on the rights of the Child (UNCRC) 1989). The CYP voice is considered essential, and a child-centred approach is cognisant of their rights being paramount. The views, wishes and feelings of CYP need to be sought wherever appropriate, whilst also respecting individuality, culture, and beliefs (Wales Safeguarding procedures 2019). Table two below lists the Wales-specific safeguarding and workforce policy. Workforce policy is also listed as it refers to and advocates support for practitioners via clinical and safeguarding supervision. Safeguarding supervision practice is also explored in more depth within the literature review chapter.

Table 2: Safeguarding CYP and Workforce Policy, Wales.

Children Act (1989, 2004)
Social Services and Wellbeing (Wales) Act (2014)
The Wellbeing and Future Generations Act (2015)
The Nurse Staffing (Wales) Act (2016)
Healthy Child Wales Programme (2016)
All Wales Safeguarding Supervision Best Practice Supervision Guidance (2017)
A Healthier Wales: Our Workforce Strategy for Health and Social Care (2020)
Strategic Nursing workforce plan ((Health Education and Improvement Wales) (2023)
Retaining and valuing nurses within the NHS in Wales. A Nurse retention plan (HEIW 2023)
Wales Safeguarding Procedures (2023)

3.2 Understanding risk factors – an ecological approach to safeguarding

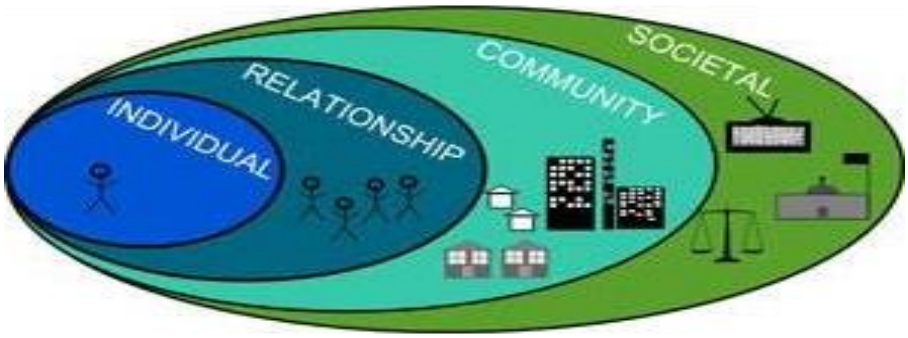
An ecological approach to assessing what constitutes risk for CYP offers a broader, and more holistic perspective to safeguarding practice. This is a fundamental process in everyday health visiting practice. However, while there is a range of terminology used in defining child abuse, it is commonly coupled with the word neglect, or with the term child

maltreatment. Such terminology may be interchanged depending on the sources available. The WHO define child abuse as:

> *"Violence against children includes all forms of violence against people under 18 years old. For infants and younger children, violence mainly involves child maltreatment (i.e., physical, sexual, and emotional abuse and neglect) at the hands of parents and other authority figures. Boys and girls are at equal risk of physical and emotional abuse and neglect, and girls are at greater risk of sexual abuse. As children reach adolescence, peer violence and intimate partner violence, in addition to child maltreatment, become highly prevalent."* (WHO 2021, online)

The WHO suggests that violence against children is preventable, and that responding to it requires a multi-system approach that includes prevention, risk assessment, and the presence of protective factors. This is also recognised in the application of Bronfenbrenner's ecological model (Bronfenbrenner 1969) which considers the relationship between four levels of influence. The model was later adapted by Belsky (Belsky 1980). These four constituent levels are: individual, family/relationship, community, and society (Figure 1). Health visitors are well placed when working with families in the early years of a child's development to assess risk by taking this ecological stance.

Figure 1. Bronfenbrenner ecological model



(Bronfenbrenner 1979)

Wales is the only country in the world to have a Future Generations Commissioner and associated legislation, namely the Well-Being of Future Generations Wales Act (2015). This sets out all public health drivers to enhance population prosperity and enhance experience in health, education, and environmental matters, which are linked to the WHO Sustainable Development Goals (SDG). These relate to the social determinants of health as set out by Dahlgren and Whitehead (1991) as well as aligning to the domains of Bronfenbrenner's ecological model (Bronfenbrenner 1979). Children and young people deserve the best start in life, but this is sometimes hampered by early childhood experiences which can damage their future physical, mental health and developmental potential.

In 2016 the WHO published their INSPIRE Strategy for ending violence against children (WHO 2016, Table 3). This links to the recommended ecological stance being taken by agencies but also relates to the wider determinants of health. It demonstrated the importance of involvement by policy makers to ensure that children's safety is paramount and emphasises the influence from the macro level that underpins safeguarding policy as well as meso (national) and micro (local) levels. The aim of the strategy is to strengthen partnerships across all levels including governments, agencies, and society more generally by placing the focus on delivery of services and placing the child at the centre, with the aim that every child reaches their full potential. It is further underpinned by the United Nations Convention on the Rights of the Child (UNICEF 1989) as well as the SDGs (United Nations 2019) which includes a wide range of global public health targets with Target 16.2 referring to the safeguarding of children:

> *"…end abuse, exploitation, trafficking, and all forms of violence against torture of children."* (United Nations 2019 online)

Therefore, the role of the HV can be considered an essential component and needs prioritising within workforce planning if positive outcomes are to be achieved for future generation's physical and psychological health (Institute of Health Visiting 2021, UNICEF UK 2022, 2024a, 2024b, NHS Providers 2024).

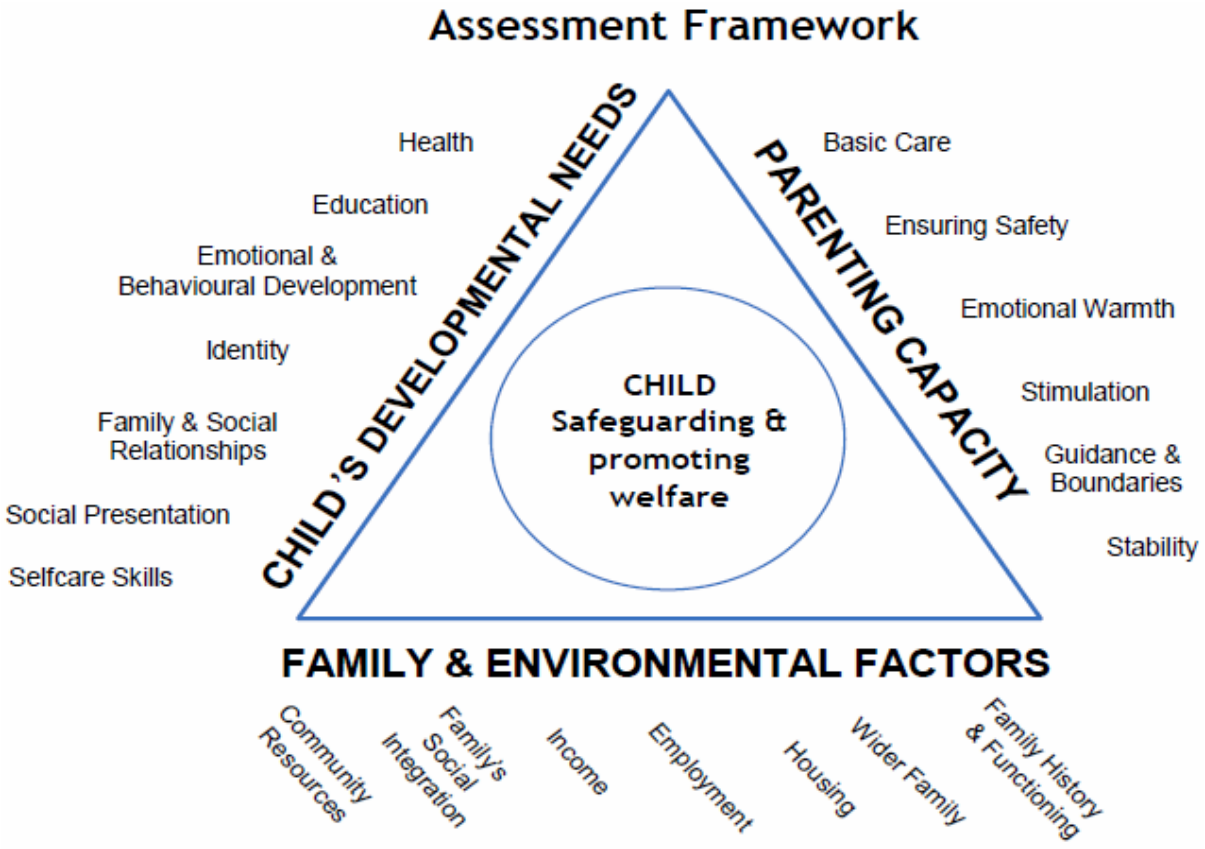
Table 3: INSPIRE acronym (WHO 2016)

Implementation and enforcement of laws
Norms and Values
Safe environments
Parent and caregiver support
Income and economic strengthening
Response and support services
Education and life skills

The aspirations of INSPIRE connect the macro, meso and micro levels of safeguarding practice by placing CYP and their family at the centre and as the priority in safeguarding policy development (WHO 2016). This is considered essential for allowing the child to meet their full potential with their basic human needs being met. For some families, the impact of wider factors shape their health, community, and society (Bronfenbrenner 1979, Belsky 1980) and also dictate whether basic needs can be met.

An ecological approach to safeguarding is a well-known concept and is associated with child protection practice and assessment in the UK today (Figure 1). Vygotsky (1978) and Bronfenbrenner (1979) developed theories which explored how individual learning is affected by family, friends, the community/culture, and the society in which they live. Bronfenbrenner's (1979) ecological model recognised that child development progresses based on the interactions they receive from family and their surrounding environment. This concept links to the assessment framework triangle (Figure 2) with the child depicted at the centre and through various domains, including the impact of the carers' parenting capacity, environmental factors, and the child's developmental needs. This assessment approach is now a fundamental element within HV practice.

Figure 2. Assessment framework triangle:



(Department of Health et al. 2000)

The seminal work of Bronfenbrenner (1979) and Belsky (1980) underpins the assessment framework (Department of Health et al. 2000) and illustrates how individuals develop within the complexity of social systems which interact and influence each other. This includes the following elements:

- The characteristics of **the individual** (Factors increasing the risk of maltreatment of the child).
- The **micro-system** explores the relationships within the family. (Family- related factors increasing the risk of maltreatment).
- The **exo-system** examines community contexts – (Community influences increasing the risk of child maltreatment).

- The **macro-system** includes the cultural beliefs and values of society – (Societal factors increasing risk of child maltreatment).

Assessing risk in the safeguarding of CYP is complex but is recognised as core practice for HVs. The interacting levels of the ecological model with the child at the centre allows HVs to explore a preventative and proactive approach to their safeguarding practice. It is essential that HVs are aware of what constitutes significant harm, and how ACEs and any escalation of risk can have significant impact on the CYP's future and well-being outcomes. Traditionally risk has been associated with familial risk factors within the home environment. The concept of *contextual safeguarding* is related to the risk(s) that CYPs are also exposed to outside of the family home (Appleton et al, 2021, Firmin and Lloyd, 2020). For example, community or societal factors that may be out of the control/protection of the parent/carer/family but exposes the CYP to significant harm. Therefore, this multi-dimensional approach to safeguarding CYP is now a fundamental element within HV education programmes.

3.3 Categories of abuse

Harm refers to the

> *"…impairment of physical or mental health …….and the impairment of physical intellectual, emotional, social or behavioural development (including that suffered from seeing or hearing another person suffer ill treatment)"* (Wales Safeguarding Procedures 2019, online).

Types of harm can include physical, emotional/psychological, sexual, neglect and financial. However, there is no statutory definition of what constitutes *significant* harm. The Children Act (1989) highlights that practitioners need to consider how and when harm becomes significant by comparing the CYP's health and development to that of others of the same age and stage of development. In determining what constitutes significant harm, a detailed assessment of risk and risk accumulation is required. This includes acknowledgment of the impact of ACEs and taking a trauma-informed approach to HV practice.

3.4 Adverse Childhood Experiences

Adverse childhood experiences have been described as traumatic events that affect children while growing up, such as suffering maltreatment or living in a household affected by domestic violence/abuse, substance misuse or mental ill-health (Bellis et al. 2016). The impact of experiencing ACEs is now well recognised and Felitti et al. (1998) brought their impact to the attention of practitioners working in the field of children's practice in late 1990 in the USA. It has since been acknowledged in more recent studies that there is not a clear list of how many ACEs and the number varies across studies (Table 4). For example, Felitti et al.(1998) identified seven ACEs as part of their research whereas more contemporary studies refer to ten ACEs which are categorised (e.g. Donagh et al. 2022).

Within Wales there have been a number of studies exploring the impact of ACEs on adult health harming behaviours (Bellis et al 2016), the impact of a trusted adult as a protective factor which supports childhood resilience (Ashton et al. 2021), the association of ACEs and mental well-being (Ashton et al. 2016), and routine enquiry into the impact of ACEs (Hardcastle and Bellis (2019). These studies refer to the nine ACEs used in the Bellis et al. (2016) study for Public Health Wales (Table 4). Webster (2022) also explored the impact of ACE's on health and development in children and the nine ACEs in the Webster (2022) study are based on a measurement tool of the American National Survey of Child Health (2016) dataset. It has been argued that the list of ACEs omit relevant factors which impact CYP such as poverty (Donagh et al. 2022). Although, Webster (2022), includes financial difficulty and '*victims of discrimination'* (p5).

It could be argued that a definitive ACEs *list* could vary based on the demographic nature of society and by how societal norms have changed. Felitti et al. (1998) refers to violence against the mother as a risk but research now informs that men are also victims of domestic abuse (Ambrozewicz et al. 2024) and this is reflected in the change of terminology identified across more recent research in Table 4. There could also be differing risk factors from rural to inner city areas. All of the research has exposed the link between experience of ACEs and a number of health harming factors including

smoking, increased alcohol intake, poor diet, use of drugs, imprisonment, violent and sexual behaviour in adults (Bellis et al.2016). Donagh et al. (2022) discuss how ACEs are also measured differently and include; measurement of *accumulation* of risk, similar to the research of Sebates and Dex (2012) who recognised that the more risk factors the higher the likelihood of significant harm occurring. Other measurements include *'weighting'* (Donagh et al. 2022, p.3514) ACEs individually, by each sub-group and by the type of ACE. It is important to note although recognition of risk/presence of ACEs as part of a holistic assessment in practice aids recognition of behaviours, physical and mental health status, however, it should not offer a way to attach a 'label' to CYP and adults. Earlier ACE research does not measure resilience and the impact of protective factors on childhood development and later health outcomes. There is now a body of research that is recognising the importance of protective factors in childhood, such as exposure to a trusted adult as prevalence of ACEs decreased. Resilience levels were enhanced when children had one or two parents who were supportive compared to those without parental support. There was a strong association in the Ashton et al. (2021) study between resilience in childhood, continual contact with a trusted adult, and various opportunities to access personal adult support. There is a stark reminder across the research that it is unlikely that exposure to ACEs will never be eradicated but as the research indicates, knowledge of ACEs to inform practice, support CYP, and help caregivers is essential in order to promote positive relationships from conception and during childhood and beyond (Webster 2022).

The Harvard Center on the Developing Child have undertaken extensive research on the impact of toxic stress, poor attachment, and neglect, on the developing brain. Their body of research clearly underpins the theory associated with how early foundations and experiences shape childhood and life beyond (Harvard Center on the Developing Child 2022). The ACE's listed in Table 4, when combined with other societal extrinsic factors such as poverty and poor housing as well as lack of local service provision, can have a major impact on the health and development of CYP. Therefore, the accumulation of risk has been identified as most damaging concern and has been identified within many serious case reviews/child practice reviews where complex,

multiple, risk factors combined to result in subsequent negative outcomes for individual CYP (Brandon et al. 2008, 2009, 2012, Sabates and Dex 2012, Webster 2022).

Table 4. Adverse childhood experiences

Felitti et al. 1998 (p245)	**Bellis et al. 2016**	**Webster 2022 (p5)**	**Donagh et al. 2023**
Psychological Physical Sexual *Violence against mother.* *'Living with household members who substance misuse, are mentally ill/ suicidal or ever imprisoned.'*	Verbal Abuse Physical Abuse Sexual Abuse Incarceration Alcohol Misuse Domestic Abuse Mental Illness Parental separation Drug Use	Difficulty getting an income Divorce/separation Death of a parent Parent served jail sentence Domestic violence Neighbourhood violence. Parent mentally ill/suicidal Parent drug/alcohol Victim of discrimination	Abuse (emotional, physical, sexual) Neglect (emotional and physical neglect) Household dysfunction (domestic violence and abuse, substance misuse, mental illness, parental separation or divorce, incarceration)

Epigenetics also seeks to explain how early experiences can have a lifelong impact and is related to the research on ACE's. Epigenetics is an area within scientific research which explores how extrinsic experiences can affect children by impacting gene expression. Inherited genes provide information that guide development (such as height or temperament). When children experience certain risk factors during development, this can alter their epigenetic markers. These markers influence how genes express themselves and can determine how and if information is released, (Harvard Center on the Developing Child 2021). Therefore, the epigenome is affected by positive as well as negative experiences and reinforces just how sensitive young brains are when exposed to stressors and personal risks. Best practice would be supporting relationships with children which are nurturing, demonstrate positive attachment, and reduce stress(ors) to enable the development of healthy, strong brains. Any epigenetic alteration will have the potential to influence future healthy development as well as resilience factors (Harvard Center on the Developing Child 2021).

This reinforces the early identification of ACEs to empower and promote future healthy relationships and prevent significant harm. This position is supported by Webster (2022) who concluded their research by recognising the importance of parent-child attachment and the need to promote resilience to enhance *'positive developmental trajectories'* (p10):

> "*Programs supporting families with young children should focus efforts on enhancing quality of attachment, especially for children experiencing ACEs." (Webster 2022, p1)*

Therefore, it is again clear that HVs are well placed to assess possible adverse risk and offer early intervention and prevention services to mitigate the impact of ACEs and trauma.

3.5 Trauma-informed approach to safeguarding practice

There is no ratified definition of what constitutes trauma-informed care (The Royal College of Nursing (Guest 2021, RCN, 2024). Trauma can be caused by exposure to any of the ACEs listed in Table 4 as well as:

> '…*technological, natural or human disasters, terrorism,'* sudden loss of family/friend member, community violence, '*refugee or war experiences, life - threatening illness'* (Guest 2022, p1001).

The Wave Trust (2021) define trauma-informed care as a:

> "…*strengths-based framework which recognises the complex nature and effects of trauma and promotes resilience and healing."* (Wave Trust 2021)

Children are particularly vulnerable following a traumatic event. The way they react is very much dependant on the trusted adult support they receive and, if nurtured with love with access to trauma informed services, they are likely to recover and reach their full potential (Substance Abuse and Mental Health Services Administration (SAMHSA) 2024). Trauma-informed approaches across many aspects of nursing are essential (Guest 2021, RCN 2025) and are becoming a fundamental element of practice. In a concept analysis of trauma-informed care, Guest describes it as:

> *"…the knowledge, recognition, respect and concern to care for victims who have experienced physical or emotional trauma."* (Guest 2021, p1006)

A trauma-informed approach to safeguarding practice involves HVs having knowledge of this concept and taking a holistic view of the individual's experience. It is often referred to as 'changing the conversation.' For example, instead of saying or thinking "*What is wrong with you?"* it changes to one that considers, *"What has happened to you?"* Although, it is also more than simply asking this type of question. Taking a broader assessment of the individuals experience, as well as the practitioners experience (who may also have experienced a traumatic event), has the potential to offer a therapeutic encounter. It becomes about listening to personal stories, not repeating the trauma but exploring how the trauma has affected the child in their daily life (Edelman 2023, Garrity and Dodd 2025). This will also involve taking an ecological approach in assessing risk as identified by Bronfenbrenner (1979) due to the impact of family, community, societal interactions with a CYP/individual. Trauma can occur on an individual level (such an event/series of events/circumstances which are physically and emotionally impactful or life- threatening, they have a long-term impact on an individual's physical, social, spiritual and psychological health), an interpersonal level (ACEs, child abuse, trafficking) and at a collective level ('*cultural, historical, social political, structural traumas impacting communities'* and can be cross-generational) and most do not occur in isolation (Grossman et al. 2021, p2). A universal approach to screening for trauma is essential in building therapeutic relationships in supporting survivors with the most appropriate resources/interventions (Fallot and Harris 2001).

Trauma, therefore, can have long-term impacts on individuals but it can be experienced and interpreted differently between CYP. Therefore, HVs need to understand the context of certain behaviours/traits/perceptions of the CYP and families with which they are working (Emsley et al. 2022). Organisations offer training in trauma informed care, for example, the Wave trust (2021) have collated evidence to raise awareness of trauma and offer a resource for practitioners. They reiterate the need to have a basic awareness (realisation) of trauma-informed care and its impact. They suggest five key principles which are identified: safety, trust, choice, collaboration, and empowerment.

These key principles are fundamental in building any therapeutic relationship with families especially within the safeguarding arena. Identification, recognition, and potential universal screening of trauma (Wave Trust 2021) as well as the impact of ACES, (Table 4) is suggested as key when establishing an early intervention and prevention plan for families (Hardcastle and Bellis 2019). Mothers who participated in the Hardcastle and Bellis research study agreed or strongly agreed that a practitioner (HV) with knowledge of ACEs improved the level of help and support provided, as the HV had a better understanding of the parents' own childhood experiences.

The Hardcastle and Bellis (2019) study was undertaken in Anglesey and participants were asked if they had experienced any ACEs. This was a pilot study exploring findings from an ACE enquiry study with mothers who had seen a HV at a routine contact. They completed a questionnaire either six weeks post-delivery or six months post-delivery. Ninety per cent of the mothers invited agreed to be participants (n=321). Once the paper questionnaire was completed (alone, individually or at a routine visit) the HV had the opportunity to discuss the topic further with the mother. This was regardless of the quantity of ACEs disclosed. The discussion allowed further exploration and support around potential impacts of ACEs on health but also on parental experiences, their wellbeing, and the outcomes for the child. Health visitors were able to support and/or signpost to a more enhanced service, as necessary.

Eleven percent of the participants experienced four or more ACEs, 16% experienced two – three ACEs, 26% experienced one ACE with 47% experiencing no ACEs. This study also allowed a focus on parental childhood history, a topic that was not routinely questioned. Forty three percent of the mothers stated that this was the first time that they have shared their experiences with a health professional. Most mothers with no ACEs felt a sense of belonging within their community (92%) whereas for those with four or more ACEs only 62% felt the same sense of belonging. Most mothers felt that this sort of questioning was appropriate and the HVs understood their experiences and were able to tailor specific support for them. One HV stated:

> *"The standout take home point for me is how well placed we are as HVs and how privileged we are for parents to confide in us and for us to be able to support them."* (p.3)

The overall conclusion of this study was that it was feasible to undertake an ACE enquiry, and that further research was now needed. Since this research took place, the resilience of families has been routinely explored using the Family Resilience Assessment Instrument Tool (FRAIT) (Wallace et al., 2017). This tool has evolved over the last few years in Wales and is now included in the Healthy Child Wales Programme (Welsh Government, 2016). Understanding parent/carers backgrounds is essential in assessing family risk and aids in an enhanced understanding which seeks to be both trauma-informed and child-centred. It is considered essential that a Trauma informed approach to healthcare is supported by national policy to enhance education and resource development at meso and micro levels (Emsley et al. 2022).

3.6 Assessment of risk

There are several risk assessments /tools to guide HV practitioners in their daily practice when assessing the well-being of CYP (detailed below). These tools allow HVs to develop an enhanced understanding of the vulnerability and risk families are exposed to. Some examples are:

- **Family resilience assessment instrument and tool (FRAIT)** (Wallace et al. 2017). This tool developed in Wales aids decision making in health visiting practice for evidence-based decision making, planning future interventions based on family resilience and need.

- **Toolkits to assess neglect.** For example, the ***Graded care profile*** designed for use with social workers to measure quality of physical care, safety, love/esteem provided by families by using a scale to assess levels of neglect. This was devised by Srivastava and Polnay (1997) and forms the basis of an adapted graded care profile tool published by local authorities within safeguarding boards across the UK.

- **Day in the life of a child** developed by Horwath in (2007) and is incorporated into UK wide safeguarding board neglect assessment toolkits. This tool focusses the practitioner on the daily activity of a CYP in a given situation. It allows the practitioner to explore and assess what it is like for CYP on waking, during the morning, afternoon, and night and explores what activities would be associated with daily family routines. It allows the practitioner to think about what it is like for that CYP in their given situation. It is a powerful tool to use in practice and brings practitioner focus back to the CYP. This is informed by speaking to the parent/caregiver or by speaking to and observing the CYP.
- **Signs of safety** created in the 1990's by Andrew Turnell (Social worker/brief family therapist) and Steve Edwards (Child protection Practitioner). The model is now being applied in child protection work across the world. It utilises techniques associated with solution-focussed brief therapy. This is a technique where parent's/carer's future is explored by practitioners with the aim of resolving an issue or problem, identifying strengths and goals to improve outcomes and achieve priorities. It can be used on a one-to-one basis with families, in the construction of child protection referrals, within child protection meetings, as well as offering structure and discussion points within safeguarding children supervision. Its principles are embedded in building constructive working relationships and partnerships between professionals as well as with parents/carers/CYP (Baginsky et al. 2020). It also advocates positive multi-agency working where critical thinking and reflection can be enhanced, as well as advocating that the CYP's experience should be the focus and remains at the centre of any intervention. The tool consists of four domains (key danger/harm factors, complicating factors, positive factors, and grey areas) and consists of three columns:

- **What are we worried about?** (Previous harm, key dangers, future harm)
- **What is working well?** (Positive factors, strengths, current safety)
- **What needs to happen?** (Safety goals, what is next for future safety?) (Baginsky et al. 2020)

The signs of safety tool is now commonly used in HV practice in Wales. It is employed regularly to structure risk assessment, safeguarding supervision, construct safeguarding action plans as well as acting as a framework to formulate referrals into the local authority and report writing for child protection conferences.

3.7 Authoritative practice in safeguarding children and young people

Assessing risk and identification of safeguarding concerns is a complex and challenging process for practitioners. Bradbury-Jones and Taylor (2015) refer to public health nurses managing a *'balancing act'* (p.79) when assessing risk and protecting children, whilst also trying to maintain relationships with families. An authoritative stance in safeguarding practice is recommended by Sidebotham (2013) based on the principles of authoritative parenting described by Baumrind (1967). This is concerned with being caring but also having control of a situation, setting appropriate boundaries, developing loving and nurturing relationships but with clear and elevated expectations to promote effective discipline. Sidebotham uses the terminology of 'authoritative child protection practice' referred to in the serious case review findings of Lord Laming (2009) following the death of Peter Connelly. Lord Laming states that the mother's parenting was 'passively accepted' by the professionals involved. Parents/carers can often disguise compliance, or they can become hostile and un-cooperative, manipulative, and so manage to successfully evade practitioners attempts to assess the 'true' situation. Most recently this has been further exacerbated by the COVID-19 pandemic where practitioners were unable to undertake home visits and utilised "virtual" means to access families which may have hampered effective safeguarding practice.

Sidebotham (2013 p.2) reinforces Laming's recommendation of authoritative child protection and suggests three domains (authority, empathy, humility) deemed "aspirational' elements of child protection practice:

Authority based on knowledge, skills, experience, competence in safeguarding practice and confidence.

Empathy which relates to the voice of the CYP. The CYP must be at the centre of safeguarding practice with recognition of their experiences and rights. A children's rights, ACE and trauma-informed approach is recommended, with an awareness of what it is it like for a CYP living in their given situation (Howarth 2007). The CYP also needs to be seen in the context of their family situation. Authoritative practice therefore has elevated expectations of parents/carers to meet the child's basic needs, enable potential, support them to deliver those expectations and be confident and able to challenge them and advocate for them and the CYP, when they are unable to.

Humility is a positive quality, a self-awareness trait which aids practitioners to explore any practice or educational limitations, build on their knowledge base and experience to enhance their safeguarding practice. This links to the promotion of multi-agency/multi-disciplinary working and the realisation that each agency could hold a different segment of information in relation to a particular family. Any single agency should avoid protecting or holding on to their own information, it must be shared if there is a risk to the safeguarding of any individual. This applies to adult safeguarding as well as CYP and has been criticised in previous serious case reviews/child practice reviews (NSPCC 2024). Partnership working across agencies is considered a key step in supporting CYP and their families. Humility within safeguarding also promotes the need for reflective practice with access to and practice of safeguarding supervision (the focus for the present study).

3.8 The context of safeguarding supervision and clinical supervision

Engagement in safeguarding supervision is essential for HVs due to the nature of their access to CYP and families (Public Health Wales 2017, Warren 2018, Smikle 2018, Guindi 2020). It has been identified that effective supervision is essential for frontline practitioners to achieve positive outcomes for vulnerable CYP and their families (Wallbank and Wonnacott 2016). As mentioned above childhood experiences shape children's future, well into adult life (Emond 2019, Appleton et al. 2022, Harvard Centre on the Developing child 2019, The Royal Foundation 2022).

Health visiting support to parents/carers can be positive to not only enhance parental outcomes but also the subsequent physical, psychological, and developmental enhancements for children (Cowley and Whittaker 2021, Burrows and Cowie 2023). When risk is identified, and HVs are concerned and require advice, support and signposting, safeguarding supervision should always be available and is considered essential to provide support, with the aim of developing effective practitioners who can critically think and analyse complex situations (Public Health Wales 2017). Safeguarding supervision also allows the practitioner to confront and discuss the emotional strain of their workload within their safeguarding children caseloads (Brandon et al. 2005, 2008, Warren 2018, Smikle 2018, Moseley 2020) and therefore takes a different stance to clinical supervision. The following section will offer a review of the status of clinical supervision within the UK to demonstrate the difference with safeguarding supervision.

3.9 The context of clinical supervision

There are various definitions of clinical supervision as a concept and how it is practiced varies across nursing, midwifery, and other healthcare professions. It has existed for over thirty years; clinical supervision therefore is not new although its delivery across Wales and the wider UK is variable. Reflective practice in and on action is advocated within undergraduate programmes and at re-validation in nursing (NMC 2019). Clinical supervision has been defined as:

> "*… a formal process of professional support, reflection and learning that contributes to individual development*." (Butterworth 2022a, p.20)

Clinical supervision, whilst offering support, can also develop knowledge and enhance competence. It can build on the scope of professional practice; encourage self-assessment/awareness and aid the development of emotional intelligence, and all this is achieved by reflecting on practice (Butterworth 2022). Knapman and Morrison (2008) refer to the purpose of supervision as underpinning the development of quality services. It can aid in an understanding of role clarity as well as influencing continued

professional development, can relate individual practice to organisational objectives whilst promoting a suitable climate for practice development.
This relates to the more contemporary models featuring clinical supervision such as the A-EQUIP model of clinical supervision (Advocating for Quality Improvement in Practice) which underpins a Professional Nurse Advocate qualification in England (NHS England 2021). The A-EQUIP framework reflects the areas of Proctor's model (normative, formative, restorative, Proctor 2008) as well as a purely restorative approach to supervision (Wallbank 2012).

The health and wellbeing of the nursing and midwifery workforce (Gray et al. 2022) was reported significantly on during the Covid-19 pandemic. This survey yielded 2,910 responses from across nursing teams and the student workforce in Wales which equates to 6.7% of the overall nursing workforce in Wales. Their key findings related to mental health and well-being, physical health, the working environment, the culture within practice and nurse's 'intention to leave.' Their data reinforces Welsh retention statistics with 6/10 nurses leaving from the commencement of the pandemic, and with the intention to leave rate of newly qualified nurses standing at 67.8%. Nurses reported feeling undervalued within their profession with 8/10 reporting work-related stress issues. This survey data demonstrate the extent of the wellbeing needs of nurses and midwives and the need for a robust framework of support. Post pandemic mental health and wellbeing needs have not ceased.

Butterworth (2022b) described the resurgence of a need for clinical supervision as a **"**renaissance" of clinical supervision awareness and practice, and in 2020 at the height of the global pandemic the discussion of the supportive nature of clinical supervision was again starting to be re-explored and highlighted as a potential support for nurses who were being exposed to complex and traumatic experiences. It is clear from multiple surveys and research that as the pandemic evolved, with increased workforce pressures placed on all nursing areas and across all teams, that nursing staff were being impacted emotionally and psychologically (RCN (Royal College of Nursing) 2022).

The Royal College of Nursing (RCN 2022) has updated their position statement on the practice of clinical supervision and recognised its importance by calling for a united position. The RCN also commissioned a scoping review into the last thirty years of clinical supervision research and theory (Masamha et al.2022).This updated review of the literature established five themes which included: defining clinical supervision/models of supervision, the terminology of clinical supervision and its perceived '(mis) trust,' alternative delivery of supervision, support/protected learning time, cost and skills required.

This literature review also relates to the underpinning approach associated with safeguarding supervision. Similarities with clinical supervision include a one to one/group format, use of a supervision contract, use of a model to structure supportive discussions, trained supervisors, and the purpose to support the wellbeing and practice of staff. The overarching benefits of good, supportive supervision were identified by Wonnacott (2012) and relate to recruitment and retention, motivation and commitment to an organisation, job satisfaction with supervision embedded into organisational culture. These topics are further explored as part of the literature review and again in the discussion chapter. However, safeguarding supervision also considers risks to vulnerable CYP and places them at the centre of the process.

This and the previous chapter have provided a history of health visiting and how the role has evolved since its conception. This section has emphasised the key role of safeguarding and the key role played by HVs. It has argued for the HV to be recognised as central to achieving public health outcomes for future generations. The HV role is salutogenic, proactive and essential in meeting the health needs of CYP and their families, and has been described as:

> "*...the backbone of early years services across the UK.... a safety net around all families" (*UNICEF UK 2022 p.21).

The concept of CYP safeguarding draws on definitions of child abuse and has been explored in a legislative and policy context. Safeguarding practice is only one element of day-to-day practice within health visiting and risk factor identification and analysis are complex activities. Exposure to safeguarding issues can be distressing for the HV and support is essential from the wider operational and safeguarding team, provided via safeguarding supervision when necessary.
Safeguarding supervision delivery is governed by policies of local Health Boards and NHS Trusts which are underpinned by national guidance across each UK home nation.

The overarching aim of this chapter has been to demonstrate the nature of the HV role, how it has evolved, and how it now looks in 2024 as a key player in the safeguarding of vulnerable CYP. It also identified how HVs are being exposed to complexities in safeguarding practice which require opportunities to discuss, debrief, seek advice, and receive support. This support can be provided via safeguarding supervision opportunities. Further detail of the evidence base associated with the delivery of safeguarding supervision will be explored in the following chapter.

Chapter 4: Literature review

4.1 Search strategy

The aim of this literature review was to scope existing practice in the delivery of safeguarding supervision for HVs. The literature review and search term development were underpinned by the research question, project aims, and objectives. A systematic approach was taken to reviewing the literature using the following nursing, allied health professionals and social work practice databases: Cumulative Index to Nursing and Allied Health (CINAHL), British Nursing Index (BNI), OVID EMCARE, SCOPUS, Applied Social Science Index and Abstracts (ASSIA). Further literature searching was undertaken within ResearchGate, Google Scholar and the Royal College of Nursing back catalogue. Search terms are included in Table 5.

Table 5. Literature review search terms

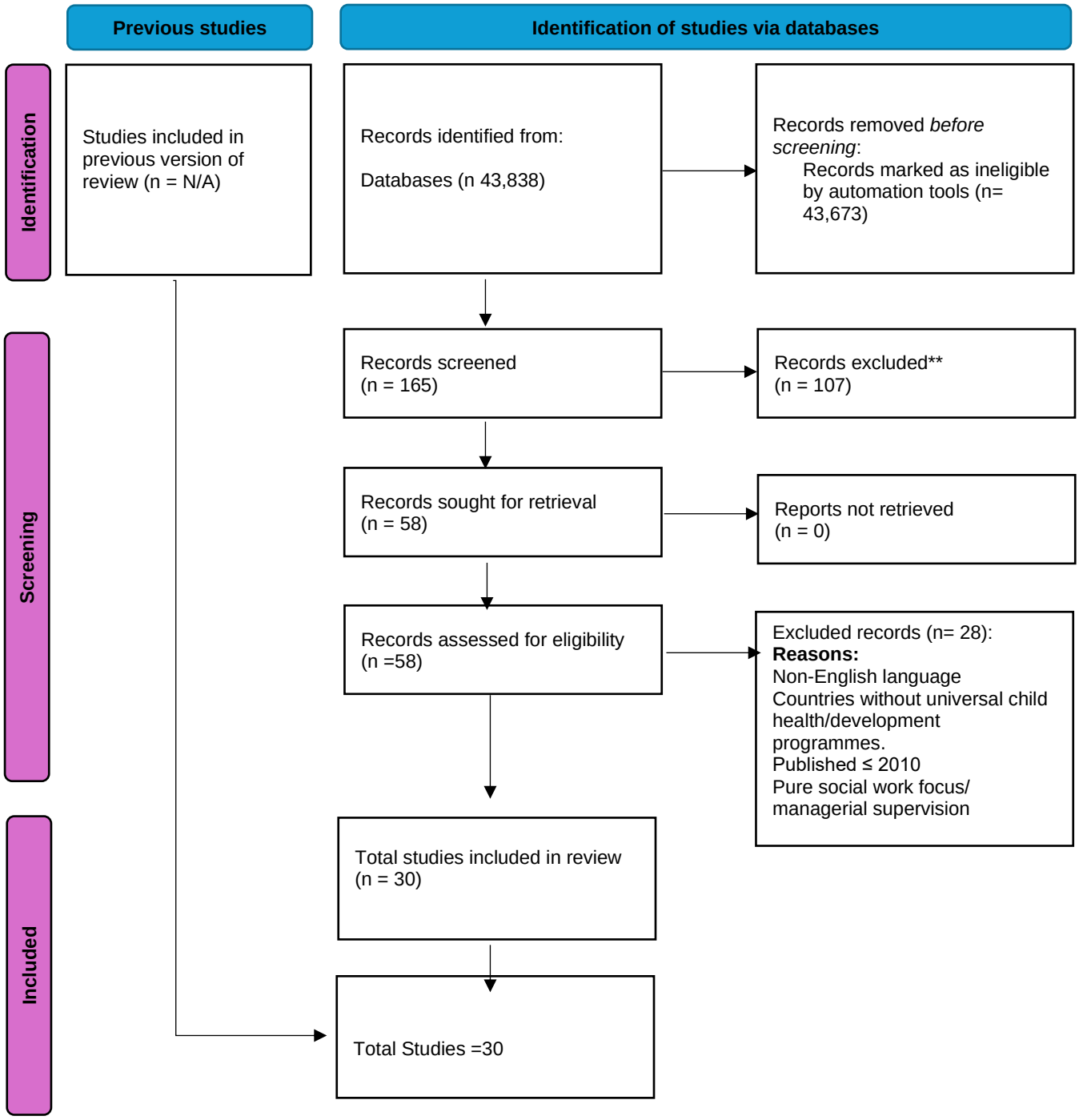
*Safeguarding, *safeguarding supervision, *Health visitor(s), *health visiting, *specialist community public health nurs*, *community nurse(s), *supervisor, safeguarding supervisor, *child protection, *group supervision, *peer supervision, child protection practitioner (s), frontline practitioners, child protection workers, home visitors, social worker (s), *online supervision, *virtual supervision, *online safeguarding supervision, *online safeguarding supervision *restorative supervision *restorative clinical supervision *restorative safeguarding supervision

The first search of the literature was undertaken in 2018 at the commencement of the research with a ten-year window set as the parameter, to allow exploration of the most recent research and literature to be included, although, this time range was extended due to the lack of literature found, and some older, seminal, literature was included across the thesis. The search was repeated in 2019 and again in early 2023 to locate new research as it was published. Initially, research focusing specifically on safeguarding supervision in health visiting was limited hence the search being undertaken again in late 2023, which was broadened to include social work practice and the terminology ‘home visitors,’ ‘child protection practitioners,’ ‘frontline practitioners’ and ‘child protection workers,’ to allow consideration of other professionals who work with similar caseloads. Within the expanded literature search, further exploration included searching for research and literature in relation to online

safeguarding supervision, the impact of the COVID19 pandemic on safeguarding supervision and safeguarding policy. This was prompted by the shift to virtual safeguarding supervision processes that occurred during the pandemic. This yielded no further results specifically related to safeguarding supervision, but did uncover a large amount of literature associated with clinical supervision in nursing. This literature was only included where reference was made to reflective supervision, restorative supervision and supervision of workers working with vulnerable families. Inclusion and exclusion criteria were applied to filter relevant literature (Table 6).

The literature was refined from an initial 43,838 papers by applying and combining key words and Boolean operators “and/or”. This process reduced the number of papers to 165. Further scrutiny and screening of abstracts for relevance to this study narrowed this down to 58 papers. Of the 58 papers, 30 papers were considered relevant by initially reading abstracts, reviewing methods used and applying the inclusion and exclusion criteria (Figure 3, Table 6).

Figure 3. Adapted PRISMA 2020 flow diagram of data base searches and results (Page et al 2021)



The publication dates of the thirty research papers spanned from 2011 – 2023. Most of

the research was published in the UK (n= 23), Ireland (n=3) with papers identifying country of origin, Australia (n=3), New Zealand (n=1). There were fourteen qualitative papers, ten discussion, and six quantitative papers. It was not surprising that research originated from these countries, as they have roles like the UK HV, focusing on monitoring the health and development of children.

Table 6: Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
English language.	Non-English language.
Countries where roles are similar the health visiting in the UK (Australia, New Zealand, Denmark).	Countries where child development/universal programmes are different to the UK.
Safeguarding supervision in health visiting, school nursing, Childrens nursing, community Childrens nursing.	Papers published prior to 2010. .
Online safeguarding supervision, impact of the pandemic and policy associated with safeguarding supervision.	Pure social work focus (managerial supervision) which was not transferrable.
13-year time span (2010 to 2023)	Management supervision.
Restorative clinical supervision research.	
Safeguarding supervision policy.	
Supervision in Social work practice.	

The Critical Appraisal Skills Programme tools (CASP 2018) were considered to appraise the literature. This was challenging due to the quality and type of research that was yielded. It was difficult to answer the included questions set out within the CASP tool across the different research methods found in the literature. The CASP framework was applied to papers of qualitative and systematic review methodology but I also had to adapt and develop my own appraisal tool due to the weak evidence base (Appendix 2). I used the Specialist Unit for Review Evidence Checklist (SURE 2018) for the six quantitative studies. Again, this was challenging due to type of and quality of research sourced. The non-research papers (n =10) were reviewed using my own initial appraisal tool and I then appraised and included all papers into my tool. In developing my own tool, the CASP (CASP 2018) and SURE (SURE 2018) criteria were considered. This

adaptation was necessary because the standard CASP criteria are primarily designed for empirical research studies, and adjustments were required to appropriately evaluate the quality and relevance of the non-empirical, but relevant, literature.

The *type* of journal was also reviewed in the overall review of the literature in relation to research impact factor. This impact factor has been used to ascertain a journal's importance and relevance as well as how often the journal has been cited over a given period of time (a year). Use of the research impact factor is now challenged by the development of the San Francisco Declaration on Research Assessment (DORA 2025) and this is acknowledged by Cardiff University. Therefore research is not assessed on impact factor or researcher metrics/status but by using the best possible data/evidence to assess robustness of the research. as well as; humility, transparency, diversity, and reflexivity (Cardiff University 2025). Therefore the development of my own appraisal tool was used to extract data, as I appraised the best evidence base available.

The following sub-headings were used to initially appraise all papers (Appendix 2):

- Author/Year
- Population
- Methodology
- Sample size.
- Ethics
- Comparisons/Intervention
- Findings
- Recommendations

The terms *safeguarding supervision* and *child protection supervision* are used interchangeably throughout the literature review, depending on the context of the research or literature being reviewed. This interchangeable use of terminology is confusing when seeking to appraise the field, particularly with terms like *safeguarding supervision*, *restorative supervision*, *restorative safeguarding clinical supervision*, *clinical supervision*, and *reflective supervision* all being used. The literature presents a

variety of definitions for safeguarding and clinical supervision (explored in Chapters 3.8 and 3.9), highlighting further the need for clarity. Consequently, this thesis proposes a new definition of safeguarding supervision in the discussion chapter.

The literature was first themed by reading, analysing, and exploring customary practice and similar approaches to safeguarding supervision. The aim was to determine the supportive nature of safeguarding supervision, whilst keeping focussed on the research question. Each paper was read in detail to establish similarities which were summarised and further analysed by highlighting key words, similar findings, themes, and profession specific practices. The following themes were derived from this analysis:

1. Restorative supervision/restorative safeguarding supervision
2. Safeguarding supervision, further broken down into
    i. The importance of safeguarding supervision
    ii. Group supervision.
    iii. Role of the safeguarding supervisor – a “safe space”

4.2 Restorative supervision/restorative safeguarding supervision

The restorative supervision theme sets the supervision scene within the context of health visiting practice. Wallbank authored a series of papers and texts around the concept of restorative clinical supervision (Wallbank and Hatton 2011, Wallbank 2012, Wallbank and Woods 2012, Wallbank and Wonnacott 2015, Wallbank and Wonnacott 2016, Wallbank 2016) and its supportive function within vulnerable workforces (due to complexity in safeguarding, workforce constraints). The research articulated that there is little known about how the elements which make up a successful supervision session impact on the individual/patient - child /young person. Lack of training in safeguarding supervision was a major finding identified by Wallbank and Hatton (2011) . Three papers (Wallbank and Hatton (2011), Wallbank (2012), Wallbank and Woods 2012)) refer to restorative clinical supervision and its use in supporting safeguarding practice for HVs and school nurses. One of the three evidenced a quantitative methodology (Wallbank and Hatton (2011) and two were discussion papers (Wallbank and Woods

(2012), Wallbank 2012). Two further discussion papers (Wallbank and Wonnacott 2015, 2016) discuss developing an integrated model of restorative safeguarding supervision. All papers are based on the original research of Wallbank, and the evaluation undertaken by Wallbank and Hatton (2011) who recognised the essential role HVs, and SNs have in the safeguarding of children and young people. They refer to how the role requires safe and effective leadership to enable a comprehensive approach in assessing the needs of the families they work with. The data in all these papers were derived from the same dataset, but each focuses on different aspects of that original dataset. This can be considered a weakness of this theme with risks of reduced external validity, as multiple papers utilising the same dataset may raise concerns about integrity (Altay and Kocak 2021). This duplication in publishing is also called *salami slicing* where publications are sliced into multiple publications (Abraham 2000, Office of Research integrity 2021). This becomes an ethical and research integrity issue as theses authors did not disclose this information. Wallbank does refer to the research/ narrative as being based on existing research, but did not detail the limited range of data sources. Despite the potential concerns, these papers were retained as part of the literature review due to the significant contribution to the field of restorative supervision and lack of other available research in this field.

In a relatively small (n=22) evaluative study (Wallbank and Hatton 2011), took a quantitative approach after being commissioned by an NHS Trust. They used a pre and post questionnaire methodology, to measure stress, burnout, and compassion fatigue of HVs and SNs, however, the sample size was low and was a weakness of this study reducing transferability (Gray et al. 2017). The aim of the research was to evaluate the effectiveness of clinical supervision in reduction of burnout and stress levels, but the descriptions given implied that the supervision was safeguarding related with links to safeguarding elements. The authors used a restorative, solution focused approach to supervision, participants were part of a leadership programme and received supervision over a six-month period.

The researchers also explored the amount of supervision training the participants had experienced previously. Nine had not received any previous training, two had received training in how to be a supervisee, eight had undertaken a course in their local Trust, one had undertaken safeguarding supervision training and two had undertaken a university supervision course. This could have potentially reduced internal validity as participants were starting at different levels, they appear to combat this later in the paper with use of pre and post questionnaires to establish a baseline. The authors raised concerns about this, as some participants were delivering safeguarding supervision without specific training. Each participant then received a half-day programme updating them on supervision models, especially in relation to a restorative approach to supervision, how to develop supervision contracts, and they were provided with a manual to reinforce the supervision training. The aim of the training was to experience quality supervision whilst updating and enhancing the participant's skills. They imply that the supervision demonstrated to the participants what was best practice and 'quality' supervision, however they did not state or define what best practice is, or what constitutes a 'quality' supervision session and provided no comparisons to other modes of safeguarding supervision suggesting a risk of bias.

The mode of delivery was deemed 'cascade' training,' which was intended to be disseminated and embedded within the local Trust. Following the training, each participant received six supervision sessions and a baseline questionnaire (Professional Quality of Life Scale (ProQUOL) (Stamm 2010) before receiving the first episode of clinical supervision. This specific questionnaire measures included compassion satisfaction, burnout, and compassion fatigue and is a well-used and validated questionnaire which has been in use since 1992. The questionnaire offers an evidence based, validated baseline of practitioners' sense of well-being, and its use is appropriate in assessing practitioner workplace perspectives as well as the support resources they have access to. In addition to this scale the 'Impact of Events Scale' (IES) (Horowitz et al. 1979) was also applied to specifically measure stress which is another validated tool aiding the assessment of stress reactions following traumatic events (Sundin and Horowitz 2018).

There were 128 clinical supervision sessions delivered to 22 participants over 6 months. The pre- and post-supervision comparisons were drawn using t-tests. The results suggested that burnout and stress were prevalent at a *clinical* practice (Wallbank and Haton, 2011, p.33). Results were similar across all participants which implied that these experiences were common. The ProQUOL results also identified that burnout was reduced by 36% post supervision training, while stress was reduced 59%. Just over three quarters of the participants stated that their psychological well-being was 'poor to OK' with only 24% reporting good psychological well-being pre-supervision. Post supervision, compassion satisfaction was recorded as high and was deemed a protective factor. Results suggested a positive impact of the supervision on the participants but this should be considered with caution due to the inherent weaknesses in the study. Recommendations included instilling a culture of change in relation to delivering a restorative clinical supervision directive at national, regional, and local levels and the need for further research on the impact of restorative supervision on health visiting practice. Restorative supervision was identified as necessary to enhance supervisee supervision experience with the space to think critically, and reflect on their practice helpful to reduce stress, burnout, and compassion fatigue. This was also identified by another Wallbank collaborator who evaluated the rollout of the restorative approach across a different Trust in England with similar results (Wallbank and Woods 2012). This paper was published a year after Wallbank and Hatton (2011) and explores the findings from the restorative supervision programme (Wallbank and Haton 2011). It offers quantitative data associated with the effectiveness of restorative supervision with updated results on compassion satisfaction, burnout, and stress scores. There is no sample size as a general overview of the impact of restorative supervision is provided. The authors provide a general statement in how Trust's select participants, there is no definitive number. It is a 'salami slice' of the original work with its integrity at risk, although, provides some updated data and recommendations for future research and is a discussion paper rather than original research.

The implementation of restorative clinical supervision from the pilot study to it being rolled out across a wider region in England, led to a further research collaborations (Wallbank and Wonnacott 2015, 2016) in which an integrative model of supervision was explored within safeguarding contexts. These were both discussion papers that underpinned the development of the safeguarding supervision model on previous research (Wallbank and Hatton (2011). The 2015 paper offers similar background to the other Wallbank collaborative papers and the same data as Wallbank and Woods (2012). The 2016 paper is a slightly more in-depth iteration of the 2015 paper with a greater focus on enhancing practice. The focus was to examine how restorative supervision might support safeguarding supervision with a key role in enhancing the supervisors' practice. They discuss links between clinical and safeguarding supervision and offered a restorative safeguarding supervision model as a way forward. The development of this model was supported by a training programme for safeguarding supervisors.

A safeguarding supervision model that combines restorative supervision and the safeguarding 4x4x4 model (Morrison 2005, Wonnacott 2014) is suggested as contributing to the development of resilience in practitioners by supporting and enabling the containment of emotions; a strategy which is considered essential within a supervisory relationship. Wallbank and Woods (2012) and Wallbank and Wonnacott (2015, 2016) explored principles of the restorative safeguarding supervision model and emphasised the essential role of the safeguarding supervisor in facilitating supervision that is effective and allows critical reflection of practice.

Further evidence was presented to justify the use of restorative supervision (Wallbank and Woods 2012, Wallbank and Wonnacott 2015, 2016) which further supported Wallbank and Hatton (2011) . They refer to the restorative supervision model being used with over 3500 UK and Australian based health practitioners enhancing compassion satisfaction and reducing burnout and stress in the below (Table 7).

Table 7: Restorative supervision impact for 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**) (Wallbank and Wonnacott 2015)

There is no breakdown of where these figures are from and there is no demographic or specific job role data associated with the participants; further detail would enhance its validity. The data from these studies suggest a positive impact of restorative supervision and argue that the model was the most appropriate due to high levels of stress and burnout associated with professionals such as HVs. Despite the model at first being health focussed its applicability to other agencies such as social work also became apparent. Good safeguarding supervision is defined as that which supports the practitioner to;

> *"...think, reflect and develop their own solutions around what needs to happen next with families."* (Wallbank and Wonnacott 2015, p.43).

Caution is recommended by Wallbank and Wonnacott (2015) as organisations should ensure that guidance is in place for practitioners that promotes well-being and support, rather than it being a process that is punitive and 'tick box' driven. Protected time and space need to be offered for supportive, and developmental conversations should take place with peer support allowing practitioners to enhance relationships with colleagues. Multi- agency relationships, communication and information sharing has previously fallen short, and practitioners are frequently recommended to improve multi-agency relationships, identified in the results from recommendations from serious case reviews (Brandon et al. 2020, Morgans and Garstang 2020). The researchers claim that this can be addressed and explored with safeguarding supervision. Incorporating a restorative approach to the 4x4x4 model (Table 8).This is proposed as having the potential to ensure restorative skills are developed by the supervisor and are central to the whole process. This included the importance in building relationships with other agencies and relationships that are open to professional challenge.

Table 8: 4x4x4 model

Four functions	Four Stakeholders	Four Supervision cycle components
Management	Service users	Experience
Support	Staff	Reflection
Development	Organisation	Analysis
Mediation	Partner Organisations	Action planning

(Morrison 2005, Wonnacott 2014)

The 4x4x4 model includes three constructs with four elements in each. This is a well-known and used model in safeguarding practice, especially within social work practice, and based on Kolb's reflective cycle (Kolb 1984). The model is theoretical but draws heavily on their empirical work and seeks to consider aspects of accountability via four functions which support and develop the supervisee. It also includes the elements of Kolb's reflective cycle which are fundamental skills for critical reflection, analysis, and action planning when child protection cases are discussed. Wallbank and Wonnacott (2015) draw on this and offer a set of recommendations for practice which cover macro, meso and micro levels of action.

Wallbank and Wonnacott (2015, 2016) also recommended a structured approach to safeguarding supervision which builds on the earlier work of Morrison (2008) in the wake of Peter Connelly's death and Lord Laming's subsequent review (Laming 2009) relating to the importance of good supervision Morrison (2008) stated:

> *"...good supervision and good outcomes for children and families are inextricably bound together."* (Morrison 2009 in Wonnacott 2013, p.13)

Referring to social care practice Morrison (2008) places the onus on managers within the service to ensure that staff are well trained and supported. Morrison's work sets the premise for Wallbank and Wonnacott's (2015, 2016) recommendations and use of the 4x4x4 model for safeguarding supervision, emphasising its importance in the support of practitioners exposed to child protection who require *good* safeguarding supervision.

The limitations of all the studies associated with Wallbank were the small sample sizes, combined data usage across research studies, salami slicing and lack of pilot testing and no randomisation leading to risks of bias affecting validity and integrity of the work presented. None of the papers (Wallbank 2010, Wallbank and Hatton 2011, Wallbank 2012, Wallbank and Woods 2012, Wallbank 2013, Wallbank and Wonnacott 2015, 2016) refer to ethical approval being obtained, and those that are research based (Wallbank and Hattin 2011) do not express any limitations to the studies. It is essential to obtain ethical approval and statements are needed when research is being presented (Jacobsen 2017). Without such approval the results need to be treated with caution and used only to indicate the state of the evidence base at present.

4.3 Safeguarding supervision

This theme aims to explore relevant and available publications to help develop an understanding of how safeguarding supervision has been perceived in relation to its importance, relevance, prioritisation, and its supportive nature for practitioners dealing with the complexity associated with safeguarding practice. Twenty-one research and descriptive discussion papers were included and discussed with ten of these having taken a qualitative stance. Other evidence is included here to help support statements made which link to the research question, aims and objectives of the thesis.

4.3.1 The importance of safeguarding supervision

The importance of not underplaying the need for supervision was emphasised by Harvey and Henderson (2014). Their discussion paper explores how reflective supervision supports child protection practice. The evidence used within the paper is dated (1994 – 2011) and could be deemed a potential weakness due to time lag, but the content was deemed relevant as the authors were exploring how to enhance safeguarding supervision practice. Their target audience was social workers, and they described a model of reflective supervision which used a psychoanalytic approach. Child protection social work practice is similar to HV experiences within child protection practice (Moseley and Phillips 2023) and therefore this discussion paper is relevant and messages are transferable to this study. Harvey and Henderson (2014) alluded to the

potential dichotomy that supervision brings, whether it be considered nurturing or controlling, and they stated that the opportunity for supervisee support, containment, attuning emotionally and connecting with the supervisees, must not be confused with a performance checking process:

> *"Supervision cannot be reduced to a tick box exercise with reflection or critical analysis being compartmentalised."* (Harvey and Henderson p.343)

Equally, Hunt et al. (2016) in their mixed-method study referred to the need for supervision to facilitate emotional attuning and reflection on cases. The study offered a holistic view of the findings with the researchers using an online survey to collect anonymous data about social workers' experience in practice as well as their perception of the organisation. They stated that child protection supervision must not be part of any staff performance review or be tokenistic. They explored child protection social work practice supervision as well as how organisations manage and respond to parental violence. They claim child protection workers can be exposed to hostile and un-cooperative parents/carers, and can feel scared, in danger, humiliated, manipulated, and coerced. The researchers point out that if a child protection worker experiences hostility, it is highly likely the children in that family experience it also (Hunt et al 2016).

The research was UK based and utilised an online survey to collect workers experiences which included 24 questions designed to collect quantitative and qualitative data. Devising a complicated questionnaire via a survey and requesting complicated data can result in a low response rate (O'Connor 2022) but, the response rate within the Hunt et al. (2016) study was 590. Participants volunteered to take part and were recruited via a community care website. The survey was developed collaboratively by a group of experts (Hunt et al. 2016 p.10) whose backgrounds are not referred to. Therefore, it is difficult to gauge what they were expert in and, what they based the questions on. The survey questions were not included in the paper with a note advising readers to contact the lead author if they wanted a copy of them.

The researchers break down the demographic of the respondents with the majority being female (82%). Sixty-five per cent of them were experienced workers having been

in practice for over five years. Only half of the participants felt adequately supported in their practice, when working with hostile and uncooperative families with some receiving no support from management. The participants experienced serious hostility including death threats, one participant was physically assaulted, and they were not taken seriously by their manager initially. To note, in social work practice in the UK, the line manager normally undertakes management supervision as well as case load discussion.

The caseload discussion is similar to those who receive safeguarding supervision in healthcare care settings (Public Health Wales 2017). Other research (Jarrett and Barlow 2014, O'Neill et al. 2023) indicates that there are potential barriers in having an open, supportive safeguarding supervision session with a line manager as it could lead into a clinical supervision or managerial supervision discussion. Participants identified from the Jarrett and Barlow (2014) and O'Neill et al. (2023) research studies preference for an external supervisor. Some managers were less than sympathetic/empathetic with their supervisees within the Hunt et al. (2016) research. One participant alluded to taking a case to supervision only when,

> "...*it's bad enough that I don't expect them to laugh about it and tell me it comes with the job."* (Hunt et al. 2016, p.14)

One worker was told that they needed to improve their stamina and resilience when working with such hostility from a parent. It was implied that the issue was with the worker rather than the parent. Another worker described a physical response in the anticipation of visiting a family and described palpitations and profuse sweating. When they sat in the family home they are '*fretting'* (Hunt et al. 2016, p.14) viewing escape routes and initially would hope that the family were not in when they knock the door. This worker was told that they required *'backbone'* to work in child protection and to '*tough it out'* (Hunt et al. 2016, p.14).

There was reference to when workers were not supported to the point where they were sent into intimidating and dangerous situations. A palpable finding was the narrative associated with the lack of support through adequate supervision and its impact on children. Forty two percent of the participants felt that the quality of intervention they provided children was hampered due to inadequate supervision and management support. The researchers reflected on the literature supporting the use of effective supervision and stated the need for supervisors to be knowledgeable about the theoretical frameworks which support the delivery of supervision. The response by organisations was variable and inadequate. Effective, intensive, and supportive child protection education and supervision was required as this was linked to the retention of staff but more importantly to further potential risk to children. The paper also collected suggestions and ideas from workers to inform and feedback to the organisation, this is useful in an attempt to improve or enhance practice. However, there was no reference to ethical approval or limitations found within the Hunt et al. (2016) paper. There was also no indication of the training of managers/supervisors although workers did suggest training in dealing with hostile/uncooperative parents rather than safeguarding supervision. The discussion section of the paper referred to the need for effective supervision and organisational support in negating the impact of working with complex families who are hostile and un-cooperative. The majority of participants did feel supported but the research identified some workers who lacked adequate support.

4.3.2 The expected supportive nature of safeguarding supervision

There are ten studies included in this section with comparisons drawn from the wider research included in the literature review as well as contemporary literature associated with the safeguarding of CYP and supportive supervision. First, Guindi et al. (2019) in their literature review reported that the research/literature were not particularly robust methodologically. Within her study only 11 papers were deemed suitable for the final review which spanned the previous ten years. The included papers offered opinion on how effective safeguarding supervision should present:

- There was no national definition of safeguarding supervision, it must be emphasised that safeguarding supervision is different to clinical supervision and sits in a different space (Wallbank and Wonnacott 2015, 2016).
- Safeguarding children supervision must remain focussed on the child/young person. (Smikle 2017, Little et al. 2018)
- Cases discussed at safeguarding supervision should extend to vulnerable families as well as those on the child protection register.
- Safeguarding supervision must support practitioners to feel safe to discuss, challenge practice, develop critical thinking and to ensure safe and effective care. (Rooke 2015, Smikle 2017, McPherson et al. 2016, Little et al. 2018)
- Safeguarding supervisors require training to facilitate reflective and meaningful conversations (RCN 2014, Guindi et al. 2019)

A qualitative study undertaken by Rooke (2015) used focus groups to explore what support mechanisms HVs use in their child protection practice. The study aims were clearly presented as was the methodology. Focus groups are a useful method to collect data from several participants (Gray et al. 2017). Two focus groups were undertaken with five participants in each. It does not state if these were undertaken face to face or online. It is assumed they are face to face partly due to the date of the paper which was pre- COVID-19 pandemic (2015). Ethical approval was acknowledged and acquired via a university ethics committee. Rooke set the scene by breaking down what support means and referred to the Plews et al. (2005) taxonomy of support which sets the supporting context of what was is to be achieved within a safeguarding supervision intervention. Plews et al. (2005) refer to support as providing emotional support that is caring for an individual, support in enhancing self-esteem, support that allows access to a network (of support), support in offering advice as well as provision of information. This set the premise for Rooke's study as they explored HV experiences of their child protection work, what they deemed supportive and a wider understanding of how that support impacts their practice. Three themes were derived from the data following focus groups which refer to how the HVs manage emotions based on the support provided, how support aids their practice and how protected time to reflect on caseloads with time

for continued professional development. Clinical and restorative supervision was seen as *support to manage emotion*' (Plews et al. 2005, p.43) but the most support was provided by other colleagues (safeguarding team, more experienced colleagues, relevant social workers). Fear, anxiety, anger, powerlessness, and sadness are listed as key emotions that HVs feel increase when working with child protection cases.

The participants varied in experience with some being newly qualified HVs who valued colleague support and advice. Rooke (2015) offers several recommendations to enhance support in HV child protection practice which include, regular supervision (amount not specified) with support to be able to challenge, a robust preceptorship programme for newly qualified HVs, continued professional development and development of peer support networks. It would have been beneficial to have more specific recommendations. For example, providing the *how to* and *what does regular* supervision equate to, as well as how could a preceptorship programme be inclusive of safeguarding supervision. Rooke (2015) makes a valid point in expressing the importance of HVs having to evidence to commissioners the impact of effective support on the well-being of children. They did not refer to any limitations within the study and recommended further research and regular evaluation of staff support within child protection practice.

Likewise, Austin and Holt (2017) undertook a qualitative study in Ireland reviewing how frontline public health nurses working with vulnerable families and children were advised/supported. The qualitative research used phenomenology and took a constructivist approach to reflect data collection and findings from an epistemological and ontological stance. The aim of the research was to build an evidence base to progress the potential development of a specialist role to further assist frontline staff working with vulnerable children and families. They recognised that supervision was important, but this role/support was not in place at the time the research was undertaken, and the researchers recognise that a leadership/safeguarding led role to support supervision was not '*fully conceptualised*' (Austin and Holt 2017, p.526) in Irish nursing practice. They also refer to the work of Wallbank and Woods (2012) and

Morrison (2005) 4x4x4 model recognising that by combining critical and reflective practice with a restorative approach to supervision, aids practitioners to make informed, critically reflected decisions.

Austin and Holt (2017) used thematic analysis to analyse the data. Data were collected using focus groups and semi-structured interviews and participants were purposively selected by public health nursing managers. Eight participants were included, a combination of associate directors of public health nursing (four), social work line managers (two), and two non-governmental line managers. Four of the public health nurses took part in a focus group, two of these were interviewed by telephone also. The remaining four participants were interviewed. Two themes were established post analysis of data and related to the stress and vicarious trauma linked to working in child protection and welfare and embracing the development of a new role to support public health nurses. The stress associated with child protection work cannot be minimised and previously recognised by Rooke (2015).

Similarly, in the Hunt et al. (2016) research, participants articulated the situations and environments public health nurses were exposed to. Austin and Holt (2017) evidence this and provide qualitative snapshots from their data. For example;

> *"…facing issues within families that are very harsh, they are going into communities that are affected by so many things....parents can be very plausible when you meet them in clinic....the house is cold and the child is not well dressed and it's (infant) overfed or it's underfed and you know, there is shouting going on and smoking, it's an indication of what's to come." (*Austin and Holt 2017. p.530*)*

These examples led to participants referring to potential vicarious trauma experienced by the public health nurses, especially if there was no supervision in place. They emphasised the need for public health nurses to be able to process their practice observation and experiences:

> *"...if there is no place to go with...it colours every decision you are.... the PHN is always going to worry about the child, they are going to bring that home and it sits with them. You never forget them." (* Austin and Holt 2017. p.530).

The researchers, despite the small sample size, make a compelling case for a specialist role to support public health nurses in their child protection work. There was discussion as to where this role would sit – locally or regionally and some of the ADPHNs were concerned about their own roles. The research concluded that public health nurses working within safeguarding practice needed access to *appropriate supervision* and that their role was a protective factor in the protection of children and young people. A specialist role to support the public health nurses was being considered.

Warren (2018) explored safeguarding supervision literature to examine the leadership qualities and behaviours of the safeguarding supervisor. This review examined literature systematically and formed part of a wider study which offered a review of the literature and an explanation as to what safeguarding supervision is and takes a discussion paper format. It included detail of the search strategy; critical appraisal tool and inclusion and exclusion criteria used in the review. Findings identified if supervision is effective, risk to children can be identified whilst also assessing need. Warren (2018) emphasised that safeguarding supervision allows frontline staff to provide the optimum care, assess risk effectively and aids the ability to plan care safely with a structured action plan. The review included the work of Wallbank and Wonnacott (2015), Hunt et al. (2016) and Morrison (2010) reiterating the importance of supervision when listening to views of, and experiences of children (Smikle 2018). The key section of this paper is the narrative around leadership behaviours, applicable to the safeguarding supervisor role. The failings of organisations are brought to public attention when there is a significant incident which has undergone a multi-faceted review of practice namely Francis (2013), Laming (2003, 2009), Munro (2009, 2011) as examples. Although these reports are now rather dated, they remain relevant as they identified significant risks and instances of harm—including fatalities among children and adults. These findings continue to offer critical guidance for actions aimed at preventing harm and safeguarding individuals. In fact, they have been succeeded by further serious case reviews/child practice reviews where the same practice issues and recommendations are similar to the aforementioned historical child practice reviews above (Coventry LSCB 2013, Lundberg 2013, Brandon et al. 2020, NSPCC 2023).

Warren (2018) in considering the supportive nature of safeguarding supervision, identified that when supervisors have a positive and compassionate leadership style, this has potential to develop a positive and effective supervision experience. Based on the review of the literature Warren (2018) lists implications for practice to include:

- The importance of safeguarding supervision being filtered through macro, meso and micro areas of practice to include its governance.
- Safeguarding teams need to demonstrate positive and compassionate leadership traits to positively impact staff well-being and safeguarding practice.
- Leadership development and safeguarding supervision training for supervisors should be provided.
- Protected time is essential for the supervisee to attend safeguarding supervision.
- Regular evaluation of safeguarding supervision practice should be in place to ensure best safeguarding supervision practice.
- The development of a supervisor feedback tool.

Safeguarding supervision is considered essential to protect vulnerable children and families and this is reiterated by Sagoo et al. (2013) who refer to the introduction of safeguarding leads and a model to support HVs. They drew on local audit as data, and although the paper is not empirical research, it makes some salient points to emphasise the importance of safeguarding supervision and takes the format of a discussion paper using practice-based evidence. Their model is structured in offering quarterly safeguarding supervision, using Kolb's model of structured reflection (Kolb 1984) to facilitate and, with a focus on four components:

- Support (via discussion).
- Mediation (supervisor/supervisee relationship).
- Education (professional development, practice learning).
- Management (implementation of policy and best practice).

Within their local area they recognised that when safeguarding supervision was delivered effectively it had a positive impact on HVs standards of practice, it focussed

the HVs on delivery of early intervention and prevention measures and referred to the empowerment of families. They saw increased rates of completed care plans in the HV records, an increase in how the care plans reflected the most up to date care. Health needs analysis had increased and there was a rise in contacts with children identified as vulnerable. Sagoo et al. (2013) also referred to delivery of supervision away from the original place of work, which allowed time for effective and protective practice. It was encouraging to note that the supervision was introduced to HV students in their third trimester of HV education, and it is one of the only papers that refers to evaluation of the safeguarding supervision to assess its effectiveness.

Lord Laming's serious case review recommendations following the death of Peter Connelly (Laming 2009), reminds practitioners of the clear directive that supervision must be open and supportive, enabling decision making with a focus on driving safe and effective care for CYP instead of focussing on targets. The emphasis here is on quality improvement through effective supervision. The child at the centre of the supervisory process is imperative and this quality improvement angle is very much a feature of the Professional Nurse Advocate (PNA) qualification. The recommendations by Sagoo et al. (2013) for safeguarding supervision practice is similar to the constructs of a newly developed approach to restorative clinical supervision (NHS England 2021). NHS England introduced a Professional Nurse Advocate qualification in 2021 which uses the application of an A-EQUIP model in practice. This refers to **A**dvocating and **E**ducating for **Qu**ality **I**m**p**rovement (NHS England 2021). This involved the functions of clinical supervision as described by Proctor (2004) namely, normative, formative, and restorative as well as a quality improvement element. The normative element refers to elements of practice, any issues and covers mandatory training. The formative element refers to education and continued professional development. The restorative element refers to the supportive nature of the supervision process, personal development with the aim to manage stress and reduce burnout. Practitioners who have completed this qualification are now able to deliver restorative supervision. NHS England aimed to train 1:20 nurses (NHS England 2021) to allow for clinical supervision to embed in practice,

and lead change in culture associated with the delivery of clinical supervision in becoming the norm in nursing practice as it is in midwifery.

Interestingly, the restorative element of the A-EQUIP model is underpinned by the work of Wallbank (2013) and Wallbank and Woods (2012) previously discussed, and aims to reduce compassion fatigue, burnout and stress and improve compassion satisfaction and resilience. Pettit and Stephen (2015) referred to the delivery of restorative clinical supervision in addressing the emotional needs of the practitioner (HV). From an A-EQUIP perspective this supports the development of leadership, something that Warren (2018) includes in their review of the literature and emphasises the need for compassionate and effective leadership in the delivery of safeguarding supervision. Restorative supervision in the last ten years appears to be the golden thread in delivery of effective supervision and is seen as beneficial within the safeguarding supervision space (Wallbank and Wonnacott 2015). The PNA programme has recently been evaluated positively in particular the RCS element. Its evaluation was mixed method in design and applied a concept of empowerment and a theory of programme change and there were 302 participants. Data were collected by use of surveys, case studies and semi structured interviews. A workshop with commissioners was also included. Adegboye et al. (2023) also undertook a rapid review of the literature to inform the study. The evaluation was detailed and robust and the evaluation of restorative clinical supervision within the PNA programme was described as:

> *"... a reflective process that legitimises the time and the necessity for nurses to understand and process difficult experiences in their roles. This could only be done with the support and underpinning of a trusting relationship. Participating in RCS was described as a positive and constructive experience by many RCS nurses which had boosted their self-confidence, leaving them restored and reinvigorated." (*Adegboye et al. 2023 p.77).

Therefore, the research and practice evaluations of RCS emphasise its effectiveness supporting its concept, delivery, and role in reducing stress and burnout. This was also identified by Griffiths (2022) who used RCS as a PNA during the pandemic and refers to nurses displaying secondary trauma when exposed to the complexities of working within a pandemic situation. This could be compared with HVs working within the complexities

of a child protection situation and experience of vicarious trauma as referred to by Hunt et al. (2016)**.** Griffiths (2022) referred to the need for stability in the workplace in their discussion paper. It could be argued in high pressured job roles if stability is ever present, but, a supportive environment where time is provided to discuss complex cases or practice issues can advocate effective patient care.

An ethnographic, longitudinal study, ethically approved, examined the power of relationship-based supervision within social work child protection practice undertaken by Warwick et al. (2022). The study spanned 15 months and included two sites in England with 402 days of practice observed and 271 interactions of social care staff and service users. They undertook semi-structured, informal interviews and observed 54 staff supervisions. Supervision in social work occurs on a one-to-one basis and for the purpose of this study the researchers present a case study of one social worker. The context of the Warwick et al. (2022) study was to emphasise the supportive nature of supervision to retain staff. This is the most robust study of this literature review.

They selected a *star case* from their research. One of the social workers stayed throughout the length of the research whereas 42 other social workers left. The researchers do not state why the 42 members of the team left the team of 54. However, they referred in their introduction to the impact of organisational culture and recommend a more '*humane approach'* (p.2) to supervision versus management supervision which can be dominating, burden the profession, as well as hampering the supervisee/supervisor relationship.

Warwick et al. (2022) offer a context to their findings: there was a change in manager and the case study social worker almost left the team if it was not for the supportive new manager. Social work has been criticised for being too process driven (Munro 2009, 2011). This is identified in this ethnographic research when one social worker was criticised for spending too much time with the families. The supervisor skills that enhanced the relationship were active listening, empathy, and security. McPherson et

al. (2016) within their qualitative study recognised the importance of psychological safety in supervision.

The supervisor within the case study was able to offer this security and McPherson et al. (2016) recommended that emotional safety be a key factor in supervision as it allows containment of a situation, as well as acknowledging supervisee thoughts and feelings. This concurs with the elements of restorative clinical supervision as the aim is to reduce stress and anxiety, contain the situation to also reduce compassion fatigue and enhance compassion satisfaction (Wallbank 2012). The behaviours of the supervisor are essential in building trust to develop open meaningful discussions (Warren 2018). The case study narrative (Warwick et al 2022) does imply that the supervisor was sat across her desk from the social worker and as the discussion unfolds and the social worker started crying, she then stopped typing. Later, she ignored the noise of emails and the session was interrupted by another social worker. This example reiterated the importance of protected time and space to have supervisory conversations away from the workplace/desk space.

Protected time and space to facilitate supervision was also a finding in a qualitative study by Little et al. (2018). Their qualitative evaluation of safeguarding supervision amongst a group of community nurses explored the context of safeguarding supervision as well as the literature, they reinforce the need for protected time which is focussed and safeguarding supervision that is child centred. This qualitative evaluation of safeguarding supervision included 25 participants which included five safeguarding nurses and 20 nurses who were either HVs or School Nurses (SN). There were 11 participants interviewed with the remainder of the participants completing a questionnaire with open ended options to allow for in depth responses. The research implied that supervision is undertaken on a one-to-one basis, but this was not explicit. Nurses take families' cases to supervision who are on child protection plans. Five themes emerged from the data relating to the context of safeguarding supervision; helpful aspects, unhelpful aspects, accountability issues and developing current practice. The supervision leads identified that practitioners could be more prepared for

supervision. There are extracts from the data that support the safeguarding supervision with one participant calling it a *'life saver'* and another stating it makes them *'think outside the box'* (p.154) It is considered to aid professional development, and the supervision is deemed supportive. The unhelpful elements of the comments related it to the supervision being like a tick box exercise, and in some cases, it was difficult to prioritise with competing practice issues. One of the safeguarding leads referred to staff members who felt as if the supervision is more punitive in nature which gives a different context, they state:

> *"I think some think it (safeguarding supervision) is intrusive, punitive. The Trust covering their own backs.....one who said she couldn't see the purpose of supervision. She should be out there seeing children."* (Little et al 2015, p.155).

This was not further explored in the research it would be interesting to know how the safeguarding lead dealt with this sort of practice and if they had any concerns that needed addressing with the HV. This research did not address the education/experience of the safeguarding leads which would have enhanced the research. The helpful aspects of the findings referred to the opportunity to reflect on practice, develop professionally, share good practice as well as improving future practice which is child centred. Similar themes recurred throughout the literature, for example, Smikle (2018) also referred to the importance of protected time and that supervision needs to be facilitated with a supervisor who is experienced and knowledgeable in the field. This is a discussion paper rather than research but offers advice based on her experience as a head of safeguarding. A definition of safeguarding supervision was offered which encompasses many of the points made in what constitutes effective safeguarding supervision. It was defined by Smikle (2018) as follows:

> *"Safeguarding supervision provides a safe, confidential space in which supervisor and supervisee can reflect on challenging cases and difficulties encountered in practice. It needs to be provided in an environment in which staff can speak freely about the difficulties they have experienced (or are still experiencing) and receive emotional support from their supervisor."* (p.38)

A further definition of safeguarding supervision will be explored as part of the discussion chapter considering the key themes extracted from the data and literature review.

Smikle's (2018) discussion paper is informative, based on evidenced based supervision models, their experience as a head of safeguarding children. The paper related to essential elements required of safeguarding supervision and stated its importance within health visiting practice. Safeguarding supervision is as a key factor in improving confidence and competence in safeguarding practice, offering clarity in action planning, allowing practitioners to '*blow off steam'* (Smikle 2018, p.37) and learn from their safeguarding experience, placing the child's voice at the centre of their practice. Some of the discussion papers offer a subjective insight by practitioners based on their expertise. Although not empirical research, they can complement research included in a literature reviews, reiterating recommendations and findings from their own scoping of research, whilst offering insight into daily practice. Their relevance from a research perspective may be challenged and questioned. Inclusivity of these papers was carefully considered due to the lack of evidence sourced in relation to safeguarding supervision from a HV stance.

The impact on the child following safeguarding supervision is not well researched (Guindi 2020). A quantitative study by Guindi (2020) explored the safeguarding supervision experience of 37 community nurses (HV, SN, family nurses) to ascertain what safeguarding modes and supervisor qualities were the most important. A survey was undertaken with the aim to question community nurses on the mode of safeguarding supervision delivery, the model used to facilitate it, the qualities of the safeguarding supervisor and any other factors that felt to be helpful/unhelpful within the safeguarding supervision process. Eight factors were measured against: feeling safe and a safe environment, experienced practitioner (supervisor), having time to critically reflect, regularity of supervision and how consistent it was, being respectfully challenged, being held to account, the application of theory to practice and the model of supervision used. The survey was structured to enable quantitative and qualitative responses.

Participants were aware of several models used in supervision, the most well-known being ‘Signs of Safety’ (74.8% Edwards and Turnell 1999) and least familiar the Peshkin model (10.8%, Peshkin 1988). The 4x4x4 integrated supervision model (Morrison 2005) was only known by five of the participants. The Signs of Safety model has been used and seen as a potentially more straight forward, contemporary assessment of risk in the last ten years and used across child protection settings. The National Society of the Prevention of Cruelty to Children (NSPCC) were commissioned to review its implementation in England (Bunn 2012). The report findings stated that the model helped focus practitioners within their safeguarding work and engage families more, enabling the child's voice to be more prominent. The Signs of Safety model (Turnell and Edwards (1997) is a well-used model and identified within the Guindi (2020) research. Although, when the participants answers were expanded upon the explanation for the preferred model was due to having a primary basic knowledge and a model aligned to social care practice. In relation to mode of delivery of the supervision, 35 out of the 37 participants preferred a mix of one-to-one and group supervision and it was felt that this would be the most effective way to safeguard children and young people.

Bradbury- Jones (2013) acknowledged the complexities of child protection work and its impact on stress development and burnout within their discussion paper. They suggested a re-focus on the delivery of child protection supervision with use of the Peshkin approach to supervision, although a less utilised model (Guindi 2020) its intent is to focus on the reflective element of supervision with an onus on the *“affective aspects of child protection work”* (Bradbury-Jones 2013 p253). Similarly to Wallbank (2012) Bradbury- Jones referred to the impact of compassion fatigue, the emotional burden of child protection work, and burnout. They also related to how supervision can become process driven rather than related to the emotional needs and well-being of the supervisee and reflects on Lord Laming’s comment following the death of Victoria Climbie, where he described the supervision of the frontline practitioners involved in Victoria’s case as *“woefully inadequate*” (Laming 2003). A reflective space to allow for an open, reflective discussion is advocated and a holistic, reflective approach by Peshkin (1988) suggested as a way forward in child protection supervision.

Scullion and Robertson (2023) more recently examined the experience of safeguarding nursing supervision for HVs and School Nurses (SNs) in Northern Ireland. A qualitative approach was used with the use of semi-structured interviews with 14 HVs and SNs. There was no break down on numbers of HV, SN or supervisor until the conclusion which states there were two safeguarding supervisors. A breakdown of participant roles would have been helpful when scrutinising the data collected. They recognised the dearth of research exploring the safeguarding supervision for HVs and SNs. Their three aims were to understand participants' experiences and safeguarding supervisor perceptions of the process. Assessment of risk in Northern Ireland uses a regional tool which was considered within the questioning, as well as how it influences practice. The tool analyses risk in relation to the child development needs, parenting capacity, family and environmental factors and working in partnership with parents. The constructs of this tool related to the assessment needs triangle (Parenting capacity, child's development needs, environmental factors, Department of Health 2000) utilised across England and Wales as well as the Bronfenbrenner's ecological model (1979) which considers the impact of these extrinsic and intrinsic elements on the child.

Data analysis confirmed three themes: supervision need, the supervision process and the value of the supervision experience. Interestingly, there was no regional guidance for the delivery of safeguarding supervision. The research did not determine whether the format of supervision is one to one or group supervision although, it did state for group supervision to be considered as a form of providing peer support. The detail of the type and duration of safeguarding supervision is absent, and this information would have enhanced the paper with further context. Peer supervision was referred to as informal rather than a structured group supervision mode of delivery.

Half of the participants preferred a longer episode of supervision to allow for completion of paperwork. During the pandemic safeguarding supervision was undertaken online which two of the participants felt was positive. The researchers recommend further research in the delivery of virtual safeguarding supervision. The analysis tool was referred to as a useful structure to the supervision and although time consuming, aids

preparation for the session. One of the supervisor participants felt a risk assessment tool should align to the "Signs of Safety" (Edwards and Turnell 1999, Bunn 2012) approach used across services as well as highlighting the time required to record the supervision session. The key points from this research related to a positive, valued, supportive experience of supervision, recognition of the importance of a risk assessment tool that applies to wider safeguarding practice and protected time of three hours, suggested for supervision as well as time to complete the paperwork (Scullion and Robertson 2023).

4.3.3 Group supervision

The supervision mode of delivery within the research literature either refers to one-to-one supervision or does not state mode of delivery at all. This short sub-theme explores the mode of delivery of safeguarding supervision and brings together some of the papers already discussed, with additional supportive evidence.

A qualitative study undertaken by Jarrett and Barlow (2014) explored clinical supervision with a group of 15 HVs offering an intensive home visiting service. Ethical approval was acknowledged and this study was part of a wider randomised control trial (RCT) which explored the impact of clinical supervision. The wider RCT was not published until 2017 (Barnes et al. 2017) and was not applicable to this literature review as it examined the effectiveness of the introduction of a trial group Family Nurse Partnership (gFNP) role to support vulnerable families in preventing child maltreatment. The HVs within this study worked as part of the gFNP programme. The programme offers an intensive home visiting service to vulnerable families and promotes the ethos of working in true partnership with the families to enable a balanced relationship with equal power between the HV and family. The families had complex needs including exposure to child protection issues and supervision was delivered two weekly for one and a half hours in groups of three-four participants by a psychotherapist. Each HV was expected to present a case for discussion. This qualitative aspect of the broader RCT used a purposive sample of *'home visitors'* (Jarrett and Barlow 2014, p33). Home visitors were HVs who were offering an enhanced service to families deemed *high risk.* Twenty HVs were initially approached with 15 agreeing to take part. The HVs were

supervised by psychotherapists due to the nature of the work. Each HV was interviewed individually. Thematic analysis (Braun and Clarke 2022) was used to analyse the data with the data being organised with the use of NVivo software.

The research identified that the HVs appreciated supervision from a different professional and they suggested that regular supervision enhanced their practice providing them with confidence and different solutions to manage boundaries when working with families with complex safeguarding needs. Group supervision allowed them to explore their own and colleagues' practice behaviours. The HVs referred to how the supervisor challenges and questions their practice with one HV stating how the supervision allowed her to explore the behaviours of a parent fully, which subsequently allowed her to visit with a different mindset. Two of the HVs did not like being challenged but accepted it was a positive experience in the long term. The HVs felt they benefitted from the expertise within the group, one HV stated:

> *"I like group supervision...I actually prefer group supervision to individual supervision...it was always really helpful, and it was good to have your colleagues as well as (Clinical supervisor) there to support you, to give your ideas." (Jarrett and Barlow 2014, p34)*

The researchers concluded by reiterating the importance of high-quality supervision for practitioners working in front-line child protection practice. They emphasised that if practitioners are going to benefit from supervision its delivery needs to be taken seriously to allow for critical reflection and enhanced practice with the child and family at the centre.

An Australian study (O'Neill et al. 2023) explored community maternal and child health nurses experience of clinical supervision using a qualitative descriptive approach. Maternity child health (MCH) nurses are equivalent to UK based HVs and the study interviewed 23 practitioners. The participants worked over several geographical areas with vulnerable caseloads. Main themes with sub themes were explored and related to the delivery of the clinical supervision (using a combination of both clinical supervision and safeguarding supervision), engaging supervisors, the demands of practice and bring a case' to supervision. Mode of delivery of the supervision varied with one area

having monthly supervision for one – two hours with 12 practitioners. Other areas had smaller groups, some had external supervisors, some had supervisors from other professions, some rotated supervisors. There was no consistency in the facilitation of the group supervision described although there were evaluations, albeit locally, to monitor the process. This could be deemed a weakness to the study as data would not reflect a universal delivery of group supervision. Limitations were referred to within the study, but this point is not identified. The teams chose the supervisors and set their own ground rules/expectations. The nurses did value the supervision, and the similar theme arose of supervision allowing the nurses to feel safe and reassured in their practice, this was clearly articulated. Supervisors were deemed effective if they facilitated a critical, reflective discussion which was professionally curious.

4.3.4 The role of the (safeguarding) supervisor – a safe space

> *"Supervisors who present as empathetic and well-regulated enable their supervisees to move from an internal state of distress to calm through...creating space for supervisees to reflect, practice and learn."* (McPherson et al. 2016, p. 76)

The role of the supervisor features as a key theme in most of the literature. McPherson et al. (2016) within their qualitative study, expressed the role safety plays in the context of feeling safe during a supervisory session and the "safe" supervision relationship. Morrison (2005) stated that previous supervisory relationships which were not particularly successful will impact future relationships and willing access or interest in supervision. McPherson et al. (2016) undertook their qualitative study using in depth interviews to explore supervision experiences of social workers in Australia. They interviewed 10 social workers (working with child and families) and 10 social work supervisors. The concept of safety within the supervisory relationship was amplified and described as a fifth dimension within the supervisory process. They recorded the other four dimensions as management, development, support, and mediation which relates to the work of Morrison (2005) and Kolb (1984). They included extracts from their data which reflected the importance of the supervisory relationship. A child protection supervisor stated,

> *"Supervision has to be built on a concept of safety, and safety, in this context, is relational safety. The supervisor and supervisee need to be clear about what the*

> *relationship is, and that this is a trustworthy relationship."* (McPherson et al 2016, p.71)

Another participant, a supervisor, refers to supervision as requiring "...*deep listening"* and the supervisor being a *"point of safety to be in tune with the supervisee*" with the supervision being '*non-judgemental,'* '*developmental'* (McPherson et al 2016, p.71) with constructive feedback being offered. Supervision was also referred to as a 'special point of safety' (McPherson et al 2016, p.71) within a complex environment with frequent exposure to child protection situations. This supervisor relates effective supervision to the needs of children and their families:

> *"Supervision provides islands in the turbulent sea for a supervisee...allowing them to explore the impact of this work, but able at the same time to remain close to, and focussed on the needs of children, and the safety of children"* (McPherson et al. 2016 p.71).

The narrative around the safety element of the supervisory relationship is impactful within this study and a safe supervisory relationship produces an environment to reflect and develop safeguarding practice. Smikle (2018) referred to a safe environment and space within their definition of safeguarding supervision. Similarly, Scullion and Robertson (2023) referred to safeguarding supervision as a positive experience with supervisors offering a safe place and space to discuss complexities associated with the protection of children.

Guindi (2020) explored supervisor experience and training in their quantitative research. Seventy eight percent of the participants felt that the supervisor should be trained/have qualification in safeguarding supervision, 64.9% felt that the supervisor must be of the same profession as they understood the role. As several studies note (Bradbury-Jones 2013, Sagoo et al. 2013, McPherson et al. 2016, Dobson 2017, Smikle 2018, Warren 2018, McGarry et al. 2018, Littler 2019, Peckover and Appleton 2019, Moseley 2020, Guindi 2020, Masamha et al. 2022, RCN 2022, Scullion and Robertson 2023, O'Neill et al. 2023), a safe space and time to receive supervision was deemed essential. This was classed as a most important factor along with being supervised by an experienced practitioner. A newly qualified HV described their health visiting practice experience as *"treading the tightrope of safeguarding"* (Dobson 2017, p.219) and stressed the

importance of safeguarding supervision which allows exploration of practice in a safe space where any decision-making remains child focused. Rooke (2015) took a qualitative approach to their research. It identified the need to support newly qualified HVs in child protection work as lack of support could lead them to think about leaving the profession, one of her participants articulated that during her first session she almost cried, and she wondered if the profession was right for her. It is essential a supervisor is attuned to the supervisee and training of supervisors is paramount and should be prioritised within organisations (Warren 2018, Guindi et al. 2019, Guindi 2020, RCN 2021). McPherson et al. (2016) are insightful to suggest safety as another dimension to safeguarding supervision. It encompasses much of the narrative throughout the literature in promoting psychological *safety* in a safe and protected space, as well as developing safe, confident, reflective competent practitioners, in the delivery of safe and effective care (Bradbury-Jones 2013). This requires a supportive, attuned, trained safeguarding supervisor who can facilitate a reflective supervision experience.

A quantitative study, ethically approved and undertaken by Rankine and Thompson (2022) explored social workers perceptions of their supervision. It is referred to as reflective supervision and the study had three components. The research involved 10 participants completing a survey pre and post an episode of supervision. This is a low participant number for a quantitative study, they are generally much higher in numbers. The participants included four supervisors and six supervisees and took place in a rural area in New Zealand. The study design and results include rich qualitative comments which appear misleading as its presentation takes more of a mixed methods stance. The data included in this study is the evaluation data from an *'action research'* study (p55) which set out to review two action research methods. The quantitative data is presented in bar charts accompanied by qualitative comments which offers comparison of the numerical data and thoughts/feelings of the participants. The researchers reiterated the importance of reflective practice within supervision to improve confidence, resilience in the delivery of safe practice. The supervisors within the Rankine and Thompson (2022) study stated that sometimes their supervision is minimised, forgotten,

or not prioritised due to workload pressures. This research focused on reflective practice in social work, and the understanding and application of it differed from a nursing perspective. However, some points made were transferable and relevant to consider. For example, how supervision aids retention and resilience in practice.

Three studies suggested the development of networks of support for the supervisors (Rooke 2015, Scullion and Robertson 2023) and if supervisors are aware of the importance of supervision, they should be emotionally intelligent to seek supervision for themselves, feel motivated to offer supportive supervision and be accessing training and continued professional development in this area of expertise. For this to occur the organisational culture must embrace its importance according to a number of sources (Morrison 2005, Jarrett and Barlow 2014, McPherson et al. 2016, Rankine and Thompson 2022, O'Neill et al. 2023).

4.4 Literature review summary

The literature review was challenging due the limited amount of robust empirical research available. There appeared to a gap in practice and evidence base which is ongoing and safeguarding supervision seems lost or at least varied and sporadic across the research. It lacks a consistent approach. The quality and standard of the research/literature is an important consideration and is based on criteria set by the hierarchy of evidence, which ranks the evidence base in terms of bias (Polit and Beck 2021). Despite the weakness of some studies a clear gap was demonstrated in the extent of the evidence base and the overall quality of evidence that was sourced in relation to my research question. The research sources would be ranked in the main as *low status* within the hierarchy which suggests it would be deemed poor quality. Therefore, this is a limitation that must be highlighted in terms of the quality, validity and rigour of the papers included in this review.

Overall, the literature search process identified only a limited amount of research specific to evaluating the effectiveness and supportive nature of safeguarding supervision in heath visiting practice, and nursing as a whole. The current evidence

base takes a superficial stance and some lack fundamental measures of quality such as ethical approval, over reliance on salami slicing and only a small number of robust, longitudinal ethnographic designs. This is not an attempt to de-value all the research and literature sourced here but it does suggest a clear gap in the research evidence and provided a clear rationale for the development of new research that is relevant and applicable.

In the literature review process I was able to appraise the literature but had to adapt and formulate an appraisal tool due to the low quality of the evidence base. Salami slicing of research can lead to a danger that information from a small set of studies is adopted and this was evident within the first theme. This could de-value the intention of the original research. Some papers were published as sub sections of wider research and some had no evidence of ethical approval. The papers accessed used much of the same evidence that I had sourced which proved challenging in offering a contemporary critique of the literature. However, this did offer some reassurance that I did not miss any significant papers. This also implies that this research is required to enhance this specialist practice of safeguarding supervision.

The structure of safeguarding supervision varied across the literature, but the desired outcome was similar in all in terms of supporting practitioners safeguarding practice and wellbeing. A focus on children and young people as part of the safeguarding supervision process was a common theme and reassuring to observe. Recommendations were made which suggested further research and one paper also offered a model of restorative safeguarding supervision (Wallbank and Wonnacott 2015).

There was very little research specific to safeguarding supervision in HV practice therefore supervision within social work practice was included. However, a limitation of the inclusion of this is that it is different to HV supervision as social workers also receive management supervision. The literature review findings were subsequently found to interrelate with the data emerging in this thesis which include:

- Protected time and space for supervision.
- Education of the supervisor.
- A structured approach to safeguarding supervision.
- Organisational influence to deliver and impact on practitioner and service user.
- Supervisor network of support

The literature review and the background to this study also informed a reflexive and structured approach to explore realistic implications for future safeguarding practice in Wales. Common themes were established and comparisons made across the literature. I was able to utilse the literature in considering and formulating interview and focus group questions, as well as establishing what I wanted to observe within the safeguarding supervision sessions. Importantly, I was able to use the available literature to apply a critical stance for what I wanted to achieve in moving forward. The next chapter explores the methods used to collect the data.

Chapter 5: Methods: An ethnographic interpretation of safeguarding supervision in health visiting practice.

The purpose of this chapter is to provide a critical interpretation and appraisal of the research design, and methods used for this study, discussing its suitability and place within health visiting, particularly in the observation of the HVs in practice and whilst being supervised within the safeguarding supervision process (Appendix 3). The chapter will justify the approach used by moving from discussion of experience in the field including how it was envisaged, to how the field was experienced in reality. As discussed in Chapter three, there is a lack of primary research that relates specifically to safeguarding supervision and the safeguarding practice of health visitors. This chapter's structure will interpret the reality of safeguarding supervision the challenges associated within everyday HV practice and the process of safeguarding supervision and how it exists (ontology). The relationships, observations, and research method to extract data will scope what is known (epistemology). From this, the value of safeguarding supervision applied within HV practice will be determined (axiology). An ethnographic methodology will inform the knowledge base and future practice recommendations, and will utilise specific qualitative techniques, to inform this thesis and future safeguarding supervision practice in Wales.

Ethnography was deemed an ideal research design/methodology when attempting to explore the reality of health visiting practice and interpreting the complexities of that practice when a safeguarding issue arises. I am a HV and previous safeguarding lead nurse which has allowed me to reflect on clinical practice, bringing my previous expertise in health visiting and as an academic/senior lecturer /programme manager for HV education. I come with a grounded knowledge base in health visiting and safeguarding practice and am familiar with some of the issues and practice experience of HVs working at this time. In January 2020, the world was hit with COVID-19, a respiratory life-threatening virus which became a global pandemic and significantly impacted global health. This in turn affected my ability to collect data and to observe and interact face to face with participants as expected. I was able to observe HVs in practice in two of the three health boards, within the constraints of national guidance

due to the associated risks of the pandemic which was at the forefront of each Health Board Infection, Prevention and Control (IPC) agendas. Group supervision was moved to an online format and most of the interviews were also undertaken online. This will be further discussed in the research methods section of this chapter.

An ethnographic approach allowed observation by immersion of the group supervision process, observations of HVs in practice, interviewing of HVs and the facilitators of the group supervision, to gain an in-depth insight of how and if safeguarding supervision supports their safeguarding practice. To re-cap, HVs are specialist community public health nurses (SCPHN) who are exposed to safeguarding issues potentially daily. The impact of safeguarding children, critically assessing, and making referrals to social services can have a negative impact on the HV emotionally, affecting their day-to-day practice if support is not provided. This specific support is provided by safeguarding teams within health boards across Wales in the format of safeguarding supervision.

5.1. Ethnography

Ethnography can be an effective qualitative approach due to its strong cultural focus (Gray et al. 2017). Ethnography has evolved since the nineteenth century where it was first recognised and linked to anthropology. The term ethnography evolved from the term ethnology due to the nature of fieldwork undertaken and is commonly used as a credible qualitative research method across disciplines and professions, but it is strongly linked to sociology (Hammersley and Atkinson 2007). Ethnography requires time spent in the field with participants to seek their views and perceptions HVs in this instance, with the inclusion of observing key informants such as SNAs who facilitate the group supervision process. This research takes an ethnographic stance to the data collection rather than months/years spent in the field which is typical of a true ethnography. I spent two working days each with four HVs in the field within two health boards. This allowed me to re-familiarise myself with the day to practice and challenges HVs face. Fieldwork allows the ethnographer time to understand a specific culture how that culture is perceived. Culture can be determined by the actions, words, and behaviours of a specific group (Polit and Beck 2021). The culture of health visiting

underpins this thesis. Healthcare professions are known anecdotally to have their own sort of culture. The way nurses behave may differ from a physiotherapist or an occupational therapist. We all have our own traits, behaviours, and practices in association with our own professions. With this comes the formation of alliances within each area of practice. Anecdotally, a person may be able to identify a HV just by the way they behave and communicate with families and other professions, although Polit and Beck (2021) state that culture is not “visible or tangible” and should be “constructed through ethnographic writing” (p.472). Ethnography offers a holistic view of a culture-health visiting in this instance as well as safeguarding supervision practice.

The emic nature of ethnography allows the researcher to explore the ‘insider’s view of a certain experience (Jacobsen 2017). The insiders/informants within this study are HVs primarily, observed in their day-to-day practice, as well their experience and insider view of their safeguarding supervision experience. The other participants and insiders within this study were the SNAs who deliver the safeguarding supervision. Agar (1986) and Bernard (1994) describe ethnography as the description of the patterns of behaviour of individuals or groups of people in a particular culture. Therefore, as HVs within their specialist role being deemed a culture within themselves, enhanced observation across practice and supervision allowed me to examine and interpret their behaviour and experiences with follow up interviews and focus groups. When seeking information ethnographers use three distinct types of information gathering; cultural behaviour, cultural artefacts, and cultural speech. They, therefore, observe what their participants do (within a culture), what they ‘make and use’ and analyse what they say (Polit and Beck 2021, p.475). This relates to how the HVs were observed in practice, within their safeguarding supervision, how the SNAs facilitated and delivered safeguarding supervision as well as exploring HV and SNA perceptions of the safeguarding supervision process. Ethnography, therefore, relies on several data sources.

5.2 Ontology, axiology, and epistemology

By investigating how safeguarding supervision supports the HV practice, and how the safeguarding supervisor facilitates the supervisory process, a systematic acquisition and critical understanding of their experience was developed. The aim was to generate

new knowledge at the forefront of safeguarding practice in relation to supervision. In Chapter 2, health visiting is discussed to set the role in context and the varying concepts of supervision defining safeguarding and setting safeguarding supervision into context (Chapter 3). This links to the application of ethnography within a constructivist framework offering a "relativist perspective" as described by Jacobsen (2017, p.88). She states that ethnography allows the researcher to explore reality and truth for everyone (ontology), which will then permit the researcher to analyse and define what constitutes (the knowledge) that reality and truth for each participant (epistemology), within a certain experience. However, Jacobsen (2017) also states that individuals can experience more than one reality. Constructivism, therefore, within qualitative research, guides the interpretation of the study design. An ethnographic approach has provided the detail required through fieldwork (Atkinson et al 2017) to not only allow immersion into the culture of health visiting, safeguarding supervision and its impact on practice, but to explore perceptions of HVs and SNAs by undertaking one to one interviews and focus groups to further enhance the data and evidence required to enhance future safeguarding supervision practice.

My stance was as an insider researcher. This provided me with a unique position and relates to epistemology defined as knowing and the generation of knowledge (Gray et al. 2017) as I was able to explore and interpret what was real and true (Jacobsen 2017) for the HVs and SNAs in their safeguarding supervision experience, which takes an ontological stance within the research, referring to what is the reality of the safeguarding supervision experience. Ontology relates to *"...the nature of being, becoming, existence, reality or truth"* (Jacobsen 2017, p.357) experiencing a situation, (safeguarding supervision within this study), existing within that situation, interpreting its reality and value (axiology) within HV practice and SNA practice. The term insider researcher in the context of this study refers to my health visiting background, safeguarding lead background and being employed within some of the health boards in which the research has been undertaken. This gives me a robust knowledge base about the role of the health visitor, safeguarding leads, and supervision process, which links very well to Vygotsky's (1978) concept of social situatedness. Situatedness refers to the relationship

and exchange between the researcher, interviewees, observation participants and focus groups (Costly et al. 2010). This relates to the research I have undertaken where my knowledge of my previous role, knowledge of the role of the health visitor/culture of health visiting, and safeguarding lead role, has been an advantage. As an insider researcher, I needed to be cognisant of the fact that I was observing as a researcher and not within roles I have previously held. Being an insider researcher therefore could also present as a barrier and therefore I was mindful of this throughout each area of the study and reflected on its potential influence.

5.3 Virtual/online ethnography

Virtual ethnography refers to the type of ethnographic research that is carried out online. Ethnographers immerse themselves in a particular culture engaging in fieldwork and in the same instance a virtual ethnographer can study an online community. A term associated with virtual ethnography combines the words of internet and ethnography and is subsequently named *netnography* (Kozinets 2010), but it is also referred to as digital ethnography, online ethnography, or cyber ethnography. It is clearly defined by Kozinets (2006) as:

> *"Ethnography conducted on the Internet; qualitative, interpretive research methodology that adapts the traditional, in person ethnographic research techniques of anthropology to the study of online cultures and communities formed through computer mediated communications."* (Kozinets 2006, p.135).

Due to the constraints associated with the pandemic most of the data were collected virtually and the safeguarding supervision was observed virtually. This delayed data collection as waves of the pandemic hit, and restrictions were put in place to minimise risk of spread of the virus. I was able to utilise ethnographic technique during observations of the safeguarding supervision which will be explored later in this chapter. Most of the interviews and focus groups were undertaken within an online environment. I used Spradley's (1980) Nine Observational Dimensions in Human Interaction, a participant observation model (Table 12) to focus my observations and subsequently analyse my data. This online approach to ethnography became a key aspect of my fieldwork.

5.4 Research design

The research was undertaken within three Welsh local health board (LHB) settings. Health visiting heads of service and safeguarding leads were contacted via email about the proposed study's intention and approved my presence as a researcher within each of the health boards. They were told of the ethical approval process and the need for sponsorship before starting the research study. Sponsorship was obtained from the HEI with ethical approval granted by the Health Research Authority (HRA) as well as a research passport being obtained which allowed me access to move within each individual health board, within the remit of ethical approval/permissions. The health boards cover a broad area, one health board is particularly rural (RHB) with one classed as an inner city /urban area (ICHB) and the third health board as a mix of inner city/urban/rural (ICRHB). They were chosen for this very reason and due to group supervision being well established in all areas.

As discussed in Chapter two, health visiting is delivered under the remit of the Healthy Child Wales Programme (HCWP) (Welsh Government 2016). There were two modes of delivery of this service at the time this research was being undertaken. Namely, via a generic service or flying start service. The research involved HVs and SNAs from within each part of the health visiting service. All observations and data collection were on health board premises or online via an electronic platform called Microsoft Teams. This was due to the pandemic restrictions in place which varied throughout the data collection phase. A range of data collection methods were used, and a pre-focus group questionnaire was planned to be used to obtain demographic information from all participants which included length of time in role, supervision preference, knowledge of safeguarding supervision policy/guidance (Appendix 3). Sixteen HVs and two SNAs completed the questions. Requests to complete the questionnaire were followed up via email and due to restrictions, the demographic questions were asked at the remaining focus groups.

Data collection methods included observation in person and online (HV practice and group supervision) with field note writing, audio recording of one-to-one interviewing and

focus groups, as well as case/field note analysis, demonstrating triangulation of data and credibility within the research findings (Davies and Logan 2012). The plan was to view and analyse health visiting records with two HVs being interviewed in each of the areas. This occurred when face to face interviews were established (hampered by the pandemic restrictions), records were also viewed when observing HV practice in two of the three areas. I was able to view records anonymously. One HV extracted a sample of her record, fully anonymised. This will be explored in more depth within the data collection section of this chapter.

5.5 Fieldwork

My work in the field offered an enhanced experience in exploring the reality of HV practice. I scribed fieldwork records throughout all aspects of field work whether it was face to face or in the online environment. The design of the fieldnotes section follows observation of health visiting practice and observation of safeguarding supervision. I used Spradley's developmental research sequence (Spradley 1980), as it complements his nine observational dimensions in human interaction (Table 9 and 11), this allowed me to focus during any observation and apply this when further analysing the data. I was able to observe four out of the six HVs I had intended to observe. There were six HV interviews, six SNA interviews and seven focus groups. I took detailed handwritten notes in a journal as the observations progressed as part of my ethnographic record. I spent two working days within two of the health boards equating to four days observation in total. I was able to observe HVs in the ICRHB. A wave of the global pandemic prevented me from observing HV practice in the ICRHB. The handwritten journal of field notes also included reflexive comments. I detailed the whole experience which included sensory detail, for example, smell- the smell of a clinic/building or the smell within a family home. This is very much part of an ethnographic observation (Atkinson et al. 2009) and offers a holistic experience and more detailed observation within the fieldwork narrative.

Table 9: Spradley's developmental research sequence

1. Locating a social situation
2. Doing participant observation
3. Making an ethnographic record
4. Making descriptive observations
5. Making a domain analysis
6. Making focused observations
7. Making a taxonomic analysis
8. Making selected observations
9. Making a componential analysis
10. Discovering cultural themes
11. Taking a cultural inventory
12. Writing an ethnography

(Spradley 1980)

5.6 Sample size

The three health boards included in the study were identified and named as Inner-city health board (ICHB), Inner-city/Rural health board (ICRHB) and Rural health board (RHB). At the commencement of this research, the ICHB had 196 HVs and 15 safeguarding supervisors, the ICRHB had 131 HVs and nine safeguarding supervisors, and the RHB had 37 HVs and four safeguarding supervisors to recruit from as participants. The number of participants recruited are identified in Table 11.

Table 10: Participants

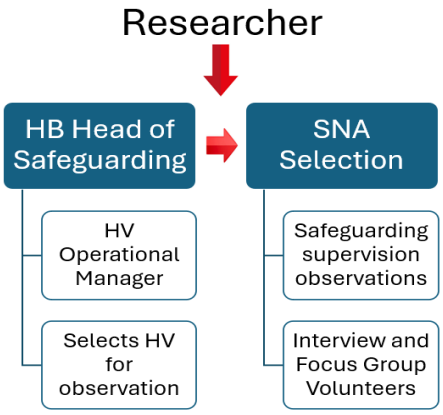
Type of observation/participation	Number of Participants
HV Observation in Practice	4
HV Interviews	6
HV Focus Groups (3)	16
SNA Interviews	6
Safeguarding Supervision observation	22

Key: HV – Health Visitor. SNA – Safeguarding Nurse Advisor

The participants were recruited via public health nursing managers and the safeguarding lead within each health board (Figure 4). These are referred to as gatekeepers by Cresswell (2013) and Wolf (2012), who state they are the main source of contact to approve access to practitioners. It was important to engage with them from

the start of the research proposal development, and I maintained active collaboration as the research began and evolved. Of the 54 participants across the three HBs, three of them were interviewed, observed in practice, and attended focus groups. Two other participants were interviewed and involved in focus groups. The operational managers, safeguarding heads of health boards and the Institute of Health Visiting became advisers/critical friends as the research progressed, similar to an advisory group of practitioners. I was able to connect with the PHW Safeguarding Network as my advisors as the research evolved, and I was able to present progress and findings to them at national meetings and they were able to consider my research findings as they developed and updated safeguarding supervision guidance for Wales.

Figure 5. Recruitment process



When recruiting participants, inclusion and exclusion criteria was applied to recruitment of participants, identified in Table 12 and participant information sheets (Appendix 3) and consent forms were provided.

Table 11: Participant recruitment criteria

Sample Inclusion criteria:
Health visitors qualified for more than 1 year.
Safeguarding lead nurses in post for more than 1 year.
Sample Exclusion criteria.
Newly qualified health visitors (0-1-year post qualification) *.
Other health professionals (in attendance in some supervision groups, for example nursery nurse, midwives).

* Newly qualified HVs were excluded as they receive one-to-one supervision for the first-year post qualification.

5.7 Research methods

The COVID-19 pandemic changed the method of data collection originally planned and the narrative will reflect this in each section. Health board guidance and policy was always adhered to, with use of Personal Protective Equipment (PPE) used, as necessary. The modes of data collection suggested within ethnography allow the researcher to observe the daily activities of the participants in depth. I used the Spradley nine observational dimensions in human interaction to focus my observations (Spradley 1980,Table 13). I considered focusing on and adapting this model of human interaction but by doing that I would have omitted some key elements of the observation and would have minimized the true picture experienced. Depending on the type of observation being undertaken I adapted the model slightly. For example, I omitted goal as this component of the model was not clearly identified within my observations compared to the other eight components featured.

Table 12: Spradley's nine observational dimensions in human interaction

Space – this captures the physical layout of the space.
Actor – the number of participants involved.
Activities – the activities undertaken by the actors.
Object – the objects present within the observation.
Act – the actions observed and undertaken by the participant.
Event – the activities undertaken by the participant.
Time – how the sequence of events unfolds during the observation.
Goal – the goals that people attempt to complete.
Feeling – the expression of emotions
(Spradley 1980)

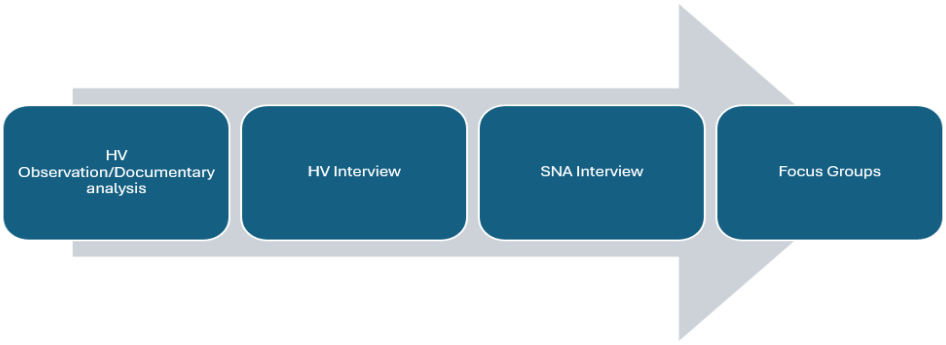
Ethnography allows the researcher as a non-participant to watch what happens and listen to what is said in the field (Hammersley and Atkinson 2007). Ethnography can provide deeper insights into people's work, daily life, and activities, collecting data from detailed observations and interviews (Reeves et al. 2008). The researcher's role is non-participative to ensure a level of 'ethnographic distance. I am a HV by background, and I

have not practiced within the field since 2008. Therefore, it was important for me to observe the field of practice over the three health boards prior to data collection in each of the health boards. The aim was to immerse myself in the culture of health visiting, updating myself and experiencing day-to-day practice. This was observational but essential preparation for me, the health visiting teams, and health boards involved. Gray et al. (2017, p.276) describe this type of learning as "being present". Spradley's (1980) nine observational dimensions in human interaction structured my observations which took place in two out of the three health boards (ICHB, RHB) due to the pandemic (Table 13). Ethnographic records were compiled within the field for my observations of HV practice and safeguarding supervision. Observation of safeguarding supervision was face to face in the ICHB and virtually, via Microsoft Teams in the ICRHB and RHB.

5.8. Data collection methods

Data collection (observations, interviews, focus groups, documentary analysis) commenced in September 2020 with observations in practice of two HVs with documentary analysis in the ICHB, followed by two HV interviews and two SNA interviews. This pattern of data collection occurred within two of the health boards (Figure 4) . The data collection period across all health boards spanned from Sept 2020 until April 2022. The timeline was lengthened due to the restrictions in place enforced by the pandemic. Observations in the first health board were undertaken socially distanced and face to face. In December 2020, a further wave of COVID-19 ensued with further restrictions in place which restricted my access to the second health board from a face-to-face perspective.

Figure 4. Flow of data collection methods



There were delays in accessing staff and priorities had altered within the health board and PhD data collection was not deemed a priority for them. The second period of data collection took place within the first four months of 2021 and was undertaken remotely. I was not granted permission to enter the second health board due to the infection prevention and control regulations in place due to the rapid spread of COVID-19 at that time. Therefore, for ICRHB I did not observe HVs in practice. Safeguarding supervision was observed online, and all interviews were carried out online utilising Microsoft Teams as an interface. The pandemic continued to be a significant barrier to data collection throughout 2021 and permission was finally granted to attend the third health board, rural in nature (RHB) in November 2021, with data collection being completed in April 2022. Due to the change in pandemic restrictions, I was able to observe HVs in practice in the third health board. Observations of group safeguarding supervision and interviews continued to be undertaken via Microsoft Teams as in previous health boards, (Table 13). Data collection took between four and six months in each health board once commenced.

Table 13: Overview of data collection methods

Health Board	Safeguarding supervision observation	Health visitor observation	Health visitor Interview	Safeguarding Lead Nurse Interview	Documentary analysis
ICHB	x2 Face to face socially distanced	Face to face, socially distanced with use of PPE	x1 Face to face socially distanced X1 Microsoft Teams	x2 Face to face socially distanced	x2 electronic
ICRHB	x2 Microsoft Teams	None	x2 Microsoft Teams	x2 Microsoft Teams	None
RHB	x3 Microsoft Teams	x2 Face to face, socially distanced with use of PPE	x2 Microsoft Teams	x2 Microsoft Teams	x2 electronic

Key: ICHB – Inner city health board. ICRHB – Inner city rural health board. RHB – Rural health board

My fieldwork firmly related to the observation of the culture within health visiting safeguarding supervision practice. The HV role as already explored, discussed, and established; is specialist in its very nature. Spradley (2016, p.3) states that *"ethnographic fieldwork is the hallmark of cultural anthropology"* and ethnographers can undertake fieldwork anywhere participating in a wide range of observational methods. This suits the aim of ethnography to explore a particular viewpoint, concept, perception, or opinion within a culture - in this case health visiting and safeguarding supervision.

Due to the safeguarding context the thesis is underpinned by a theoretical framework(s) which relates to safeguarding practice but also can interlink with a person-centred practice framework which focusses on well-being and support of practitioners and the development of healthful cultures. An ecological approach to safeguarding children is a familiar theory used in safeguarding practice and must underpin health visiting practice as safeguarding children is paramount. Risk assessment within health visiting practice is undertaken with an ecological approach in mind. Therefore, the Bronfenbrenner (1979) ecological approach of human development was used as the underpinning theoretical framework. Alongside this, the person-centred framework of McCance and McCormack (2021) was considered in the development of a safeguarding supervision framework which considers a restorative approach whilst developing and then maintaining a healthful culture (Wallbank and Hatton 2011, Wallbank and Woods 2012, McCance and McCormack 2021)

5.9 Theoretical frameworks

5.9.1 Bronfenbrenner's ecological framework of human development

An ecological approach to assessing what constitutes risk for children offers a broader, holistic perspective to safeguarding practice and something that is undertaken in HV practice and considered at safeguarding supervision consciously, but sometimes subconsciously. An ecological approach to safeguarding is a well-known concept and associated with child protection practice and assessment in the UK today (Figure 1). Vygotsky (1978) and Bronfenbrenner (1979) developed learning theories which explored how individual learning is affected by family, friends, the community/culture,

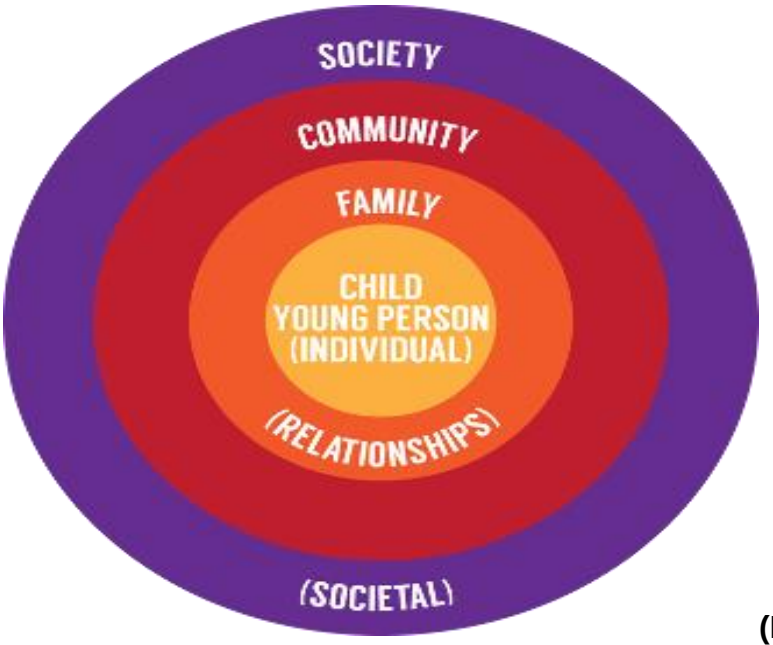
and society in which they live. Bronfenbrenner's (1979) ecological model of human development recognised that child development progress is based on the interactions they receive from its family and surrounding environment. This concept links to the assessment framework triangle (Figure 2) with the child depicted at the centre and it addresses through its domains, the impact of the carers parenting capacity, the environmental factors and the child's developmental needs. Bronfenbrenner describes the domains within his framework as the:

- Microsystem
- Mesosystem
- Exosystem
- Macrosystem

The seminal work of Bronfenbrenner (1979) and Belsky (1980) (Figures 1 and 4) underpins the Assessment Framework (DoH 2000) used throughout local authorities in the UK today and determined that individuals develop within the complexity of social systems which interact and influence each other and includes:

- The characteristics of **the individual.** (What increases the risk of maltreatment of the child?)
- The **micro-system** explores the **relationships** within the **family**. (What increases the risk of maltreatment which is family related?)
- The **exo-system** examines community contexts. (*What is it about the community that increases the risk of child maltreatment?)*
- The **macro-system** includes the cultural beliefs and values of society. (What is it about **society** that increases risk of child maltreatment?)

Figure 6. An adaptation of Bronfenbrenner's (1979) ecological model



(Moseley 2022)

When applying Bronfenbrenner's (1979) model in assessing risk, it involves examining the child's characteristics (physical, emotional, psychological, behavioural). At this level, characteristics can affect child development. Exploration of the complexity associated with family size, family relationships/dynamic, support and protective factors is essential. Consideration will need to be given to family stability as this can directly affect the children as well as parenting capacity which directly influences the way in which parents/carers care for and prioritise their children (Figures 2 and 4). From a community level, the support the community provides must be factored in. For example, are there community factors which would impact the CYP safety and wellbeing, placing them at risk of further harm. Risk factors from a societal level can also impact the safety and wellbeing of CYP. These factors could include safeguarding, public health legislation, cultural and religious beliefs.

Assessing risk in the safeguarding of children is complex. The interacting levels of the ecological model with the child at the centre allows practitioners to explore a preventative and proactive approach to their safeguarding practice. It is essential for

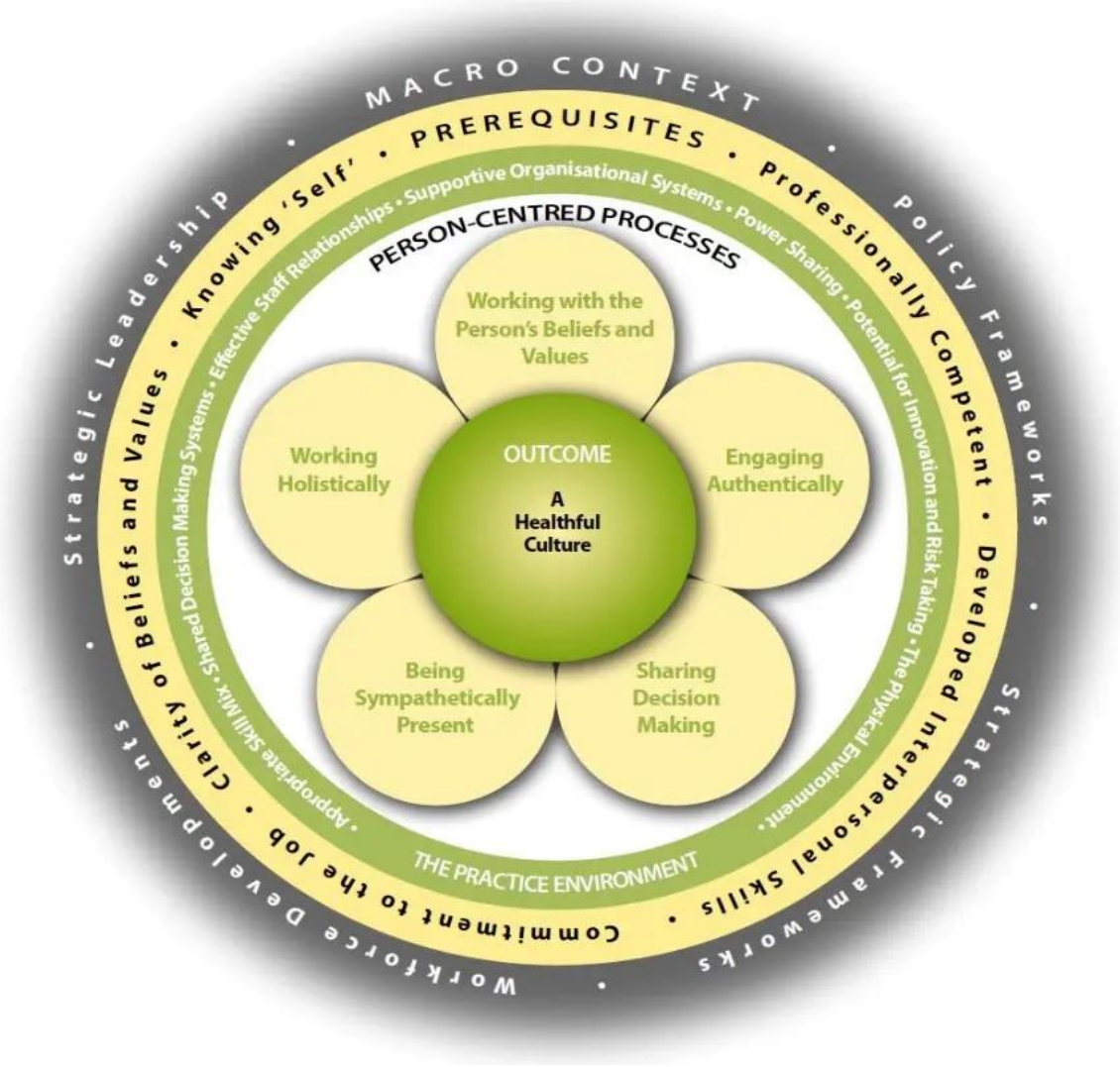
practitioners to be aware of what constitutes significant harm, and how ACEs and escalation of risk has a significant impact on their future wellbeing outcomes. Traditionally, risk is generally associated with familial risk factors within the home environment. The concept of *contextual safeguarding* is related to the risk(s) that CYP are exposed to outside of the family home (Firmin and Lloyd 2020). For example, at community or societal levels and be out of the control/protection of the parent/carer/family, exposing the CYP to significant harm.

The concept of assessing risk and the complexities of safeguarding children should be at the forefront of HVs attending safeguarding supervision and taking families to discuss. Whereas the SNA facilitating supervision requires the necessary knowledge, expertise, and experience in safeguarding supervision to engage, empower and enable HV safeguarding practice. Safeguarding supervision should be underpinned by a structured approach, clear purpose, and direction. It should place the practitioner at the centre and aim to advise, support, and develop a healthful culture in safeguarding practice. This could take a restorative supervision stance. Restorative supervision aims to identify any anxiety, as well as identification of learning and development needs, whilst offering creative, energised and a solution focussed approach (Wallbank 2007, Wallbank and Wonnacott 2016). Therefore, a restorative supervision approach to safeguarding supervision to equip and enable practitioners, links to the development of healthful cultures set out by the research of McCormack et al. (2021) and in particular, the McCance and McCormack person centred practice framework (2021) (Figure 7)

This is applicable to delivery of a structured safeguarding supervision as the SNAs' responsibility in delivering an effective supervision session is paramount in supporting HVs in their safeguarding practice. Health visitors and the SNA should have the underpinning theory of safeguarding supervision as part of their SCPHN education. The application of Bronfenbrenner's ecological model, considering the detail within the Assessment framework triangle (Figure 2) can underpin HV and SNA risk assessment and has been used in consideration of what supports an effective safeguarding supervision approach. These models were considered before and during aspects of the

data collection process when observing and trying to establish the supportive nature of the safeguarding supervision observed. From an organisational and supervisor perspective the person-centred practice framework (McCance and McCormack 2021) was referred to frequently.

Figure 7. The person-centred practice framework



(McCance and McCormack 2021)

Chapter 6: Data collection

The first part of my data collection included spending four initial days observing two HVs in practice in the ICHB. The field notes were structured using Spradley's (1980) Nine observational dimensions in human interaction. I was mindful of each domain, and my initial observations were detailed (Table 14), as I progressed through fieldwork my observations became more succinct although captured the essence of the observation and more importantly the nature of the work undertaken by HVs. Table 15 describes the space in which the observation commenced. I was able to spend two subsequent days in the RHB which offered a different geographical perspective. It is essential that all five senses are utilised when in the field if appropriate. In ethnography research, senses need to be sharpened examining the participants, their culture, environmental detail and being specific in field note taking. It is common for ethnographers to take jottings during their observations (Hammersley and Atkinson 2007, Emerson et al. 2011), allowing them to expand in more depth later within their field note accounts of their observations. The ethnographic researcher needs to be able to identify participants without identifying them on paper. Negative and absent responses can be as significant and powerful as positive and frequent responses. Compilation of fieldnotes is fundamental practice within ethnographic research and proof that the researcher was present (Atkinson et al. 2007). The fieldnotes were initially handwritten in a fieldwork journal enabling a detailed capture of responses before being transcribed. An example is placed in the below table (Table 14).

Table 14: Example transcript: Field work notes 01.09.20 & 02.09.20 ICHB health visiting service.

Space: This Flying Start (FS) base is at a local leisure centre; FS bases are based in local authority buildings due to the FS funding stream from the Government. This base is on the outskirts of city. Driving into the car park I was faced with a red bricked leisure centre closed currently to the public due to its takeover by a regional rugby team. It was a sunny morning, feeling cool and quite autumnal. I reversed into a car park space at the front of the building. The COVID-19 pandemic has meant their training facilities have been taken over by a field hospital. There was a training 3G pitch at the left of the leisure centre which was not in use today. The car park had overgrown weeds and grass between the car parking spaces, due to lack of use throughout COVID-19. I met the HV in the car park and we entered the building from the side entrance on the right of the building. The building is dated in design – a typical 1970/80's, paint work is worn on the door with key fob access. On entry onto the building there was a pile of black bags (not excessively full and approximately 3-4) on the right-hand side containing last week's PPE (aprons, masks, wipes). These will be removed later. The door had to be held shut on entry to ensure it had locked. One flight of stairs climbed. Folded up pram on the left. Entrance to office on left, fob access, we were first to arrive, automatic lights on entry. The office smelled of anti-bacterial gel. The office was a large, long office with a total of nine desks. Four desks on one side with four desks on the other side divided by individual partitions down the middle of the desks. There was one desk placed at the end of the row, again divided by a partition. The desks formed a T shape.

As you walk into the room on the left, there is a large white board on the wall and 3 filing cabinets and one filing cabinet with its back to the window (4 in total) next the single placed directly next to it (the 1 filing cabinet is directly in front of you as you walk into the room with the white board and other 3 filing cabinets on the left. The single cabinet is to the left of the first small window which is cracked and labelled as such. The T shaped desks run through the middle of the room. Under the window there are PPE supplies for staff to take out on visits on a single table. Under the table there are packs of aprons in brown boxes and boxes of surplus surgical gloves. There is unused highchair propped against the radiator under the second window with a stair gate placed behind the highchair. There is a pink wastepaper bin next to the highchair. The walls on this side of room, in-between the windows are scattered with A4 posters with several types of information (significant and relevant phone numbers and FS processes). There is another whiteboard in between the two shuttered windows. This lists the staff members and their mobile contact numbers (HVs and nursery nurses) on the left-hand side and from left to right caseload number, number on child protection cases on caseload, children with 'care and support input number of looked after children on caseload, new births, and transfer in of clients). The nursery nurse data from left to right includes caseload interventions, ante-natal contact, groups, and infant massage. There is space to walk in between the windows and the desks, there are chairs at each desk. Two of the windows have shutters as one is broken. Next to the HVs desk there is another filing cabinet, to

the left of that, a small cabinet with a fax placed on it. Each desk has a three-drawer pedestal cabinet. Under each desk. This varied to the left or right of the desks. Opposite the four desks under the window lie the other four desks directly opposite, divided by a partition. The HV team leader (HV TL) sits opposite the HV to the right of a larger window which faces the front of the leisure centre, overlooking the front car park. The four desks on the HV TL side have their back to 2 store cupboards, the toilet, and the well-equipped kitchen. Desks in use by staff members are cluttered due to work being accessed with paper, post it notes, mobile phones and telephone headsets. There is another white board behind the HV TL as an information board containing policies/pathways. There are A4 posters in poly pockets to the side of the white board stuck to some pipework as well as behind the pipework. They are stuck to the wall with Sellotape. To the left of these posters is the kitchen then the toilet. Outside of the toilet is a mini filing cabinet with anti-bacterial gel and wipes with instructions to cleanse door handles, toilet flush, taps, post use due to COVID-19.

6.1 Observation of group supervision

It was planned to observe two safeguarding supervision groups in each health board. This occurred in the ICHB and ICRHB. In the RHB, I observed three sessions; as in the first observed session, there was only one HV present. This health board offers joint supervision with midwives and health visitors. The ICHB had commenced mixed supervision with nursery nurses, and one attended my first observation. Field notes were collated for further reflection and in-depth analysis. Each observed supervision was undertaken on a separate day and was not audio recorded; data were collected through use of fieldnotes. Health visitors need to be able to talk freely in the session and it was felt recording may hamper this, although having a researcher present may also impact on how the HVs present their cases. I reassured all participants prior to the group commencing, to remember that I was present as a researcher observing only. I also stressed that I will not be participating within the group in any way. They had the opportunity to view the participant information sheet relating to the research at least two weeks prior to the observation. This allowed any questions to be directed to the researcher and an option to opt out prior to the commencement of the observation. Many of the HVs knew me due to my previous roles and I emphasised my role as a researcher at each session. It was hoped that I blended into the session and that the HVs did not feel restricted in being open in their case presentations and subsequent discussion. The HVs were reminded to anonymise any family brought to supervision or use a pseudonym in line with Nursing and Midwifery Council Code of Conduct (NMC 2018) and the Data Protection Act (2018).

Through observing the group supervision session, the health visitors' perceptions and in particular, interaction and attitude to group supervision became evident. I was able to explore the world of safeguarding supervision through observing health visitors' responses, verbally and non-verbally. Spradley (2016 p.3) refers to ethnography as 'learning from people' rather than studying them, learning from participant responses which informed further development of the interview schedule. The safeguarding supervision groups took place in a mutually agreed venue by the health visiting and safeguarding teams. They were scheduled for between 1- 2.5 hours in length (health

board dependent) with a varied number of HVs attending across the three health boards. The numbers in attendance were recorded. Spradley's (1980) framework was used to formalize field note structure as well as subsequent interviews. An example of how this was applied in the supervision observation is captured within the below table.

Table 15: Application of Spradley's (1980) framework

Space - Where is the supervision undertaken, what is the environment like, social distancing will be considered. The detail of the environment will be reflected throughout the fieldnotes.
Actors – Observation of the HVs and SNAs.
Activity – The activities that occur during the observation.
Objects – This will relate to the layout of the physical environment.
Acts – The behaviour/actions/responses of the HV and SNA within the session.
Events – Recording of the actual event – safeguarding supervision.
Time – The events timeline.
Goals – This refers to the expectations of the participant, their expectations of the supervision.
Feelings – Any emotions observed during the event by the participants including researchers' feelings.

6.2 Pre- Focus group /interview demographic questionnaire and consent.

I planned to undertake a pre-focus group questionnaire (Appendix 4) prior to the focus groups and subsequent interviews to explore the broad demographic determinants of the participants. The aim of obtaining this data allowed exploration of how long the participants had been working as HVs as well as which area of health visiting, they work in (generic or flying start). They were asked to rate group supervision and one to one supervision using a Likert scale. It was hoped that their knowledge of local and national policy would also be determined. Due to the pandemic restrictions, which allowed home working at this time, this information was sought in the introduction at focus groups and the questions adapted regarding preference of style of safeguarding supervision. This applied to consent also. Some participants were unable to access resources to scan and email consent forms. Some photographed and emailed them to me. I ensured my record of consent was recorded verbally on recordings of each focus group, where each participant consented to taking part in the study.

6.3 Focus groups with health visitors

Focus groups are a useful means of data collection when accessing a group of participants for the purpose of data collection (Gray et al. 2017). They are commonly used within nursing qualitative research. It is important that focus groups are undertaken in a non-threatening environment (Kruegar and Casey 2015). In general, participants within focus groups are selected from the same discipline or area of interest, there is some commonality amongst the participants. Focus groups have been reported to allow participants to express themselves in a different way to which they would express themselves in a one-to-one interview situation (Kruegar and Casey 2015). There are many benefits from a resource perspective in utilising focus groups in research. Participants may feel more confident to express themselves in small groups, and discussion can potentially trigger new ideas and concepts. The researcher or facilitator of the focus group requires the necessary skills and attributes to facilitate discussion, empower individuals to feel confident to become involved, and strengthen the group dynamic, aiding a free flow of discussion and sharing of thoughts/ideas. Some disadvantages to focus groups include participants who dominate the discussion, an inexperienced facilitator/researcher leading the group, too many participants within the group and lack of respect within the group. Therefore, the group facilitator must set out ground rules prior to the start of the focus group and ensure all participants are clear of the process and purpose of the group.

The focus groups with the HVs followed on from the observation of the safeguarding supervision session. The observation informed the development of the questions with flexibility to add/remove questions which were semi-structured in design. The initial plan was to undertake each focus group within the health boards. This was possible in one of the three health boards (ICHB). Focus groups were undertaken online via Microsoft Teams for ICRHB and RHB. One focus group was established from the two safeguarding supervision sessions observed within each health board. Participants were asked to volunteer to attend the focus group and an in person maximum number of twelve participants was set for face-to-face groups. The first face to face groups were of four and five participants and took place on health board premises, socially distanced

and mask wearing was in place as per Government and health board guidance. I was concerned about communication whilst wearing masks and reading facial expressions as well as whether this would hamper interaction between the group as well as if sound would be muffled. Therefore, I took more in-depth field notes within these first two sessions.

All focus groups were audio recorded with field notes also being taken. Transcription recording of participants was anonymised. Participants did mention each other's names, but these were omitted from transcriptions as was any mention of specific area associated with the discussion. Ground rules were set prior to the discussion starting and did include discussion of anonymising all family names and areas. Spradley's (1980) framework was applied throughout observation of the focus groups and interviews. Questioning (Appendix 6 and 7) explored the mode of supervision received, what works well within the supervision, the number of cases taken, how cases are prioritised, how the discussion within the supervisory process impacts on practice, the structure of the supervision, if participants access one to one as well as group supervision and if they feel it enhances their safeguarding practice.

6.4 One to one semi- structured interviews with health visitors

In depth interviewing is a common research technique to gain data in qualitative research (Jacobsen 2021). Open ended questions are used but in the case of semi-structured interviews the questions are merely guidance and prompts, which allow the researcher to explore points/topics as they arise. They allow the interviewer a sense of freedom whilst offering a structured approach to maintain focus around the research question. The interviewer can probe the interviewee with aim to expand a particular response whilst also observing body language and from an ethnographic stance interaction with the surrounding environment.

Following the focus groups, two HVs were asked to volunteer to be interviewed. If no – one volunteered the SNA would be asked to randomly select participants. There were volunteers at every health board. I wanted to explore their supervision around a family that they had brought to the supervision session in more depth, and if they had

undertaken a practice visit post supervision and if that session had influenced their insight in the family issues/risk assessment. The sample size was six HVs across the three health boards, two from each. I continued to make use of the ethnographic framework by Spradley (1980) to ensure consistency and it was used to formalise a structure to the interview and how the HV potentially related to the visit, drawing on all her (participants were all female) senses. I was also cognisant of the underpinning knowledge of the HV from an ecological model perspective in relation to the assessment of risk.

The nine dimensions were at the forefront of my questions in asking the HV to examine the home visit undertaken post supervision. The framework and semi-structured questioning were applied to the HV interview. The overarching aim was to explore participants' experience of safeguarding within the home and how the safeguarding supervision process had guided their practice. The questions were designed to allow me to gain an ethnographic insight into the HVs own observations within the safeguarding visit they have undertaken, as well as exploring and interpreting their perception of the support safeguarding supervision provides. Questioning considered a combination of me observing the HV within the interview and their view on the home visit and the impact of safeguarding supervision (Appendix 6 and 7).

Table 16: Reflection of home visit post supervision

Space - how the home environment is set out/ the HV interview setting.
Actors - The participants are the health visitors, but the family will be referred to within this context and questioning will explore health visitors' perceptions and description of family 'make-up.'
Activity – This will relate to the activity within the home visit and the activity within the interview with the HV.
Objects - Exploration via the interview of the components of the physical home environment, as well as the interview physical environment.
Acts – Questioning will explore the family responses within the visit as well as the HVs verbal and non-verbal responses within the interview.
Events - The home visit experience will be explored with the HVs perceptions, application of the supervision to practice.
Timeline - Timeline of the home visit as well as the interview.

Goals - HV perception of the family goals and expectations as well as the expectations/goals of the HV within the visit and following the visit.
Feelings - any emotions perceived by the HV within the family home, the family dynamic/ emotions explored, and the emotions of the HV during the interview.

Each interview was audio-recorded with a Dictaphone, stored safely as per ethical considerations – in a locked cabinet, within a locked room when not in use. Questions were structured and designed to obtain in depth rich qualitative data and took a chronological flow to enhance structure and flow for the interviewee (Polit and Beck 2021). Whilst the interview was being recorded, I took an ethnographic stance in observing the participants throughout the process and made ethnographic field notes. Interview questions are presented in Appendix 5. I undertook one face to face interview socially distanced on health board premises. The other five interviews were undertaken virtually, via the Microsoft Teams interface (due to the pandemic and latterly due the distance/location of the HVs). The ethnographic field notes of the online interviews took a different path to if I was interviewing in person. I had to read facial expression online, sometimes the signal would be interrupted, and the interview would stop while the interviewee signed back in or, the interviewee was in an office with background noise, and I was able to see lapses in concentration as conversation drifted and I attempted to draw the conversation back to the interview.

6.5 Documentary analysis

Following the HV interviews and on the same day, I aimed to review how they recorded the safeguarding supervision within their health record and then also review how they document their home visit. I wanted to explore if the advice and support provided within safeguarding supervision is transferred into practice, and if this was depicted within their documentation. I was able to do this with one HV post interview in ICHB and in person with two HVs in the RHB. One HV anonymised the narrative from her record and emailed it to me and the remaining two HVs discussed, read out what their record obtained during the online interviews. The documentary analysis involved the HVs extracting their safeguarding plans (if electronic records were used) extracting any communication with the safeguarding lead nurse associated with the family brought to

supervision, and the outcome of home visit out of the patient record). Those who were able copied and pasted the plan onto separate documents to ensure family anonymity or hid family details from my sight to allow me to view the record. The participants anonymised any identifiable information as stipulated within the approval process. One of health boards used paper records and these HVs were the HVs who discussed what they had written and where they had recorded that information. These data collection techniques have the potential to capture rich data that can inform practice. This ensured triangulation of data to improve the rigour of the research (Davies and Logan 2012). The criteria for the documentary analysis are captured in Appendix 10 and were applied when viewing the four sets of records. This triggered conversations with all HVs about accountability of who records the supervision session – the HV or the SNA.

6.6 One to one semi-structured interviews with safeguarding nurse advisors

I interviewed 6 SNAs across the three health boards all of whom facilitated the group supervision sessions I observed. The interviews were semi-structured in design with an ethnographic stance applied as with the HV interviews. I undertook two face-to-face interviews, socially distanced on ICHB premises. Masks were worn as per health board and government guidelines. Four interviews were undertaken on Microsoft Teams. The questions explored the experience of the SNA (considering the person-centred practice framework and ecological model), the level of training/any training that the SNA has undertaken to deliver this type of supervision, as well as their perceptions as to how effective the supervision process is for HVs as well as any perceived challenges/barriers in delivering the safeguarding supervision. I was particularly interested in how the SNAs have been trained to deliver safeguarding supervision. I explored this as well as their understanding and knowledge of the structure of the session, their knowledge of safeguarding supervision theory and its application to practice. I wanted to discover how health boards train their SNAs, as safeguarding supervision is an integral part of the SNA role, as well as determining what support the SNAs receive, in the form of their own supervision. Each interview was audio recorded on a Dictaphone. Example interview questions used for the SNAs are found in Appendix 11.

The supervisory role must be effective to enable the supervisee (HV) to feel supported and empowered within their safeguarding role. They require a supervisor who is knowledgeable, trained, and confident in facilitation of the supervisory process. The aim of supervision is to foster self-reliance for the supervisee, build confidence and belief in their potential as practitioners. This was a key element of this ethnographic study by involving the supervisors as key informants.

6.7 Gaining ethical approval/ethical issues

The study was undertaken according to the Research Governance Frameworks for Wales (Welsh Assembly Government 2009 (initially) , Health Research Authority 2025 (subsequently)). The study was sponsored by Cardiff University and NHS approval was obtained via the HRA. Informed consent was obtained from each participant in the format of a written consent form. This included consent for the interviews, observation of group supervision, HV practice and focus groups. Information sheets were provided and included the research aim, method, proposed benefits, and any potential risks, intended use of data and ethical principles that the researcher would adhere to (Appendix 5). The four ethical principles developed by Beauchamp and Childress (2013) allow nurses and midwives to consider their *'ethical competence'* within their practice ensuring patients are at the centre of their practice and in the development and delivery of research to cause no harm. (Dunn 2024). From a research perspective they apply to participants involved in a study (patients or practitioners) as well as the researcher adhering to the NMC code of Professional conduct (NMC 2024). The Code of Conduct must be adhered to with its four underlying constructs of prioritising people, practising effectively, preserving safety, and promoting professionalism and trust (NMC 2024). These constructs/standards within the NMC code work in partnership with the four ethical principles (Beauchamp and Childress 2013) of:

- Autonomy
- Beneficence
- Non- maleficence
- Justice

One ethical dilemma that presented itself early on was I had taught many of the HVs who potentially could be included in the study as participants (2013 – 2020), I had also worked in one of the HBs as a Lead Nurse in Safeguarding (2007 – 2013) and been a HV in two out of the three Health Boards early on in my HV career (2003 – 2007). I was therefore truly clear from the outset of considering the research in these areas and assessed any risks to research rigour and integrity with my PhD supervisors. The safeguarding heads and operational managers were consulted and saw this as advantageous rather than bias and therefore they selected HVs for observation, and the safeguarding leads governed which safeguarding supervision sessions I had access to. A clear boundary was put in place with the HVs if I had taught them as I had had a lecturer/student relationship with them previously. I was clear that I was observing their practice as a researcher only.

In relation to this study, the participants (HVs and SNAs) were autonomous in the fact they could leave the study at any time and input into the study at their discretion. This principle inter-relates with the prioritising people element within the NMC code of conduct with the recognition of individual control, choice, and consent. They were informed about the study via a Participation information sheet (Appendix 3). Participants were given a minimum of five working days to read the information sheet and were encouraged to raise any issues prior to being asked to participate in the study.

The plan was to collect the consent forms and transport them to university premises, scan and upload them to a password protected computer. I specified that during the upload process (one-two days maximum), any paper copies would be stored in a locked filing cabinet within a locked room. As the primary researcher I would only have access to the locked filing cabinet. Once uploaded, the consent forms would be destroyed by being shredded. Consent form collection and capture was hampered by the pandemic. I was able to follow the above process with six of the participants whilst observing and/or interviewing them in practice. Some participants scanned and emailed their consent forms and those who had no access to a scanner provided me with verbal consent which was recorded with the transcriptions of interviews/focus groups.

As part of the ethical approval process, I made the research ethics committee aware that within the supervisory session, HVs will be discussing families and confidentiality must be maintained. The HVs would be asked to anonymise the discussion in line with (NMC) guidelines (NMC 2018). This was included in the information sheet prior to the supervision. This relates to the ethical principle beneficence and non-maleficence. The study was exploring if safeguarding supervision was effective and if so, the study would potentially benefit their practice in the future and subsequently the babies, children, and families within their caseloads. If the HVs are being supported within the safeguarding element of their role, their emotional well-being, resilience, compassion satisfaction could be enhanced. Beneficence relates to promoting the best interests of patients and links to the prioritising people standard within the NMC code with non-maleficence ensuring no harm befalls a patient and therefore interrelates with the preserving safety standard. It is central to nursing and midwifery practice to do no harm (Dunn 20224, NMC 2024). Within research, it is central to do no harm to the participants (WHO 2025).

A process of escalation was in place if poor practice was identified, I was to inform the Head of Safeguarding initially. Health Board processes were adhered to, and all information gathered was kept confidential, except where disclosure may affect patient or staff safety. The participant information sheet stated that the information will be disclosed to the area SNA, the line manager, Head of Safeguarding, and the Deputy Executive Nurse Director. If any safeguarding issue arose during any aspect of the data collection, the process set out by the Wales Safeguarding Procedures (Wales Safeguarding Procedures, 2019) and Social Services and Well-being (Wales) Act (Welsh Government 2016) would be followed. The ‘Justice’ ethical principle relates to equality in healthcare (Dunn 2024). Its application to research implies the element of governance which sits with the ethics panels and ethics process, as well as the advisory panels set in place to ensure equity and fairness across any research study and its delivery to ensure patient safety and well-being. (NMC 2024)

An informal advisory group of professionals was established from the start of the project to access, and trouble shoot ideas on an individual basis. This initially involved a

representative from the safeguarding team at PHW, the safeguarding lead nurse within each of the health boards, a HV not involved in the study, and a HV academic. The role of the advisory group of professionals was to discuss and consider any potential ethical issues and potential solutions. Access to Health Board leads continued as well as an established relationship with the Designated Leads for Safeguarding at PHW. I have also been able to engage with a lead from the Institute of health visiting who acts as a critical friend.

Focus group and interview data were transcribed by an external accredited transcriber as well as the researcher. A confidentiality agreement was agreed and signed by the transcriber. As primary researcher there was an expectation to undertake information security and consent training. This was completed prior to data collection commencing. Data transcripts will be kept for 5 years on a password protected computer to which only the research team and the Data Custodian at Cardiff University have access.

Transcripts were anonymised with a study number. Participants' names have not been stored with the transcripts. The focus groups were undertaken at health board premises when able. With pandemic restrictions in place at the time the research ethics committee were contacted, and I met with the Chair to gain permission to undertake some observations and interviews online as this mode of data collection was not included in the original research ethics application. This was consented. All data was anonymised and stored in line with the Data Protection Act (2018). The data was secured, archived, and will be deleted after five years. There was potential that practitioners could become upset when discussing cases (in the supervision process). The ethics criteria set out to support them via the SNA. It was indicated within the consent form that they can withdraw at any time from the data collection. Face to face groups were planned and geographically placed where support was accessible during the duration of the group. This was more challenging when online meetings occurred although, support could be provided by the SNA face to face or online if necessary. I identified myself as lead researcher and facilitator of the focus groups and interviews as well as role of observer. Due to my previous experience as a Lead Nurse Safeguarding

Children, professional boundaries were maintained with any practice issues being addressed with the Head of Safeguarding. It is essential that awareness and competence of ethical matters is at the forefront of nursing and midwifery practice and research to ensure integrity and acting in the best interests of participants and the patients they care for.

6.8 Data analysis

Data analysis, coding and management in qualitative research involves converting mass datasets into reduced segments which are more manageable (Polit and Beck 2021). Analysis within a qualitative paradigm involves the discovery of ideas and concepts through a process which is inductive and there are a variety of processes to utilise which code and analyse data. Analysis is commenced by establishing broad categories (Polit and Beck 2021) which are subsequently coded and themed. A theme is described by Polit and Beck (2021, p.543) as:

> *"…an abstract entity that brings meaning and identity to a current experience and its variant manifestations……. a theme captures and unifies the nature or basis of the experience into a meaningful whole."*

Spradley (1979) refers to thematic analysis to include a similarity principle and contrast principle. The similarity principle relates to looking for similarity within the data with similar meanings or traits, and the contrast principle refers to identifying distinctive features within themes the categories. When it comes to ethnographic analysis Polit and Beck (2021) state that ethnographers are always searching for themes or patterns within participant behaviour. This is indicative of them being immersed within a culture to allow for enhanced research experience with a deeper understanding. Spradley's (1979) research sequence is sometimes used to analyse ethnographic data and consists of 12 steps which includes data collection and analysis. He includes four levels of data analysis:

- Domain analysis (Domains are broad categories (themes) and these are recognised within this first phase).
- Taxonomic analysis (Decision of the number of domains to be featured in the analysis).

- Componential analysis (Analysis of similarities/differences within the culture/research)
- Theme analysis (the uncovering of cultural themes)

As part of the data analysis process, I reviewed and considered the underpinning theory related to qualitative data analysis and applied Braun and Clarke's (2022) six phases of reflexive thematic analysis to my data. It offered a straightforward approach and a framework that was applicable to the type of research methodology I had chosen. Braun and Clarke (2022) describe thematic analysis as a robust method of analysis especially to new researchers. Thematic analysis allows the researcher to systematically develop, analyse and interpret data via coding to establish key themes. Braun and Clarke (2022) take the thematic approach one step further by taking a reflexive stance. Taking a reflexive approach to data analysis can enhance the process. Braun and Clarke (2022) define reflexivity as involving:

> *"…the practice of critical reflection on your role as the researcher, and your research practice and process…Reflexive TA captures approaches fully embedded within the values of a qualitative paradigm, which then inform research practice."* (p.5)

This definition appealed to my own reflexivity during not only data analysis but through this whole process as an insider researcher. I therefore applied the six phases of reflexive thematic analysis (Braun and Clarke 2022) to interpret my data. Due to the extensive data obtained I found taking a systematic approach to its analysis offered structure and focus. I opted not to use an electronic data analysis tool. I captured my data on Microsoft word and then transferred it onto excel spreadsheets. My chosen process was explored under the contemporary six phase headings of reflexive thematic analysis (Braun and Clarke 2022).

Phase 1: Familiarising yourself with the dataset:

All my data was transcribed onto a word document. The recorded interviews and focus groups were kept secure and for future reference. To grasp the extensive data gained, I immersed myself by listening to the transcripts in sections. I read and re-read my data,

listened to the interviews, and made notes on the word document as to any dominant key words which were established into codes (key words/phrases/ Appendix 8).

Phase 2: Coding

Codes are described as the *building blocks* of analysis (Braun and Clarke 2022, p229). I was able to identify key sections of data that generated interest and contemporary ideas pertinent to my research question. These were given code labels Braun and Clarke (2022) state that coding can be given different levels. I did experience this and some codes either matched similar codes and therefore were amalgamated or, some codes were omitted from the overall these established as they were not as prominent. Each dataset was coded and subsequently themed.

Phase 3: Generating initial themes.

Themes are developed from the codes established and I was soon able to distinguish patterns within the data. This was enhanced by continuous immersion within the data; re-reading and listening to interviews. I was able to cluster the codes across each set of data – HV interviews, SNA interviews, focus groups and field notes. I constructed the themes which were based around the data. They took shape based on each of the professionals (HV and SNA) involved and the impact of COVID-19. The codes were representative of specific meanings and themes related to those meanings in a broader context.

Phase 4: Developing reviewing themes.

This phase allows checking of the themes to the data. This was achieved by re-reading and reviewing all data. I checked the themes to ensure they related to the coding and extracted narrative (this was compiled on spreadsheets – Appendix 8). Some themes were refined, and they could be amalgamated within a broader theme and presented as a subsequent sub-theme. It was important to remain focused, reflexive and with my eye on the research question as there was risk to drift with so much data.

Phase 5: Refining, defining, and naming themes.

Refining the analysis of data was undertaken to ensure that each theme was well established. Braun and Clarke (2022) refer to *"what story does this theme tell*?" and *"how does this theme fit into my overall story about the data?"* (p.36). To establish this, I started writing up an overview of each theme with its potential structure including the sub-themes.

Phase 6: Writing up.

This is an integral part of reflexive thematic analysis and should start from phase three to allow for immersion in data and ongoing analysis. As soon as the codes led to theme development, each section of the findings from the data analysis started to take shape and included direct excerpts from the data to bring the narrative to life. I was able to use the voice of the participants to emphasise themes with real life experience and their perceptions with the aim of producing an analytical, compelling narrative.

This methods chapter has set out to justify and demonstrate the appropriateness of the ethnographic stance taken. This contemporary approach is used to explore the supportive nature of safeguarding supervision for HVs. The chapter breaks down into the detail of how the research was undertaken including how data were collected, methodology used with the consideration of key theoretical frameworks which underpin safeguarding children as well as taking a person-centred approach to practice. The ethical process is described which leads into how the data were analysed using the systematic approach described by Braun and Clarke (2022) as reflexive thematic analysis. The data analysis section leads into the next chapter which encompasses and demonstrates the final writing up phase as described above.

Chapter 7: Findings: Health visitor perceptions of safeguarding supervision

The findings from the analysis of data were divided into the next three findings chapters with the following main headings:

- Health visitor perceptions of safeguarding supervision.
- Delivery of safeguarding supervision – The SNA perspective.
- The impact on the delivery of safeguarding supervision during the COVID-19 pandemic.

Each chapter is further divided into sub-themes, they will each be summarised before progressing to the next chapter and conclude with an overall summary. The impact of COVID-19 is included as a shorter chapter at the end of the findings section as safeguarding supervision delivery changed due to the restrictions that were mandated at that time, and it was included to explore whether safeguarding supervision support was hampered or not. It is relevant when exploring the supportive nature of safeguarding supervision and relates to overall aim of the research. The narrative around the impact of the pandemic naturally evolved during interviews and focus groups specifically. I also make note of my observations across the health boards. To note, data suggested that COVID-19 had a significant impact on the role and responsibilities of the HV in accessing the families within their caseloads and impacted their relationships with each other and other agencies. This is not included in this chapter as it navigates away from the research question. For context, the usual HV service was depleted for approximately seven months. Health visitors shared their perceptions of safeguarding supervision which follows. They relate to their overall experience including the time receiving safeguarding supervision during the pandemic.

7.0 The positives of safeguarding supervision

The interviews and focus groups with HVs explored what they felt were the benefits to receiving safeguarding supervision, their experiences and perceptions varied. This seemed to be determined on how much one to one supervision they felt they required which also seemed to be linked to their experience in health visiting. Some participants

were more confident than others, which is expected based on role experience and time within role. Some participants had vulnerable families within their caseloads which required discussion and support from safeguarding advisers more regularly, compared to those with less vulnerability within their caseload. One of the HVs, a year post qualification responded to my question regarding regular access to supervision, particularly one to one, stating:

> *'I think firstly it's probably because of the nature of my caseload because it's a vulnerable caseload. Secondly, experiences I've never come across before. I would always ask for advice because I'm hoping that as I become more experienced in my role then I'll be able to pull on that knowledge base, without having to access safeguarding supervision first, but I would always ask if I wasn't sure 'coz I think that's really, really sensible, safe and professional.'* (HV2 ICHB).

At the time of data collection, she preferred one to one supervision,

> *'I've been qualified for a year, but there's always a new experience. Sometimes you know what with COVID and things there isn't a team member or somebody you can ask for support. Sometimes you are in this situation where you think.... you are so embroiled in that situation.... It can be quite emotive.... with safeguarding and things and I think sometimes it's really sensible to get somebody outside looking in to see right, OK, what have you done? What haven't we done? Did you know to see that kind of bigger picture?* (HV2 ICHB).

Some of the more qualified HVs accessed one to one supervision less frequently. One stated:

> *"I very, very rarely have I had one to one, well I've had telephone calls so yes that is one to one just to run something past somebody and make sure what I was doing was correct."* (HV FG ICHB).

This HV only accessed ad hoc one to one supervision if she was really struggling with a case.

> *"It's just when I'm struggling, I think, or I think I'm wavering a bit or am I trotting along a little bit in a certain case, but it is very ad hoc yes, I don't need it regularly I must say. There's always somebody there if you need it which is great, to know there's someone there.* (HV4 ICRHB).

Health Visitors were very aware that family needs and situations vary, sometimes workload could feel overwhelming HV5 RHB referred to this as *'being full'* hence the need for safeguarding supervision,

> *".... you're full so you can't see it and that's the whole point of having it isn't it? .... we all know what we're supposed to be doing.... we've all had safeguarding training …. we all know the policies but sometimes families don't fit policies, do they?.....Families don't fit this little ideal of this little box."* (HV5 RHB).

Safeguarding supervision aims to facilitate a structured discussion with the outcome of offering potential solutions/options to complex safeguarding-based issues associated with families within the HV caseload.

> *"Sometimes you just need someone to say.... go do that"* (HV5 RHB).

Health visitor one (HV1, ICHB) felt it provides her with support and expert opinion. When asked if safeguarding supervision aided her practice she stated,

> *".... Yes, it does, offers reassurance, also as well I think when your safeguarding supervisor.... they've got that experience in safeguarding, the ways of the law, and things like that.... they've got more knowledge then of the process I suppose and a little bit more objectivity as well, they can see something that you won't see."* (HV1 ICHB).

The SNAs in this health board had access to 'higher level' electronic records which they access to inform the HV if there are any concerns or new risks identified which the HVs find particularly useful.

> *"The SNA had different access on the electronic health record compared to the health visitors for example, they could access midwifery information mental health information and domestic abuse information. As HV1 and the SNA were speaking there was some chatter amongst the other HVs which caused some distraction for R briefly. The SNA provided an overview of the plan of action for the HV1 who was writing some notes on her A4 'Signs of Safety' pro-forma." (Filed notes – face to face safeguarding supervision ICHB)*

The SNAs access this information within the group supervision sessions to aid critical thinking and risk assessment. HV3 (ICHB) stated that,

> *"Supervision can .... confirm that you're on the right path or steer you down another path and either way that's going to give you confidence to take your next step and kind of move forward in beginning your evidence investigation."* (HV3 ICHB).

During my observations of safeguarding supervision I observed the interaction of the SNA and HVs and how peer support was employed and appreciated.

> *"The SNA advised that they review the risk factors associated with the case and they talk through them together. Although there had been no domestic abuse incidents recently there was a history of violent offending 10 months ago, there had been short period of child protection registration. There was some discussion around how probation services could support the family further. The discussion was rich between HV1, HV2, the NN, and the SNA."* (Field notes - face to face safeguarding supervision observation ICHB)

I also saw how one SNA accessed enhanced information via the electronic record to offer further insight into the supervision narrative.

> *"The SNA continued to review the domestic incident information and history of this family and shared the information with the group (No MARAC, PPN shared with local authority, engaging with GP, supportive grandparents). HV2 asked "where do we go?" There was a broad discussion about the previous risk factors and protective factors. HV3 was able to offer some history of mental health issues and previous child protection referrals. The SNA was able to reinforce this history with a background of support received as well as summarising there had been four PPNs over the year, three of which were mental health related and one associated with domestic abuse."* (Field notes, safeguarding supervision observation ICHB)

Instant access to the electronic record was useful and used in two of HBs.

7.1 Access to and variability of safeguarding supervision

The regularity of safeguarding supervision varied across the health boards. For example, in the ICRHB within the flying start service access to safeguarding supervision was six monthly via the corporate safeguarding team. The corporate safeguarding team covers the whole health board for safeguarding advice and support and offers regular safeguarding supervision to all HVs and SNs.

> ***"Space:** Online group supervision via Microsoft Teams, accessed from my home. Health visitors and SNA were in their office bases.*
>
> ***Actors:** Five HVs in attendance, SNA 3 facilitating. General introductions given, started promptly, general 'chit chat' to start.*
>
> ***Objects:** Online space, each HV and SNA had 'blurred' backgrounds. During the HV discussion the camera flickered intermittently, and she had to turn camera on and off due to the poor 'bandwidth' in the office. There was a lot of background noise (conversations).*
>
> ***Acts/Events:** SNA set ground rules, I turned my camera off post introductions, consent obtained verbally to observe. Reassured participants the observation*

would not be recorded just fieldnotes to be taken. SNA opened the discussion asking if anyone had a case they would like to discuss.

Each HV gave a summary of the cases they could discuss, (HV1 – HV5) and the SNA listed the cases to be discussed and in what order. (One case to be included here but three cases were discussed in total).” (Field notes - Virtual group supervision observation ICRHB)

The flying start service are also offered safeguarding supervision on a one-to-one basis by their ‘vulnerable leads.’ This equated to supervision occurring every three to four months within the ICRHB. This was confirmed by HV3 (ICRHB) who refers to this culture within flying start in this particular HB.

“We tend to have a culture in Flying Start...you have six monthly with Flying Start lead, safeguarding lead and then six monthly corporate. Obviously …. time wise it works out at every three months, and I think pretty much everyone is on that but sometimes the three months might lead into four because of you know various different commitments.” (HV3 1CRHB).

These *commitments* would refer to attendance at a child protection meeting which would take priority. This HV enjoyed the different types of supervision this included feeling reassured by the other cases brought to supervision by other HVs in the group supervision format.

“I think I like the mix of both, I quite like the one to one because you can really, you know you’ve got the time then you can really pull it apart, …. and really nit-pick at it.... and really concentrate just …...and then I think I like the group supervision to talk about lots of different experiences and lots of different opinions coming in.... not just about my case …. as I said that is kind of quite you know, quite reassuring...” (HV3 ICRHB).

Health visitor six (HV6) in the RHB agreed that a mix of both styles of supervision is useful.

“.... it’s two totally different concepts and I suppose next question you might ask me is would I go back to one to one and I think a mixture of both is probably best.” (HV6 RHB).

Other HVs felt reassured within the group supervision setting gaining support from each other as well as the realisation that others had similar caseloads with similar challenges, making then feel less alone with their caseload anxieties.

> *"Each HV gave a summary of the cases they could discuss, (HV1 – HV5) and the SNA listed the cases to be discussed and in what order."* (Field notes – Virtual safeguarding supervision observation ICRHB).

The mix of one to one and group appears supportive to HVs as when asked which they prefer HV5 (RHB) was surprised at her response to my question.

> *"If you'd asked me this a couple of years ago, I would have said one to one definitely without a shadow of a doubt because you've got the safeguarding lead's full experience, full attention, it's all about you and your caseload isn't it so you literally go through more than you do in teams" (in group supervision)* (HV5 RHB).

Within a group supervision session HV5 felt she was able to learn from colleagues' practice.

> *".....You learn what other people are doing, what other people's caseloads are like, how they interact, how they ask questions, and that's, I like that in practice, I always look at, because everybody works differently, we're all doing the same job but everybody, so you learn don't you? You learn from other people."* (HV5 RHB).

Health visitor two (HV2) from the ICHB found the safeguarding leads helpful within the safeguarding supervision situation.

> *"I do find them (safeguarding leads) helpful on every session we have..."* (HV2 ICHB).

It was clear that there was a variation in the delivery of safeguarding supervision across the generic health visiting service compared to the flying start service although a continuous thread when analysing the data showed that HVs in general, found group safeguarding supervision supportive. HV6 (RHB) found the safeguarding supervisors in her area supportive, organised and prepared for the session.

> *" …each of the supervisors are very helpful and supportive in dealing with some of the complex cases in particular, ...I'm assuming they obviously have their safeguarding meetings so anything new and current they're quick to share... at the beginning of safeguarding supervision to enable discussion and like I say before any cases are brought to the table so yeah, I definitely think that they come prepared." (HV6 RHB)*

7.2 Perceptions, comparisons, and access to One-to-one supervision

When asked, the majority of HVs used to prefer one to one supervision but now also saw the benefits of group supervision. During data collection, one to one supervision was referred to as offering HVs a more in-depth session of cases brought to supervision. In comparison and within the group supervision setting, they felt conscious of the time restriction within it – taking up the time of others in the group. This was observed in my first group supervision observation where one out of the three HVs discussed three cases rather than one.

> *"She (SNA) turned to the first HV (HV1) who proceeded to give an overview of the concerns about her caseload listed that she had one family with a child on the child protection register, one child under a care and support plan, and four looked after children within her caseload. She also had two very vulnerable families that she was concerned about. Identification numbers were shared with the SNA so as not to identify the client that was being discussed and to maintain confidentiality… HV1 moved on to discussing another vulnerable family. This was a complex case involving substance misuse, domestic abuse with probation involvement…* (Field notes, face to face safeguarding supervision ICHB).

The HV (HV1 ICHB), did ask permission of the other HVs and safeguarding lead to progress each discussion. She was also a participant in my interviews and stated,

> *'I think I prefer one to one……., it all depends on how many cases you've got, if you haven't got many, I think that group is good, like I say there's 'for and against' for them both* (HV1 ICHB).

The HV team described here was the team observed in safeguarding supervision who shared an office within the same local health board locality. Although, during the first group supervision observation HV1 apologised to the group for taking three cases.

> *"HV1 apologised as she asked to bring another two cases to discuss one would be a quick update as the child was off the CPR (History of sexual abuse). The other HVs in the room accepted the HV needed to discuss another case and agreed as they 'didn't have that much to discuss.' (HV2 ICHB)."* (Field notes, face to face safeguarding supervision ICHB).

This HV also referred to how the HV team shared within the office setting,

> *'We do discuss the cases as they come in, you know as they arise.'* (HV1 ICHB).

This is common practice within the HV team. I observed discussions/reflections of visits which acted as a de-brief of the visit, this was particularly visible within the HV observations in the ICHB. Different modes of support were accessible. HVs accessed group supervision, peer support within the office setting and one to one safeguarding supervision.

One HV suggested there could be a combination of one to one and group but stated she preferred one to one.

> *"Personally, I really like one to one supervision 'coz I feel you can get like really into a family into a safeguarding family you know, you know the chronology and you can find lots of advice, you know that's really.... supportive.'* (HV2 ICHB).

Health visitors reflected on the group supervision format within the focus groups also and referred to HVs not being able to discuss a case if one case tales much of the allocated time.

> *" …it depends what case is being brought that is quite complex, it can go on and then you feel, oh, I can discuss mine? Have I got time? You know, things like that and I think it's really good, there's lots of good points with group supervision as you are learning from each other and it's good to get each other's perspectives…"* (HV, FG1 ICHB)

> *"…I think sometimes you tend find somebody will discuss a lengthy case and then you kind of think, it's getting to like four o'clock and you're thinking, I still have things to do, you think, I won't make a big thing. There's a bit of that that goes on because there's time constraints…everyone is busy but at the same time it's important for everyone to have their say…and have the opportunity to speak if they want to…which is probably why people say bring your one case because there is always going to be quieter people."* (HV, FG1 ICHB)

Despite the benefits from one-to-one supervision there was recognition of HVs learning from each other within a group supervision setting with HV2 (ICHB) endorsing this,

> *"...it's really good to learn from other colleagues. So, I would say maybe 70/30 so 70 if I was going to put in a percentage 70 for like one to one, 30% for group. So maybe two of those would be a one to one and one of those would be a group. Yes, split it up a little bit, so one to one, then a group supervision and then a one to one.'* (HV2 ICHB).

Health visitor five (HV5, RHB) supported a combination of group and one to one safeguarding supervision stating,

"There are benefits to both.... massively." (HV5 RHB).

Health visitor one (HV1, ICHB) also saw benefits to both modes of delivery,

> *" I think there are benefits to both because when you're on one to one you've got the undivided attention where you can just get your cases over and done with whereas, if you're in a group supervision you've having to listen to others, but you can also learn from others as well...."* (HV1 ICHB).

It was interesting to consider the terminology used here with one-to-one supervision as *'just getting' t*he cases discussed and *'over and done with'* as if it was a chore and then in the group situation, *'having to listen'* as if this could be a chore too for the HV. Although, HV1 (ICHB) did recognise that various aspects of safeguarding practice are identified in the group situation.

Various ways in which to structure group safeguarding supervision were suggested by the HVs. Health visitor four (HV4, ICRHB) felt group supervision supported her more than one-to one but wanted it to be longer than the one hour it had been reduced to.

> ***"Time:** Supervision was booked for one hour, 13.30 - 14.30, the first case discussion started at 13.40 and ended at 14.20 leaving 10 minutes for the other HVs to discuss their cases."* (Field notes - Virtual safeguarding supervision observation ICHB)
>
> *"I'd like it to be more structured.... more focused, and a longer session."* (HV4 ICRHB).

Health visitor (HV4, ICRHB) also recognised that HVs *'just'* turn up to the session rather than sign up which impacts on the time spent on individual cases if there is a larger group. The impact of a large supervision group was also observed. HV6 (RHB) felt that,

> *"...a mixture of both would be useful.....because well I think, I already get it because if I do ring up for safeguarding help and ask to speak to somebody I get that supervision there, one to one, anyway but if it was like a designated time that they came to the office like they used to and we go through the notes of those families that were on the register then yeah I think that's useful too."* (HV6 RHB).

As with some of the other HVs, HV6 (RHB) also thought that an opportunity to have face to face one to one would be beneficial:

> *"I'd like it to continue as it is on teams and perhaps twice a year that we have a one to one where we're face to face in an office talking through some of the cases."* (HV6 RHB).

There seemed to be a criterion within health boards to determine the type of case to be brought to one-to-one supervision and HVs appeared unsure what that criterion was in full for one to one or group supervision.

> *"For 1:1 if they meet the criteria of you know the safeguarding criteria, I can't remember, I think it's …. conference, (child protection conference) ... those that are drifting, those that have been on the register for a long time. So, I take the ones that meet the criteria and anyone really that you're concerned with*." (HV3 ICRHB).

Ideally, this HV would like many more cases reviewed.

> *"I mean I would like to take all of them. Let me come with 20 notes and then you know and discuss each one. I think I used to when we were newly qualified, I think that was the case but now it's yes, just take the ones that meet 'the criteria' and any ones ... that you're really unsure about."* (HV3 ICHB).

Health Visitor five (HV5 RHB) valued one to one as a newly qualified HV from an experienced supervisor and stated.

> *".....because you're flying start and you do tend to have a lot of safeguarding, at that point when I first qualified it was still one to one supervision and it was ***** who was very, very experienced. We'd have the one to one, you know she really helped me and supported me and she was always available if I needed to ring her."* (HV5 RHB).

All newly qualified HVs can access one to one supervision for one year post qualification, this is common practice across all health boards in Wales. After that initial first year HVs move to group supervision with one to one available on request. One to one supervision appears to be available but not as regularly accessed HV6 (RHB) recalled,

> *"I can't remember the last time we had face to face (one to one) safeguarding supervision, that was years ago I think."* (HV6 RHB).

Health Visitor (HV6) felt that one to one supervision offered a more detailed view/conversation about her caseload. The HVs did feel supported in relation to accessing safeguarding advice.

> *"…. if you've got something and it's urgent, you'd ring…. you'd go for one to one* (HV5 RHB).

The health boards have safeguarding hubs where staff can call within a Monday – Friday working day (9am to 5pm). This was reinforced by HV6 (RHB),

> *"If I did find that there was an issue then I'd contact the safeguarding hub and have a one to one with a supervisor and ask what maybe the best practice would it be..."* (HV6 RHB).

7.3 HV perceptions and feelings around Group supervision

Health Visitors are instructed to take one case to safeguarding group supervision. The process varies across HBs as already indicated. Preparation is expected but not mandated or monitored. Group sizes varied during the observation period from 3 – 11 practitioners in a group. HV4 (ICRHB) found a mix of HVs from across the health board beneficial and as explained in the methods chapter this health board was divided into five boroughs.

> *"It hasn't overly bothered me (group supervision) because it's quite interesting to see, yeah you might get somebody from one borough and then somebody from another Borough..... so sometimes it's really positive.... I don't mind that part of the .....structure of online group supervision."* (HV4 ICRHB).

Health visitors sign up to their supervision session without knowing who is going to be on the session with them. On occasion HVs who work in the same office have signed up to the same session.

> *"There's been times when I've gone into a session and if it's your team all in that session then there's nothing new because you know all the cases already because you've discussed it, so that can happen now and again, you think well we're the same people that I'm in the office with for supervision and that isn't always useful."* (HV4 ICRHB).

This was experienced in the first safeguarding supervision observation where the whole team from one office was present (three HVs and one nursery nurse).

> ***"Actors:*** *Health visitor 1 (HV) 1, HV2, HV3, Safeguarding nurse advisor (SNA), Nursery Nurse (NN), Researcher (R)*
>
> ***Space:*** *The supervision took place at a General practitioner (GP) practice outside of the city centre. The small town was an affluent area, and the health visitors came from one surgery."* (Field notes – Face to face safeguarding supervision observation ICHB)

HVs did recognise the benefit of a general group discussion compared to one-to-one supervision. One HV stated it felt less *'tick-boxy'* and more supportive in way due to access to the facilitator's knowledge within a protected, allocated timescale.

> *"I think I like the groups better, it feels a bit more, yeah, it's not as tick boxy I would say, it's more of a support"* (HV4 ICRHB).

The group situation advocates discussion and sharing of practice.

> *".... somebody might bring a case and sometimes it almost, it might jog your memory and you think oh do you know what, I had one similar to that, oh what did you do and that can lead you...."* (HV5 RHB).

In one of the health boards safeguarding supervision is undertaken with HVs and midwives. This model offered a varied response within the focus groups and interviews. Health Visitor (HV6 RHB) enjoyed the multi-disciplinary approach to safeguarding supervision.

> *"I feel comfortable, I like the fact that it's multidisciplinary.... I like the structure, it's informal, I don't feel it's stressful, I feel it's useful."* (HV6 RHB).

> *"I like the multi-agency, Ilike the fact that we've got midwives, it's usually midwives in our group but there's talk that we could have the school nursing team. I like the fact that we have more than one discipline there and I think that's, I find that really useful" (*HV FG RHB)

The move to group supervision was unsettling for some HVs as one to one felt more protective in some ways.

> ***"****I remember saying well I don't find it as beneficial; I'm really struggling with it (group supervision) and she said (previous supervisor) 'oh just give it time, see how you go"* (HV5 RHB).

Initially group supervision was undertaken face to face. This was moved online during the pandemic, and it was felt that online group supervision was a barrier due to HV knowledge of navigating Microsoft Teams and health boards providing the necessary resources (laptops, cameras). Some HVs refer to feeling uncomfortable during safeguarding supervision which was observed by the one of the HV participants who recalled,

> *"I remember one supervision and that was face to face so it must have been pre COVID, and a colleague brought a case and safeguarding lead had said, 'well what would you all do?' I think she all felt a little bit ...because we were discussing it, I think she felt a bit like 'oh well I've done this and this but because …...it was an actual live case that was being discussed I think she felt....I can't speak for her, but it was just her how she was reacting and she's quite a quiet person and I almost felt oh you're thinking that you've not done your job."* (HV2 ICHB)

Health Visitor (HV2, ICHB) read the non-verbal signs demonstrated and told the HV whose case was being discussed that she had done a good job. She felt the safeguarding supervisor should have picked that up.

> *"I did always think looking at her thinking oh ….you know... have to kind of like, oh you've done a really good job but that was me, and I remember saying that because I picked up on that rather than the person who was leading, which I would have thought that that was her role."* (HV2 ICHB).

The role of the SNA and their experience in managing a safeguarding supervision session is explored in the findings from their data transcripts. There can be some reluctance to talk within the online group supervision session which was identified by HV4 (ICRHB).

> *"Face to face (group supervision) is nicer, it's a longer session, it's a good couple of hours. It could just be the fact that I'm not used to working online as such for meetings, and there's certain etiquette with teams and you put your hand up to speak and things, but it can disrupt the flow a little bit of a conversation. I think we're doing the best we can within a very strange time (COVID-19) you know online but it is a very short ….session but I think it has to be because some people are reluctant to speak anyway ….if you've got a group of people that are reluctant to speak on an online one it can be very tricky to handle, I suppose."* (HV4 ICRHB).

This health board made the decision to reduce supervision to one hour online during the pandemic. This came with several challenges which HV4 (ICRHB) alludes to whilst stating a preference for face-to-face group supervision.

> *"..... face to face is much nicer because it's just a bit more personal, it feels more supportive and more protected, you've not got people coming in and out of the office and the phones ringing in the background and notes shoved in front of your face while you're, you know you're trying to have a supervision session. You feel very protected when it's face to face, it's off site, it's usually at a different location in a room and no one bothers you there for a good few hours."* (HV4 ICRHB).

The interruptions described here were observed during every observation of online group supervision and explored in the group supervision observation section.
HV1 (ICHB) felt pressure within the group supervision session as to not discuss some cases as they may not interest group members.

> *"....I think then that you could perhaps think well I won't discuss that one today, the less concerning …. because everyone has got to have their turn, we've got perhaps, people might have visits arranged.... but yes, you do feel that when you've got a lot as if.... others are going to be bored."* (HV1 ICHB).

One HV felt less pressurised/scrutinised in group supervision.

> *"I felt perhaps one to one there was more scrutiny with our safeguarding nurse..... I found more scrutiny.... I felt a little bit uncomfortable but since it's become more group like I don't feel the focus is just on me"* (HV6 RHB).

Two of the six HVs were conscious of talking too much. Health Visitor (HV5, RHB) implied she would always have a case to discuss due to the nature of her caseload and that 'generic' caseloads seem to have less 'child protection' and less worries.

> *"A lot of the generic health visitors haven't got child protection or haven't got any worries, so I did feel that I was kind of.... because there was always someone I could talk about because I'd always got some form of safeguarding/child protection family that if nobody else had got anything well I could say well I've got one.....I would always hold back to see if anybody else had got anything but if I had got something to discuss then I would discuss it and that doesn't bother me."* (HV5 RHB).

This is an interesting point as the generic HVs observed in the group supervision sessions brought some of the most complex cases to discuss. The flying start

caseloads are smaller but in practice, not necessarily holding more child protection cases.

Further benefits of group supervision were included in the interview with HV3 (ICRHB) who described it as:

> *".....you've got sets of ears listening....and looking at the situation from an outsider point of view and then coming back with....hopefully quite valid kind of advice....and it just helps you to feel a little bit more in control I suppose that you've kind of de-briefed and think right okay let's start again with a little bit of a clearer vision sometimes."* (HV3 ICRHB).

This HV also felt less alone, more reassured as HVs were experiencing complexities similar to her caseload.

> *"I do find it really interesting when other people have got families as well that they're talking about, you know I do find that interesting and almost reassuring that actually....you're not in isolation, you know dealing with what we're dealing with....it almost gives you a little bit more confidence I think as a practitioner."* (HV3 ICRHB).

7.4 Safeguarding Supervision enhancing critical thinking.

The interviews aimed to examine if safeguarding supervision allowed the HVs to critically think within their experience and examples from practice that they were bringing. A common thread within the data were how the HVs learned from each other. HV2 from the ICHB stated:

> *"I think I take on board really what I discussed at the supervision, you know if anybody has given some really good advice and really good pointers …...I suppose just, I just try and get a clear understanding about where you're going to go really with this family which I have done. So, for me if supervision was good because you know I mean you get to talk about the facts and see how other practitioners and their safeguarding kind of response to it and see if you've missed anything or if you can improve on anything and it just helps give you a little bit of clarity on moving forwards."* (HV2 ICHB).

This participant went on to explain that she liked listening to other people's cases. By listening to their experience, and how they would deal with certain situations, allowed her to leave supervision with *"fresh ideas*" or helpful advice of accessing new services which would support the family that she had brought to safeguarding supervision. She referred to,

> *"It does one of two things.....it kind of promotes more of a professional curiosity, and more of 'oh I want to know' you know, it's almost that I need to do more I suppose."* (HV2 ICHB).

This was supported by HV6 (RHB) who felt the group perspective,

> *"...can perhaps offer different fresh perspective or insight onto it (case being discussed)."* (HV6 RHB).

Critical, reflective discussions were observed at safeguarding supervision observations. The conversation generated information gathering and potential solutions to guide the HVs further.

"The other two HVs continued to listen in to HV1's discussion as did the nursery nurse. They had turned towards her; the NN faced her on the opposite side of the room with the other HVs sitting to her right but turned to face her slightly. This family had six-week-old twins; they were engaging with external agencies. 'Families first' were involved and undertaken "Grow brain' work with them. The HV was unsure of the context of the 'Grow Brain' work and the nursery nurse was able to update her on what it involved. HV-1 had engaged and liaised with probation service and the family were on a care and support plan. Regular contact was being pursued. The SNA reiterated the issues and recapped the concerns and the family appeared to be engaging and doing well with intensive support. Probation requested that HV-1 visited regularly, she stated that if such intensive support was required does it warrant a child protection plan rather than a care and support plan? The NN interrupted and asked if she could 'chip into' the conversation and her knowledge was welcomed. She went into more depth about the 'Grow brain' programme which was Internet based and it is a parenting programme. There was then some discussion around concerns associated with online programmes. The SNA reviewed the electronic health record looking for any recent domestic abuse incidents and had a brief look at the history associated with this family, which was intensive." (Field notes – Face to face safeguarding supervision observation ICHB)

Health Visitor (HV3, ICRHB) felt that supervision made her think more with other HVs assisting with their ideas based on their practice experience and feelings surrounding the risks associated with the family discussed. A case was reflected upon during the interview which this HV brought to the safeguarding supervision session.

> *"So, I suppose yeah it just enabled me.... I'm fairly assured that this is what it is (critical thinking). I think making other practitioners aware of what my thinking process is, and almost you know encourage them to give right now, we need to give a lot more ownership now (to their practice) and responsibility to mum and keeping it a little bit.... tighter as opposed to her maybe drifting you know between services."* (HV3 ICRHB).

The observation identified the complexity of the cases HV3 (ICHB) was referring to. Each of the HVs present were able to advise and support the HV with the concerns raised. It was recognised that HVs are exposed to complex family situations daily. HV4 (ICRHB) brought a particularly complex case to supervision. She felt that supervision helped her think critically also,

> *"I suppose it just gives you.... different ideas really on how to approach the situation."* (HV4 ICRHB).

The case discussed was a new family into the caseload which required urgent safeguarding assistance (domestic abuse/honour-based violence related, and refuge was required).

> *"With this case I felt quite clear with what I had to do and what my role was, but it was just good to talk about it because it was really, a really upsetting case, I've not had anything quite like it before."* (HV4 ICRHB).

She also felt that supervision was a good space to discuss the types of cases that drift over months or years,

> *"I've had cases that have gone on for years and years and years and you wonder if you lose sight sometimes so to have supervision can sort of clarify things a little bit."* (HV4 ICRHB).

Other HVs can offer a different insight into the case. This HV was well established, had been qualified a number of years and was still challenged,

" ...*you think you know what you're doing and you try and do your best but actually some other person may come and just say well have you tried this, have you tried that, and you think oh gosh I hadn't thought of that or no I haven't approached it that way so it (group supervision) is really positive."* (HV4 ICRHB).

This was supported by HV5 in the RHB who took a similar stance stating,

> *"...half the time you've probably done A and half of B but almost you can't see the wood from the trees can you and you just see someone, and almost when somebody says to you oh yeah that makes perfect sense, why didn't I think of that?"* (HV5 RHB).

This interview was very thought provoking with this HV referring to the term *'I am full" or "we are full."* This implies that the supervision that is supportive is needed. Health Visitor (HV3 ICRHB) had taken a complex case to supervision, and she felt the supervision allows more in-depth analysis of the situation.

> *"I think you just you analyse it don't you and think right is what I'm thinking.... quite extreme? Is it? But then where is my evidence.... or....it's not to try and just think in one way and try and come at it from different angles."* (HV3 ICRHB).

Health Visitor (HV2, ICHB) felt that the supervision enhanced her critical thinking and analysis and explained this in detail,

> *"I think it does aid my critical thinking because I think sometimes you can be so involved in the responsibility of safeguarding that actually sometimes somebody outside looking in can see the other factors that maybe you've missed, so you're so you're so zoned in on: Is that child safe? I can't get to see that child, I'm worried because I know all this about that family, but actually sometimes it's really useful for somebody ...who's not as involved, being able to, kind of ... put it down and say right... 'OK so this is what you're worried about' like using signs of safety you know what are we worried about? OK, but what's working well? What's happened before? Where could we go with this?.....so from that then every time a new safeguarding issue arrives, I kind of pull on that experience. That critical information that I've had, and maybe it makes me think a little bit wider really and focusing in straight away."* (HV2 ICHB).

This was a common theme during interviews, the HVs felt supported by their peers and valued their experience and in particular, their objectivity.

> *"You need somebody else to come in and just look at it from a different angle, someone who is not involved with that family as well. So, it definitely does help critical thinking because.... you can just look at it from a different angle and may just change .... your assessment even, you can look at it from another point of view."* (HV5 RHB*).*

Safeguarding supervision also advocated the HVs feeling more professionally curious. HV2 (ICHB) understands professional curiosity as,

> *"...not just taking it on face value, there is a concern, but is it a concern that you know needs to be acted on now.... could we look a little bit deeper just to give us a bit more of a chronology really? So yeah, curious to really look back maybe and see, yeah, and find other professional's opinions."* (HV2 ICHB).

There were examples of learning and development seen during observations, as well as it being articulated. The example below is lengthy but demonstrates not only relevant, critical discussion amongst the HVs present but learning around dealing with a complex case.

"The youngest child was fed via a Naso-gastric tube, and this was slowly trying to be 'weaned off.' The HV felt Mum was very derogatory about the children and she had been concerned about their emotional well-being. Paediatrician was involved with extra support from the local authority. There had been no thorough examination of the child, everything was taken on mums reporting stating that the child-cannot tolerate any food. The HV had addressed this with mum previously. Older child displaying disruptive behaviour, smashing up bedroom.

Tube fed 6 times a day for 1.5 hours a time and is strapped into a chair for the duration. The HV has discussed timing of feeds with the mum. Meeting planned with paediatrician and speech and language therapist.

HV concerned that educational needs need to be met.
Mum engaging with dietician, on a strict regime.
HV concerned with how food is being processed.
Mum not attending HV clinics. Concerned as potential FII, constant negativity of mum, poor engagement with childcare setting and therefore her educational needs not being met. The child is being strapped into a chair six times a day for 1.5 hours at a time. HV had offered further referral for support but mum had declined. No nursery attended since the pandemic. HV concerned that the child is being kept on the NG feeds to suit the mum and her needs. One of the HVs (HV2) asked if HV1 and spoken to the mum about the missed appointments. HV1 was told that the family had been poorly and had not made another appointment yet.

HV2 asked if there was a formal diagnosis for the child. HV1 was not aware there had been a formal diagnosis and had contacted the paediatrician. The SNA enquired who the paediatrician was and explained that if a FII referral was being considered that this takes a vastly different route to a 'normal' child protection referral (and discussed the process and risks involved).

HV3 asked if the family were receiving any extra family support. (HV1 was not aware).

HV2 asked for clarification of local authority input – HV1 stated that the case was now closed, and discussion was generated on how the local authority came to that conclusion.

HV1 wants to make another referral and is going to write a chronology of events and concerns. There had been no abdominal scan or recent investigations. The child is strapped in a pram for 9 hours a day. HV2 asked HV1 if she had escalated concerns to social work manager.

HV3 asked about the dietician input – have the feeds been reviewed? If so, when? What is the plan to gradually reduce the feeds? How does the child's weight look on a centile chart? If feeds are reduced, is weight reducing or is she being fed as well? Potential neglect as not meeting the child's needs. If the child is gaining weight – how? Is she being offered food and tolerating it on top of the NG feeds?

The SNA stated she was searching for the FII policy and reiterated the concerns especially in relation to being strapped in a pram. HV1 stated one feed is given when she is asleep.

HV3 asked how this has gone so far without a review. What is the gag/swallow reflex like? Has she had a video fluoroscopy? (HV1 stated that the mum failed to take the child).

HV3 offered a plan of action – to speak to support worker and social services, paediatrician, childcare setting, and nursery to collate evidence. Track 'did not bring' appointments. Collate health evidence. Can you discuss with Named Doctor for child protection? HV3 felt that further tests are required on the child and if not taken to pursue a referral. She also referred to if there was no diagnosis could the mum pursue these down a legal route especially if there was a misdiagnosis? There may actually be no need for an NG tube.

The SNA stated that the HV must speak to the paediatrician and dietician and start collating evidence to build a potential referral relating to FII. All missed appointments and significant events to be placed into a chronology.

HV1 stated that she had referred previously under the physical abuse and emotional categories of abuse…" (Field note – Safeguarding supervision observation ICHB)

Health Visitor (HV6 RHB) was able to reflect and learn during supervision, from her peers as well as the supervisor.

> *"I think what can happen at supervision is that others in the group might highlight something that you might not have thought about, you may have, like you say you reflect on a situation but they may bring something that you've not thought about and that just takes it a little bit deeper that you're analysing things perhaps a little bit deeper."* (HV6 RHB).

There was a difference in experience in relation to if safeguarding supervision aided critical thinking picked up by HV5 (RHB).

> *"It would depend on who's leading it….because I do feel that there's some more experienced lead safeguarding supervisors…….I find one particularly helpful, she doesn't make me feel silly and like I say she will almost lead you without you*

realising, you know, whereas another one kind of will say, well what do you think you should do and puts it out to the team and you're kind of like... and then it goes quiet and everyone gets uncomfortable. I do think it depends how it's led doesn't it?" (HV5 RHB).

This will be further explored within the safeguarding adviser section but emphasises the need for a safeguarding supervisor who is adequately trained in the delivery of supervision.

7.5 Facilitation of Safeguarding supervision

Ground rules are generally set prior to each session which HV6 (RHB) felt were effective,

"I think because ground rules are set at the beginning that if anybody wants to speak then put your hand up, it's quite polite should I say, yes we do it quite politely nobody just butts in." (HV6 RHB).

***"Acts/Events:** SNA set ground rules, I turned my camera off post introductions, consent obtained verbally to observe. Reassured participants the observation would not be recorded just fieldnotes to be taken. SNA opened the discussion asking if anyone had a case they would like to discuss."* (Field notes – Group supervision observation, ICRHB).

Within the RHB the move to online group supervision was appreciated due to the geographical expanse of the area.

"You can just drop in; you haven't got to plan it too far in your diary that you can think right I'm going to be at that visit and then it's going to take me 45 minutes to get to safeguarding supervision." (HV6 RHB).

This HV did raise the issue of resources including Wi-Fi connection which had caused initial connectivity problems.

Health visitors want to feel supported and advised effectively by their supervisor. There is a risk that a dominant character takes over the session. This has been recognised and articulated by HV4 (ICRHB),

".... certain people dominating the sessions....it depends how good the facilitator is in making sure that everyone has got a chance to speak so again it just depends on who's leading the session at that point."

The facilitation of the group supervision was referred to on several occasions during data collection. The HVs were honest and open. HV6 (RHB) valued the supervisor opening up the discussion.

> *"She (the supervisor) opens it out to other people in the group as to have they come across it before, how did they deal with a situation, is there anything they could advise me to do differently or change.... Have I ticked all the boxes that needed to be ticked or have I missed something, and you know I find that useful."* (HV6 RHB).

This peer supervision was once again valued and referred to as a supportive element of the group safeguarding supervision experience. Health Visitor (HV4 ICRHB) was impressed by the facilitation of the group supervision she attended as the supervisor followed up the session with further information.

> *"It was really supportive, really good, in fact afterwards she sent me an email....with more information on resources and where to go....well she'd obviously gone away and tried to support me with a little bit of resource which was really, really useful and I've not had that before actually, no one has done that before so that was quite a new experience."* (HV4 ICRHB).

She also reflected on a previous experience that did not feel as supportive and quite critical of the HVs practice.

> *"....I think it depends on who's facilitating the session.... I've come out and I think oh gosh.... that wasn't useful because you're picking holes in somebody else's practice here rather than trying to look how to.... I know we have to do that, of course we do, we have to be critical we have to look at how we improve things."* (HV4 ICRHB).

Health Visitor (HV5 RHB) saw the benefit of group supervision,

> *"Somebody brings something, and you think oh that's interesting I could do that... really depends on who's leading it and the person who's leading it has to.... be able to lead it in a way where they've got the experience."* (HV5, RHB).

She felt her supervisor in the last session she attended was,

> *"...very good.... She almost tells you, like advises you, but you don't feel like you're.... you don't feel stupid if that makes sense, you're kind of like ...she's supportive, it's very supportive in how she gives you the advice which I think is important."* (HV5 RHB).

She also compared this supervisor to others who had been less directive. This HV was observed in practice, and we discussed in between visits what her supervision needs were which were reiterated in the interview. During our discussion she said that if she is accessing one to one supervision, she needs support, she is calling for support as,

> *"I'm full to the brim, I need to know what to do, I can't think, I can't see the wood for the trees."* (HV5 RHB).

She needed an objective view somebody who was not emotionally involved with a case. She alluded that this is what is needed in group supervision. It's ok for group discussion but sometimes, you need to be told what you can do.

> *"We all know what we're supposed to do and sometimes if you're going, if you're going to the next level and saying right where do I go from here, it's because you're full and you just need someone to say you need to make sure you've done a, b and c."* (HV5 RHB).

This HV in practice referred to safeguarding as *"scary, I can go to court" so* if she is calling for one to one advice or requires direct advice in a group situation, she needs a direct approach rather than being asked "what would you do?" She sounded a little frustrated during the interview and said;

> *"I wouldn't be ringing you if I knew. You know... that's not being mean or disrespectful it's just sometimes I just think you're full as a practitioner*." (HV5 RHB).

The data within this section is predominantly from HV interviews as they were able to be more open without influencing other HVs who would be in a focus group. The impact of safeguarding children cannot be underestimated and then there was the impact of the pandemic which added a further burden to HV practice. Therefore, the facilitation, duration and structure of a supportive safeguarding supervision session is paramount.

7.6 The duration and structure of safeguarding supervision

During the safeguarding supervision observations each SNA followed a similar process based on their own individual HB guidance.

> *"The SNA introduced the format of the session that they would discuss cases and go through the cases one at a time as well as there being an educational element at the end of the session. Looking at me, the SNA stated that she had asked each of the HVs to bring at least one case to the session and that*

generally, each HV would bring one case to discuss. Health visitors were asked to complete a signs of safety assessment on each of the families that they brought to supervision. This was completed on an A4 piece of paper which had been emailed out to them by the SNA prior to attending. The SNA had the same piece of paper and would populate each of the domains of the tool as the HV was speaking about each family. The SNA sat with her laptop and pieces of paper in preparation for the health visitors to share their concerns." (Field notes – Face-to face Safeguarding supervision observation ICHB)

Health visitor three (HV3, ICRHB) was able to describe her safeguarding supervision experience and the structure of the session.

> *"....normally it's for two hours so it would be kind of done in a private room for two hours, you know a corporate safeguarding lead team member would be there (facilitating)….and then yeah in my experience it's been a case of …...a little bit like the disclosure at the beginning (consent)....we can talk about whatever if I feel anything has/maybe needs to be escalated then that's what would be done, people could talk about a particular case, or they can talk about safeguarding in general or a bit of policy or a bit of procedures or a bit of oh this is the new thing..... that has come out and we now have to do"* (HV3 ICRHB).

When asked if the HVs had seen a set structure, or expectations of safeguarding supervision she replied, *"I haven't seen any writing or anything like that...."* and added that ad-hoc telephone supervision is made available via safeguarding hubs across all health boards.

> *"You know there's someone on the telephone"* (HV3 ICRHB).

During the pandemic, the structure and length of supervision changed within this health board to one hour online. One hour was considered not enough time by HV3 (ICRHB)

> *"...an hour, and it's online which I don't particularly like online, I would prefer meeting" (*HV3, ICRHB)

and when questioned suggested an 'ideal' safeguarding supervision model which consisted of face to face,

> *".... every six months (corporate safeguarding team) and three months then within the Flying Start service."* (HV3 ICRHB)

This participant recognised the safeguarding team sent an email to remind the HVs to prepare and the HV felt reassured by this reminder as well as the structure of the supervision session.

> *"I quite like the fact that it's private and it's, you know there's a reflective time, you know so and they're relatively small groups." (HV3 ICHB)*

Health Visitor three (HV3 ICHB)felt able to talk about relevant cases. She did raise that at least two hours is needed and sometimes time ran out, so the HV was unable to discuss her case.

> *".... if you've got a burning desire to talk about something, great, but if other people have as well then maybe you could run out of time before you have your own session (discussion)." (HV3 ICRHB)*

In this instance there is a possibility to join another group or access one to one supervision.

> *"I mean I suppose there's an opportunity then you could say actually can I join the next group maybe, on the next date perhaps?" (HV4 ICRHB).*

There are several dates offered as a cycle to the HVs and they access whichever date is convenient for their diaries.

HV3 (ICRHB) enjoyed the information sharing element of the supervision,

> *"I'd quite like any new information that would be quite good, you know a bit of information sharing as well while we're there. You know this is kind of hot off the press type of thing or these are the changes that have been made, that kind of, the admin stuff as well...."* (HV3 ICRHB).

Sharing of some sort of education or health board update is common practice in safeguarding supervision. HV4 (ICRHB) thought that any education should be separated from the supervision session.

> *"I'd want the training to be separate actually, so when we were having our meetings, I think it should just be supervision, just to discuss our concerns and again have that protected time to discuss that."* (HV4 ICRHB).

Health Visitor (HV5 RHB) felt the group supervision is organised in her area stating,

> *"…it's quite structured in the supervision it's led by someone, and they deliver what they need to tell, you know the information that gets put out for us all*." (HV5 RHB).

Sometimes HVs may not bring cases to discuss or, just one case will be discussed.

> *"I've yet to have been to one where everybody has got a case to discuss and if you have and you haven't got time then you'd say look I've got something to discuss can I meet you after or I really want to discuss this or whatever...." Therefore "safeguarding leads now have a bank of cases for us to share. So, they'll share one on the screen, we'll write it down and then you know she'll say go away and do your strengths, your barriers, your harm statement, you know. What's working well, what's not, what's got to happen."* (HV5 RHB).

This is explored further within the SNA findings chapter and poses the question as to why cases are not brought or prepared utilising the structure suggested here.

7.7 Preparation for Safeguarding supervision - the HV perspective

During the interviews, preparation for safeguarding supervision was raised. Of the six HVs interviewed, five were seen in the observed group safeguarding supervision. The SNA perception of preparation will be explored in the SNA findings section but the HVs articulated that there is some preparation that takes place. In the ICRHB HV4 referred how the HVs are informed of the safeguarding supervision session due to take place,

> *".... we just get an email saying can you bring a relevant case if you want to bring one for discussion, that's all we get."* (HV4 ICRHB).

Health Visitor two (HV2, ICHB) refers to how she prepares but states that this can be difficult as sometimes cases are discussed with the team leader or in some areas there are other 'vulnerable leads' to offer supervision as well as outside of the 'corporate safeguarding supervision.' This occurs within the 'Flying start' teams.

> *"So, we are normally asked to take a case to safeguarding supervision, um can be difficult sometimes, because you've already discussed it with your safeguarding team leader. So maybe you try and take another one. I would just take one that maybe is not on the register (child protection) that I'm not so concerned about, one that I'm... is teetering maybe on the edge." Maybe one that I'm thinking, ooh, I've done this, I've done this, I've done this, but you know something still doesn't feel right. I would take the ones I'm a bit worried about."* (HV2 ICHB).

Those families on a child protection plan will have professionals working with them to improve their situation. Health visitors commonly use the term '*teetering on the edge*.' It is these families that are often brought to supervision. These families have several risk factors but perhaps do not meet the local authority threshold for referral. Or the HV thinks they meet the threshold and is having difficulty escalating concerns. It is these cases that the HVs find support in supervision.

> *"If there wasn't anybody, I was really worried about, which I don't think happens. There's always somebody you're worried about. ... I think it's really important to have that reinforcement of your practice, and maybe I could take something, one that I'd already done that is obviously off the register. Or had I done everything? Had we followed all the guidance that we should have done so it would normally be when I was worried...."* (HV1 ICHB).

'Signs of safety' (Turnell and Edwards 1997) is a tool which allows practitioners to reflect on the risks associated with a family. It has four areas: Harm factors, complicating factors, grey areas, and positive factors. Health visitors use these to complete referrals, author reports and in some health boards structure discussion in safeguarding supervision. HV3 (ICRHB) shared how 'Signs of safety' could be utilised.

> *"I would print off the signs of safety...I would write down basically underneath each heading what my thoughts were and then I would take it then to the meeting..." The narrative would then be duplicated in the HV record evidenced by HV3 (ICHB)….. "then we would write the headings.... signs of safety....in the body of the narrative of the notes."* (HV3 ICRHB)

Health Visitor (HV3 ICHB) also explored preparation for supervision and if a practitioner would speak up, take a case, or sit back and listen.

> *"....If you're prepared to go to the supervision and you're prepared that you want to speak about it and you want support then I suppose that would depend on the practitioner really whether then you write down if it's a complex case, you know you write down using the signs of safety form and then you take it and then jot down people's notes, you know kind of feedback, or whether you've had a particularly busy week or you know and you go in just to kind of you know either yes I've got a case that I can think of or, I'm quite happy to listen to another person's case. I suppose it's what you want out of it is what I can imagine*." (HV3 ICHB).

This implies that not every HV takes a case to discuss. This was also reinforced in group supervision observation where not all HVs discussed a case. Health Visitor six (HV6 RHB) tried to take a family to each supervision,

> *"I always have a family in mind and if I don't have a family in mind, because it's not all about my families and there is quite a few at the supervision, I'd like to hear from others but I know that I can always access individual safeguarding supervision from the team about that family if I'm unable to discuss them at a meeting."* (HV6 RHB).

This HV had experienced a bigger supervision group where not everyone could discuss their case. This was also experienced in this area when observing the group supervision, when there were 11 participants.

> *"**Feelings:** Supervision group involved 11 participants, HV/Midwife mix, some with camera off. SNA managed as best as she could. Not all participants brought a case. Explored with SNA in de-brief post observation about managing number attending and the HB process."* (Field notes – virtual group supervision observation RHB)

Health Visitor six (HV6) particularly enjoyed the multi-disciplinary mix of the group and was keen to share information and experience within the group setting when prompted by the supervisor. Some HVs spoke about how they prioritised safeguarding supervision. HV5 (RHB) prioritises group supervision,

> *"I have a session and then I book another one straightaway, three months later."* (HV5 RHB).

Whereas (HV4 ICRHB) drew attention that it was compulsory within health board and if not completed the line manager would be informed.

> *"I make sure I do....I always do it regularly and book in straightaway after my session....it is part of your PADR , you know part of your mandatory training so you have to achieve that anyway.....you have to sign in and give your payroll number and ….it's quite easy to book on again if you have to cancel....I know management do get told if ……you don't attend*." (HV4 ICRHB).

Health Visitor six (HV6 RHB) prioritised her safeguarding supervision, there are some reasons why attendance does not occur,

> *"...we have to attend so many sessions a year, I try and attend them all anyway because I find them useful and informative so I do try, obviously if there's a case conference or a core group those are the only reasons, I wouldn't be able to attend."* (HV6 RHB).

Health Visitor five (HV5 RHB) was able to prioritise which cases need further support/discussion, and made it clear she would access the safeguarding hub if urgent advice was required, and if she had no cases to discuss she would "*just rock up*."

7.8 Recording safeguarding supervision

Safeguarding supervision and any safeguarding discussion should be recorded within the HV records. I observed some HV records and saw first-hand where the safeguarding plans and supervision records were recorded as part of documentary analysis, anonymised below.

> ***Case note copied from safeguarding supervision notes from (Date inserted) Telephone discussion with HV.***
>
> *HV has been unable to contact Mum despite arranged and opportunistic visits to arrange CHILD X development assessment. There is a history of poor engagement and missed appointment visits. One Police protection notice (PPN) has been received in (Date). Neither Mum nor CHILD X have been seen by their GP since March 2020. Mum has expressed anxiety about COVID-19 which may contribute to her lack of engagement. DAD has experienced significant Adverse Childhood Experiences (ACEs) in his childhood; the electronic records reflect the struggles in social situations.*
>
> ***Plan:*** *further opportunistic visit; if parents home explains concerns, if not letter to be posted to parents outlining HV concerns and action needed if parents fail to contact HV within a time scale, review the childhood records of both parents to understand what may influence their parenting capacity, update GP with concerns, if parents do not engage consider a referral to Children's Services.*
>
> ***Case note copied from safeguarding Health Visitor notes from (Same date inserted)***
> *Safeguarding advice/ Supervision following DNA for developmental review as appointed by letter.*
> *Previous history of non-engagement and DNA/CNA*
> *Poor engagement with Health Visiting Service-Please see Safeguarding case note also (date inserted).*
> *x 1 Previous POLICE PROTECTION NOTIFICATION.*

Health Visitor liaison with Childcare admissions- Retrospective report from Team who shared that CHILD X attends Nursery but has not attended last week and today due to illness.
Childcare shared current number for Mum held-different than on HV notes
This above information not known at time of Safeguarding Supervision.
See Significant Event Chronology completed.

***Plan** - Health Visitor to contact childcare for professional liaison.*
Health Visitor to attempt contact with MUM on new number available.
Health Visitor to opportunistically attend home for contact if unable to reach by phone.
If no answer at home visit, then as Safeguarding Plan - letter to be delivered with Health Visitor concerns and invitation to re contact Health Visitor within time scale this will include advising parents of Health Visitor needing to make contact with Children Services if no response as currently health needs in view of development and seasonal flu vaccinations for CHILD X not being met.
(Documentary analysis case note ICHB)

The above extract demonstrates how the SNA has inputted information as well as the HV. The information is succinct and a clear action plan is put in place with a safeguarding plan specified. An electronic platform can prove efficient in the sharing of information and recording instruction from one practitioner to the other.

Two of the health boards used an electronic record and one health board used paper records. Health Visitor five (HV5 RHB) in the RHB referred to previous practice when one to one supervision was common practice and implied recording was more straightforward. She referred to,

> *"...the good old days when the safeguarding nurse would then email you with what you'd discussed and then you would file it.... so, in a paper record you used to have like your family element, your child element, and then there would be a safeguarding section at the back and that would have your copy of your minutes of meetings, copy of the child protection plans, and then it would have your safeguarding supervision records as well."* (HV5 RHB).

With the move to electronic record keeping a note is added to the record stating '*discussed with safeguarding lead.'* Health visitors add safeguarding plans to their record based on their safeguarding supervision discussion. This was observed in four of the six HV records reviewed. It was not possible to observe in one health board that used paper records due to COVID-19 restrictions at that time. One of the HVs (HV4

ICRHB) who used paper records explained how she included the supervision note in her documentation.

> *"I would write an entry about the discussion and what the plan is as a result of that supervision. I still try and sum it up really, if I can, not always the best way of documenting it I have to say, but I'd need some sort of structure." The SNA does not regularly review the safeguarding plan. Although, this did occur when it was face to face and one to one. "I'm assuming if it was face to face, they may do (sign the record) …. No, they haven't signed it in the recent years no, they used to when it was the one to one, they would always sign."* (HV4 ICRHB).

The SNAs within the other health boards can access the HV record due to the electronic health record systems used.

One experienced HV (HV6 RHB) utilised the safeguarding leads to have oversight of any child protection report writing.

> *"....frequently, they read my child protection reports before I submit them or share with the family, I'll always send them my reports in to have them proofread and they may not know that family, but I find it's important that they have a read over it first to look at.... if I've got a query about anything I think our safeguarding team are very open and I find it really easy to work with them so I know I can pick the phone up and somebody would get back to me."* (HV6 RHB).

The support provided by the safeguarding teams was appreciated by the HVs and they recognised the importance of efficient documentation within their HV records. The ICHB uses an electronic health record. HV1 (ICHB) would contact the supervisor to review her record if any additional information was added.

> *"....any notes that I make.... if I've got concerns, I will notify my safeguarding supervisor. I never wait for supervision, never, never, I just notify and I just ask her can I have your opinion or because I always feel that perhaps I want her opinion today, tomorrow, you know on how to proceed.... the supervisor has come back and said I've added this or can you put this in so yes, she does actually read them which is good because it's feedback again isn't it?"* (HV1 ICHB).

This demonstrates the advantages of an electronic record accessible across a health board. This was also discussed with HV2 (ICHB) who felt being able to add information which can be accessed by the supervisor in a timely manner, allowed for discussion and further risk assessment with sharing of up-to-date information. She described in detail how the HV record was structured and how effective it was to have the SNA be able to

access the health record. The HVs valued the safeguarding team expertise, and their accessibility was evident during questioning via interviews and focus groups.

7.9 Preparation for home visits post safeguarding supervision

The interviews with the HVs explored if and how safeguarding supervision supported safeguarding practice. The original research plan was to visit a family that had been discussed and safeguarding supervision with the HV. Unfortunately, this was not approved by the research ethics committee therefore I attempted to explore how the supervision assisted/advised/supported the HV in preparation for a visit to the family once the supervision had occurred. To prepare for a visit post supervision HV2 (ICHB) reflected on supervision by referring to her records of the safeguarding action plan.

> *"I would always reread the Supervision/the safety plan.....Make sure that I've got everything in place for a referral (child protection) if it was needed to be put in at the time of the contact."* (HV2 ICHB).

Also, the safeguarding leads in the ICHB can access family records via the electronic system used. Therefore, following supervision, the HVs have access to further information. HV2 (ICHB) referred to the safeguarding adviser accessing more detailed information which would further inform her visit and subsequent assessment.

> *"...Safeguarding' were able to access.... the mother and father's files and they were able to tell me that there's a lot of ACE's (Adverse childhood experiences) with those parents, that there was a lot of non-engagement, a poor kind of engagement with services on the dad's side as well."* (HV2 ICHB).

This allows the HV to assess for potential impact of these risk factors. All the HVs referred to how they reflected on their safeguarding supervision conversations and subsequent safeguarding plans prior to home visiting the families discussed. HV1 (ICHB) was confident that the plan suggested was followed and alluded to it offering more of a structure to the visit.

> *"To be honest I think that we usually follow the plan anyway.... once it's been discussed in supervision, I suppose yes there is more of an agenda so that we know obviously what we aim to, what we're hoping to achieve...."* (HV1 ICHB).

This was reinforced by HV3 (ICRHB) who was more reflective prior to her visiting. She refers to the complex family she brought to supervision where there was suspicion of Perplexing Presentation/Fabricated/Induced illness. Perplexing

Presentation/Fabricated/induced illness occurs when a parent/carer feigns/exaggerates/falsifies an illness of any type which could be /physical or psychological (Royal College of Paediatrics and Child Health RCPCH 2021).

> *"I personally reflect, if I've taken this particular family that we've spoken about to supervision then I reflect on the supervision firstly, maybe do my signs of safety (risk assessment tool) so I've got a little bit more of a clear plan of ….a better understanding and then I write a plan about what I'm going to do at what stage and then going into the family."* (HV1 ICRHB).

The information and support from the supervision session allowed HV5 (RHB) to reflect prior to a home visit. It made her think of the type of questioning to be used to allow for the most information to be disclosed by the family,

> *"....you reflect on the supervision and then you almost, I suppose you plan a little bit in your own head don't you, the questions that you're going to ask? So, you know that you're going to....do some open leading questions because you want....you don't want to be direct but you want to kind of like 'oh how are you?' …...because you're trying to get certain information. You know if that's what you want or whatever the supervision has told you that you need to glean from that home visit really isn't it?'* (HV5 RHB).

The supervision seemed to influence the type of questioning used to extrapolate further information to inform the risk assessment during the HV visit. The safeguarding supervision experience was influenced by its facilitation. Health visitor perceptions of group safeguarding supervision were generally positive. They felt it was supportive and reassuring listening to colleagues and they valued other colleagues' expertise and advice. Health visitors did state they would like a mix of group and one to one supervision, and they offered comparisons and preferences. Across the three-health board's delivery of safeguarding supervision varied and it was moved to an online provision during the pandemic, and I was able to explore how they felt the supervision was facilitated and structured to aid their practice and critical thinking particularly in the interviews where I felt HVs were able to be more open. Following observations, interviews and focus groups including the HVs, I was keen to explore the SNAs' perception of the supervision process and the next chapter explores their education and training to support safeguarding supervision delivery, how they felt with a move to group supervision, their confidence in facilitating it, their perception into how prepared the HVs

are for safeguarding supervision and how they engage with them during the process. The recording and monitoring of safeguarding supervision is also included.

Chapter 8 Delivery of safeguarding supervision – The safeguarding nurse adviser perception

My data collection was structured purposely to interview and observe HVs prior to interviewing the SNAs. This decision was taken to allow me to shape questions for the SNAs based on the data from HV participants. One-to-one semi structured interviews were undertaken with six SNAs across the three health boards. This was to explore any differences in experiences across the three geographical areas as well as accessing SNAs with variable experience and with different professional backgrounds (HV, School Nurse and Midwife). Safeguarding Nurse Advisors are senior members of the safeguarding nursing team, generally at band seven on the agenda for change pay scale. There were variations used in the terminology associated with facilitators of safeguarding supervision. Examples are ‘safeguarding nurse adviser/advisor,’ ‘lead nurse/ lead nurse safeguarding’ and ‘vulnerable lead.’ These nurses can sit within corporate safeguarding teams or within areas within the health visiting service, namely, the Flying Start service. The research aimed to explore how confident they felt in delivering safeguarding supervision, as well as the education that underpins their safeguarding experience in practice and their knowledge base to facilitate and manage safeguarding supervision.

Following group supervision, observations and interviews I was able to theme the findings as follows:

- Education and Training
- A move to group supervision.
- Confidence
- Engaging the HVs
- HV Preparation for safeguarding supervision – the SNA perception
- Recording and monitoring of Safeguarding supervision

There were similarities with some of the HV perspective findings, my observations of practice, and safeguarding supervision. The SNAs agreed that HVs did not prepare sufficiently or prioritise the supervision sessions. This was explored in the interviews with the SNAs as well as observing HV engagement during a safeguarding supervision

session. Several factors could be attributing to this. For example, health board policy/guidance directive with clear expectations set out for the HVs would be beneficial. Some of the HVs were unsure of the criteria to bring cases, unclear of local and national policy which would impact their engagement. SNAs also expressed concern over engaging with the HVs over Microsoft Teams, they had less control of participation, HVs turning cameras off, connectivity and they were unable to read body language, and this was a barrier.

> ***"Objects:** Online space, each HV and SNA had 'blurred' backgrounds. During the HV discussion the camera flickered intermittently, and she had to turn camera on and off due to the poor 'bandwidth' in the office. There was a lot of background noise (conversations)."* (Field-notes, virtual safeguarding supervision observation, ICRHB)

Some of the SNAs expressed concern over the move to group supervision initially but were reassured with one-to-one supervision being an option as well as access to ad hoc supervision for urgent enquiries. The first question to all SNAs was about the education and training they received to equip them to deliver safeguarding supervision.

8.1 Education and Training

The responses received from each SNA were similar in relation to their experience of support and education to deliver safeguarding supervision. Preparation was brief, ranging from on-the-job observations to one day training. Safeguarding Nurse Advisor (SNA5 RHB) reflected on the training they received:

> *"I did go for a day session in... (Area named) but unfortunately the whole day was cut short due to extremely bad weather... I didn't feel it was really substantial it wasn't detailed enough; it was more like talking about group supervision at a point where I think at that time, we were giving individual supervision and it was some considerable years back. Otherwise, the only other thing that I have done is to observe a couple of supervision sessions again this was on a one-to-one basis with my previous counterpart."* (SNA5 RHB).

The research explored if the SNA could recall any of the content and the participant response was;

> *"...they were talking about some methodologies and the structures, how things were working...yes, the methodology behind the supervision itself as opposed to*

actually engaging with the professionals and it was more structure based." (SNA 5 RHB)

The questioning probed a little deeper and asked if any models of safeguarding supervision were discussed. The interview was carried out virtually on Teams, and there was a pause, the participant had to really think hard about the content of that shortened day of training. In relation to the types of supervision discussed within the training and they struggled to recall.

> *" No, no, like I say, it was going back a considerable period of time ago, I think we might have talked across Gibbs, John's but they were, I can't remember much more about it other than that but of course Gibbs and Johns are quite well known anyway so it was something that I was aware of previously to be able to take people through."* (SNA5 RHB).

We discussed that these were models of reflection and the SNA thought that the training was over four years ago. She seemed content with the training she had received. The SNA had searched for further safeguarding supervision training previously, but due to cost this was not an option at that time, SNA6 (RHB) had attended a one-day safeguarding board training day in 2019.

> *"...There was lots of talking about sort of the dynamics of groups and how to kind of facilitate a session really rather than kind of it being a training session... I seem to remember them talking about leading... it's about getting them to discuss their (supervisees) cases and scenarios and kind of sitting back and allowing that really rather than leading the session. I think that's the kind of impression I got from the training from what I can remember. There were things about the sort of structure in sessions... about how to kind of try and encourage them to participate so yeah that's pretty much all I can remember of the session."* (SNA6 RHB)

Safeguarding Nurse Advisor (SNA6 RHB) was unable to recall any models of safeguarding supervision,

> *"...not off the top of my head, that's terrible, isn't it?"* (SNA6 RHB).

The questioning continued to investigate the delivery of safeguarding supervision and how SNA 6 (RHB) structured the sessions they facilitated, based on the training and with the use of a particular model/any model.

> *"I wouldn't say that I do particularly have anything in mind, I suppose because I came into supervision, and spent a lot of time shadowing the nurse specialist doing it and I kind of yeah sort of followed their lead on their sessions really, and I suppose that develops the longer you do it. But no, I can't say there's a specific model that I would say I could refer to off the top of my head, no."* (SNA6 RHB).

This SNA felt the training they attended "was a really good session." Safeguarding Nurse Advisor (SNA1 ICHB) and SNA2 (ICHB) both received similar training which was a day in length. Their training involved exploring,

> *"...different areas or different angles... people's perceptions of what they perceived as what would be regarded as safeguarding. I think there was a case study and there was a group because there were people from different areas... so we looked to see how they did it as well. There was documentation.... I can't fully remember it; it was when I first started"* (SNA1 ICHB).

They were both positive about the training,

> *"...it was a really good day.... they went through one model and I'm trying to think, the ones with like one to one and then group."* (SNA1 ICHB).

This participant was unsure of any specific models of safeguarding supervision, I gave some examples and they stated,

> "*.... it rings a bell. But I remember us focusing a lot on our style."* (SNA1 ICHB).

Safeguarding Nurse Advisor (SNA1, ICHB) had been in her role for 16 months with SNA 2 in post for 2.5 years. She stated,

> *"...nobody has ever sat down with me and said right, when you get a group, this is how you would it, no."* (SNA1 ICHB).

Safeguarding Nurse Advisor (SNA3 ICRHB) had no formal training, she was six months in her role at the time of the interview.

> *"So, when I started my role, I joined some of the other leads on their group supervision so I could observe and then I took part with some of them sitting in on mine, so that they could be as a backup and also just check on me I guess, so that was my process when I started. I guess I went to two or three sessions with other people and then maybe I had one session with someone sat in on mine"* (SNA3 ICRHB).

Therefore, SNA3 had had no theoretical aspect to her supervision training with observation of other SNAs only in preparation for the safeguarding supervision element

for her role. She had been a participant of group supervision as an experienced school nurse and was aware of the format and purpose of group supervision,

> *"I was really happy to take that on (group supervision)."* (SNA3 ICRHB).

SNA4 ICRHB had undertaken safeguarding supervision training when one-to-one supervision was common practice and she estimated that it was approximately 8 years ago.

The questioning probed further to explore if any types of safeguarding supervision models were highlighted within the training.

> *"…they did but I can't remember because I tend to use Kolb's you know, I tend to use the reflective cycle and I think that's the one we did ...talk about it and I have tried but I find that a little bit, not with the groups, but supervision over the years, I've tried, it's a little bit more cumbersome (Kolb's model)."* (SNA4 ICRHB).

At the time of SNA 4's training, HVs were receiving one to one, face to face supervision. They recalled,

> *"I think there was a bit of discussion about the group, but it was mostly one to one and the purpose of it.... the basics of safeguarding supervision...challenge, all that kind of thing."* (SNA4 ICRHB).

The approach and access to safeguarding supervision training across all health boards had similarities. It was generally coordinated by the Safeguarding network in Public Health Wales and/or the SNA observed other SNAs in their safeguarding supervision before facilitating their own sessions. Health boards had started to move to a group model of supervision from 2018 rather than offering predominantly one-to-one supervision in health visiting.

8.1 A move to group supervision.

The SNAs were asked to think about how they felt when there was a move to group supervision to one-to-one supervision. SNA5 RHB recalled,

> *"I must admit initially you feel it's quite intimidating as a supervisor because it is a significant change... On a one-to-one supervision basis, we used to go through almost every case that the health professional brought to us.... when we moved through to group supervision you were never going to be able to cover everybody's cases, you were reliant on them bringing the cases... So, you were*

> *having to address the shyness or the reluctance of professionals to engage in groups and additionally now of course that's now on teams as well rather than face to face. But I think actually it is the same, people are still quite reluctant to bring cases, complex cases, to have them analysed within supervision more so than there was face to face on a one-to-one basis."* (SNA5, RHB).

During one-to-one face-to-face supervision, the SNA can discuss the complexities within a whole caseload, with a move to group supervision where HVs could bring one case,

> *"We were very much taking a step away from having that overall picture (of the caseload).* SNA5(RHB).

All of the SNAs understood why group supervision was introduced as one-to-one was *"unsustainable"* (SNA2 ICHB) for every practitioner. The remit of the safeguarding teams had broadened and although HVs receive regular supervision so do other practitioners. For example, inpatient children and young people wards, Child and Adolescent Mental Health (CAMHS) teams and accident and emergency teams. The concern to move from to one-to-one supervision was reiterated by SNA4 (ICRHB) with several issues raised but, they could see the benefit also to group supervision.

> *"...not that happy really, more in relation to.... putting the onus back on the health visitors.... I felt it was.... almost a step too far initially anyway."* (SNA4 ICRHB).

Later in the interview they refer to feeling *'bothered.'* They articulate this as.

> *"...that bothers me, the difference between the ones (one- to-one) we used to do.... they don't necessarily bring them to group whereas they would have brought them.....to one-to-one supervision so that does bother me a little bit really."* (SNA4 ICRHB).

They felt they had *'less of a handle'* (SNA4 ICRHB) on what was happening within caseloads now that the supervision was predominantly in a group format. Safeguarding Nurse Advisor (SNA 6, RHB) was a midwife by background and had adapted the delivery of safeguarding supervision to include health visitors. They had seen a rise in attendance to group supervision from a midwifery perspective and she related to how HV attendance at safeguarding supervision was good. On reflecting on the HV/Midwife mixed group SNA 6 RHB felt it was a good combination.

> *"I think that adds quite a lot of richness ... we have different issues in different areas for safeguarding. The practitioners being able to talk about their experiences. So personally, I feel that that's been quite a benefit having the mixed groups."* (SNA6 RHB).

Safeguarding Nurse Advisor (SNA3 ICRHB) was extremely comfortable with the move to group supervision.

> *"Well, I knew it was part of my job description before I started, I taken part in group supervision as a practitioner previously, so I knew the format, I understood the process and what was expected so I was really happy to take that role on."* (SNA3 ICRHB).

This SNA who was new in post felt confident and this was displayed in her demeanour, her tone of voice and was more than likely due to being exposed to regular group supervision as a school nurse, it was regular practice, embedded, and the norm in school nursing practice. She reflected on her early experience.

> *"I think people (practitioners) will always need the ad hoc one to one, that has its place as well because you can't prepare people for every scenario, can you? So, you (the HV) have the ability to pick up the phone Monday to Friday and get that immediate advice, you couldn't be without that. So, it has a way of supporting people, education and sharing, that immediate supervision is a different game, but we can't do without either of them (one to one and group supervision formats), they both need to be there."* (SNA3 ICRHB).

With the move to a group supervision model in safeguarding practice, the SNAs were questioned about their confidence in its delivery and facilitation.

8.2 Confidence

The SNAs had a wide range of experience within their field of practice. Three were health visitors, two were school nurses, and one was a midwife. Their length of time within their roles varied from 16 months to 20 plus years. Their experience brought varying degrees of confidence in facilitating safeguarding supervision which extended into how they read practitioners non-verbal communication, assessed risk, and communicated to support safeguarding practice. Health visitors were placed out of their 'comfort zone' during the pandemic with a move to virtual group supervision. They adjusted to this process but with some hesitation and a steep learning curve from a digital resource perspective. Not only did they have to learn the new skills of accessing

online meetings, but they had to navigate online etiquette and have confidence to speak up in each meeting. Safeguarding Nurse Advisor five (SNA5, RHB) tried to explain what good supervision meant to them,

> *"So, we have to try to engage the HVs a lot more within that (group supervision) and get them so that they're confident to speak out within a team and I think that is coming, that is moving as they learn that it's a safe space. I know the HVs did not like it initially."* (SNA5 RHB).

The SNAs attempt to identify if the HVs were struggling with safeguarding practice issues, this was often determined by how well the HVs engaged in a supervision session. Safeguarding Nurse Advisor five (SNA5, RHB) said;

> *".... they won't tell us what they're struggling with and unless we know it's hard for us to give them further information."* (SNA5 RHB).

If concerns arose, then the HV had the option to contact the SNA outside of the session and liaise with the HV line manager.

> *"We have this face-to-face ability even if it's on Teams to be able to read the facial expressions, you can pick up when practitioners are upset... And I will sometimes call a practitioner or even speak to their line managers if I feel that things are too much"* (SNA5 RHB).

The interviews therefore in the first instance explored how confident the SNAs felt as well as how they engaged the HVs in the group discussion.

In relation to their confidence, they were very honest with comments such as.

> *"I would say initially it was relatively low (confidence) but that's a number of years back now. I actually quite enjoy delivering supervision now, confident in the respect that every once in a while, you'll get a question where you think 'oh God' I'm not quite sure on the answer with that but I think that's actually probably quite good for the practitioners as much as it is for us. It keeps us on our toes..."* (SNA5 RHB).

This was one of the SNAs with a school nurse by background and had experienced supervision within that role with a heavily weighted safeguarding caseload. She felt she brought that experience into her SNA role as well as her experience teaching parents, children and teachers and acknowledged that although she may not know the answer to

provide a solution at once, it prompted her to keep up to date from a professional practice perspective.

Safeguarding Nurse Advisor three (SNA3, ICHB) had a school nursing background too, she felt confident facilitating safeguarding supervision.

> *"Well, I feel confident, I just see it as a conversation really with the practitioners, so I don't feel uneasy about it. As with anything in that sort of regard, if there was some if something came up and I felt it was outside my expertise then I would make a point of getting back to the person. So, I don't feel uneasy about it."* (SNA3 ICRHB).

This confidence was observed, and SNA 3 had positive feedback following the session.

> ***"Goals:** HV to receive structured and supportive advice to guide practice in a complex case presentation."* (Field note – Safeguarding supervision observation ICRHB)
>
> ***Feelings:** The discussion took up most of the supervision with the HV relaying the background to the case. She appeared genuinely concerned looking for support from her colleagues. Questioning was reciprocal to process the main issues before a supportive plan was put in place*." (Field note – Safeguarding supervision observation ICRHB)
>
> *"... just that they found it useful and thanked me for my time and I had that off two of the HVs that attended that day."* (SNA3 ICRHB).

This SNA seemed to underplay the significance of the praise. They used the word 'just' when explaining what had happened.

Safeguarding Nurse Advisor six (SNA6, RHB) was a midwife by background and experienced in delivering group supervision in midwifery prior to the combine HV/Midwifery group supervision. She felt confident too as her experience developed.

> *"Much more confident than I used to be, I'd say with experience I think, and also, I'm not afraid to kind of say if I'm not sure about something...it's quite important."* (SNA6 RHB).

Credibility as a practitioner also factored into their confidence.

> *"I suppose I have credibility as a practitioner as well because I do clinical (practice), I do have more (credibility) within midwifery though.... The HVs*

probably see me slightly differently because I'm not a HV. But then none of the others (SNAs) have practiced for quite a long time in clinical practice. I don't think they see us any differently.... I've not had a HV you know thinking that I shouldn't be doing supervision because I'm a midwife.... I haven't had any negative kind of feedback on that in any respect." (SNA 6 RHB).

Three of the SNAs had a HV background. SNA1 was a new supervisor. They had found their first few sessions quite challenging due to supervising HVs who had had over 30 years' experience in the role, although they were able to engage them in discussion eventually. They reflected on one of initial group supervision experiences.

"I had a group of very experienced HVs who've been health visiting for 30 plus years and they'd sit around the table and just like the newly qualified one sitting there, then I would go around the table.... I would look.... nobody would look when I say, 'who's next then?' I would look at one particular, experienced HV and she'd say, "oh I've got nothing.' I've been on the caseload I know it very well." (SNA1 ICHB).

The SNA had practice knowledge of the caseload referred to above, it was SNA1's previous practice area and they felt there would be something to discuss but they had to work hard to get the experienced HV to share a case. When she (the HV) eventually did, the newly qualified HVs appreciated the discussion,

"You know, I find the newly qualified really appreciate that." (SNA1 ICHB).

They had also had a challenging situation which they described as making them feel demoralised. A senior HV team leader was in a supervision session, five HVs should have been present and three of them had turned up. The senior HV had brought one case for discussion, which occurred when one of HV managers interrupted the session. SNA1 described that.

"The health visiting manager just came in, barged in opened the door without knocking and said (to the senior HV) 'you're needed in a meeting.' I had to turn around and say oh, we're having safeguarding supervision and she was like, 'oh, I've done mine, can I go?' ...I just felt it was very, very rude." (SNA1 ICHB).

The senior HV realised the other HVs needed to bring a case and opted to stay briefly, but this pressurised SNA1 to finish the session quickly.

> *"From that moment on I felt then that we were in a rush, I felt then oh, I've got to hurry up with this now because she needs to go, and I was completely demoralised then."* (SNA1 ICHB).

The SNA completed the session with the two remaining HVs which offered them a more detailed discussion. Following the session, they were able to reflect on the situation, think about how they could approach it, they ensured on communicating with HVs prior to the session and was able to articulate that supervision needed to take priority. The senior HV attended a later supervision session and was,

> *"...really engaging and came up with ideas and it was really different."* (SNA1 ICHB).

(SNA 2, ICHB) also a HV, works in the same health board (ICHB), she had been a SNA for two years, six months. When exploring how confident she was she stated,

> *"I feel really confident with group supervision now... I think with group supervision I feel my knowledge of safeguarding and the plans and things I feel competent with, and I think a lot of it is the management of people then and how many cases they bring in and the relevance of that."* (SNA2 ICHB).

She referred to the observed group supervision session within this health board. She identified the anxiety displayed by one of the HVs in the session stating:

> *"...you kind of feel the anxiety and I felt that it was good to be able to just support her there and then she felt confident in the group to do that but I think because I know that group I think before the next supervision then I would speak to them and let them know about one-to-one supervision"* (SNA2 ICHB).

This SNA appeared to be quite insightful within her group supervision session and she displayed an air of confidence compared to SNA1 who although efficient appeared a little more nervous and it is assumed that this is due to her inexperience within the role. Although, SNA2 referred to an incident when she was challenged to challenge a HV and she recalled she felt confident to do that,

> *"...the challenge is quite a word to use but sometimes it's also coming to...so they (the HV) may say, 'oh, do you think I could give it until next week to go in and speak to mum next week'....if I don't feel we should be waiting that long I'll say, 'Actually you need to speak to her today."* (SNA2 ICHB).

She felt that this sort of challenge was positive, allowed discussion and a plan to be developed for the HVs to record in their records. Safeguarding Nurse Advisor four (SNA 4 ICRHB) was a very experienced SNA (17 years' experience) and the third SNA with a HV background. When exploring her confidence, she said

> *" ….the actual delivering the ….group supervision doesn't faze me but I must admit I'm not, I wouldn't say not confident in it, but I'm aware of limitations with group supervision I am aware of situations that are sometimes difficult to manage within a group, so I feel confident in as much that I would know/ be able to handle not necessarily myself, but know what to do with them (the HVs) if that makes sense."* (SNA4 ICRHB).

This SNA managed challenges within the group observed, and her lack of confidence is associated with confidence in the group supervision model rather than her own confidence in its facilitation. Each facilitated session was managed slightly differently with the SNAs confidence/lack of confidence being noted as well as their engagement with the HVs. The school nurse and midwife advisors appeared more comfortable in their delivery to a certain extent, and they had had more exposure to the group supervision practice within their previous roles. Therefore, it was potentially more familiar to them. In comparison, the HV SNAs needed to adjust from a one-to-one model of safeguarding supervision to the group supervision process.

8.3 Engaging the HVs

The SNAs were mindful that they needed to engage the HVs and that use of 'Teams' was a potential barrier as well as HV confidence in sharing their cases to be analysed in a group setting. Safeguarding Nurse Advisor five (SNA5 RHB) felt that face to face group supervision is more effective.

> *"....it depends very much on the ... HV and their confidence to talk …. I've discovered it's an awful lot better for practitioners when, as we are now.....you can see each other and talk to people, and you can see face to face. I feel that Teams group supervision works far less, and you get far less contribution from practitioners if they have no camera... I will try and pull people in just using their names to the discussion but from that you get a lot less engagement from practitioners without cameras."* (SNA5 RHB)

During observation of safeguarding supervision there were several HVs who did not use their camera. For context, five online safeguarding supervision sessions were observed

with two sessions observed face to face (socially distanced with masks). SNA5 (RHB) explained,

> *"Technology is holding them back..... Face to face, you know you've got that engagement but it's when you've got a practitioner... Turned away (from the screen) and they are obviously concentrating on something totally different and you're just on in the background and then I will try and pull them into the conversation."* (SNA5 RHB).

This SNA supervised other professional groups and used an example of practitioners going onto 'mute' to answer phones, open doors and talk to other people within the office environment. This was observed during observations of safeguarding supervision with practitioners seen talking to each other if they were in an office setting and sharing a screen, one supervisee was distracted by a child as she was working from home, one practitioner was knitting and then took a phone call. This was within a virtual safeguarding supervision session where HVs were supervised with Midwives. Safeguarding Nurse Advisor five (SNA5 RHB) reflected,

> *"…. they haven't got anywhere else to go, have they? They are all at their usual desk so people will still come through the doors the phone was still go, and it's that shut off of everything else that people find particularly difficult at the moment."* (SNA 5 RHB).

She recalled feeling frustrated when supervising a group of practitioners (HVs and midwives) who share a computer and she cannot see all of them due to social distancing, and they turn the camera off and put the sound on mute. She hoped they were talking about the case being discussed,

> *".....you can't control that, and you know in some ways it could be beneficial.....but I don't think that works as group supervision when they are not sharing with everyone else and the facilitator."* (SNA5 RHB).

The pandemic proved a significant challenge in engaging with HVs. Safeguarding Nurse Advisor five (SNA5 RHB) felt HVs were bringing less to supervision. She was concerned,

> *"Everybody is so, so busy …...having to prioritise priorities .... and they're acting without gaining themselves that little bit of support in relation to what they're trying to address, and I think it's more likely to be the latter."* (SNA5 RHB).

Safeguarding Nurse Advisor six (SNA 6, RHB) felt she was able to manage dominant characters within the online group situation. She felt there was no difference in group dynamic compared to face-to-face supervision.

> *"I think people seem as engaged on teams.... you might have somebody who wouldn't necessarily speak face to face or be as confident because you can hide a little bit even if you've got your camera on and you can hide a bit behind it."* (SNA6 RHB).

Interestingly, this SNA facilitated the session where one practitioner was knitting, and one was discussing a case with a child on her lap. (The supervision sessions in this health board include HVs and midwives). The FGs did explore what the HVs felt about this mix of professions, some found it positive, and some felt it was a challenge at times. This was reflected upon by one of the HVs in the RHB focus group.

> *"My experience of supervision with midwives has not been particularly good.... I haven't found it particularly supportive I found it very distracting because midwives don't seem to be as interested in what's going on.... I sat there and thought 'what is the point of this?"* (FGHV RHB).

Another HV from the RHB FG stated,

> *"I didn't feel it was very protected.... supervision has got to be meaningful.... the midwives didn't really understand the processes and things....it wasn't meaningful for me, but it was obviously for them."* (FGHV, RHB)

This HV went on to state,

> *"It just makes you feel your sitting there and wasting your time really because you know you want something to push yourself and actually it wasn't pushing myself or making myself think because you know exactly what they were talking about."* (FGHV, RHB).

A different HV participant had attended supervision the morning of the FG and had a positive experience with the midwives in attendance.

> *"It was really professional. Everyone shared their views.... I felt really comfortable having a different view …. I felt it went really well."* (FGHV, RHB)

Whilst the SNAs try to engage the HVs, barriers continue to exist, especially in this health board with this mix of professions.

The SNAs were very aware of the need to engage proactively with the HVs if the session was going to be meaningful. Once one HV opens up about a case this seems to trigger further discussion and HVs sharing more cases. SNA1 (ICHB) reflected that,

> *"...drawing that out of them...can be challenging but then as they start talking and we start picking up little points they go yeah, oh yeah..."* (SNA1 ICHB)

They seem to open up and engage proactively with prompting from the SNA and critical discussion with their peers. Newly qualified HVs are keen to engage in supervision, SNA1 referred to fear associated with the complexities of safeguarding,

> *"I think it frightens them."* (SNA1 ICHB).

The newly qualified HVs have access to regular one to one supervision in the first year of their role as well as group supervision, they are keen to engage in both. Safeguarding Nurse Advisor three (SNA3 ICRHB) also reflected that sometimes the HVs just don't want to share. She deals with this by

> *"Just inviting them into the conversation and ask for their opinion or ask them personally if they want to share anything, but you can't make people.... I guess it's just a bit of encouragement."* (SNA3 ICRHB).

None of SNAs identified major concerns with regular non-engagement of HVs although they did refer to distractions when online. SNA 4 (ICRHB) refers to,

> *"....we do the usual spiel at the beginning and then I have somebody who is on their phone and you think, 'it's not really appropriate really' the idea of the session is that everybody takes part equally and you can't even tell on 'Teams' who's got their phone on...."*

This SNA offered some insight into a positive experience and compared with a less positive perspective. She describes the *'perfect session.'*

> *"Dynamic health visitors...you get the occasional group with a good mix of dynamic health visitors, and I can almost sit there and not say a lot you know.... it's what I would call a perfect session. Then other sessions that I know a couple of us have described 'like pulling teeth' and you're saying, 'look you must have a case to bring...and they just don't."* (SNA 4 ICRHB).

Safeguarding Nurse Advisor two (SNA 2, ICHB) reflected on when HVs may disengage in a session,

*"I do try to pick up on that and bring them back in." (*SNA2 ICHB).

She realised that workloads were busy and fitting in supervision can be a challenge,

*"I think they're really focused on their cases, and they want to plan, and they want reassurance and that's their main priority." (*SNA2 ICHB).

During group supervision HVs should be engaging for the full amount of time allocated. The observations of supervision did witness HVs arriving at the session and asking what time it would finish, or, saying they have to leave early to undertake a visit. This potentially added pressure to complete the supervision and the education element. This occurred in the observation of Safeguarding Nurse Advisor two (SNA2, ICHB) session,

"So you may need to speed up the education aspect of it because you can sense it and you want them to have that information as well." (SNA2 ICHB).

Discussion at the supervision sessions varied as did preparation of the HVs in readiness to share cases about which they were concerned. Some HVs came with cases and some groups started their discussion slowly. Therefore, how the HVs prepared was explored with the SNAs.

8.4 HV Preparation for safeguarding supervision – the SNA perception

The general consensus was that HVs do not prepare for safeguarding supervision. Firstly, the research explored how the HVs were informed of safeguarding supervision and whether they were aware of any specific expectations of them and if the SNAs felt they prioritised it. Some of this narrative has already been explored with HVs asking to leave early with some SNAs feeling rushed to complete the session or interruptions that have occurred that leave the SNA feeling demoralised. In relation to HVs leaving early SNA1 (ICHB) stated,

"You feel it's quite rude, oh how dare you, this is my session but, no, I appreciate …...they have.... big caseloads. If they'd let me know when they first come in, I'll try and do them.... first and just check with other members of the team...it's difficult, it's challenging..." (SNA1 ICHB).

Health visitors informing the SNA they would need to leave early was observed only in the face-to-face supervision sessions within the ICHB. In relation to preparing the HVs

for the supervision, SNA1 emailed them to inform them of the date with a calendar invite, as well as emailing them the 'Signs of Safety' tool.

> *"I say bring that with you.... if you've started one, bring it with you and we can develop it over time."* (SNA1 ICHB).

Some sessions are booked three months in advance to ensure there are no clashes with baby clinic or annual leave. Another calendar invite is sent the week before the session with the 'Signs of Safety' document re-attached. In the ICHB, the HV team leaders all have the All-Wales Safeguarding supervision guidance which the SNA also takes to supervision for HVs to refer to if necessary. The SNA was asked why this sat with the Team Leader and if all HVs had access to it and have read it.

> *"We give it to the team leaders in the hope that they will disseminate it to the staff, but the staff know where to access it if they need to."* (SNA1 ICHB).

It was unclear if all HVs were aware of it and had read it.

Safeguarding Nurse Advisor two (SNA 2, ICHB) completes the same process in preparing the HVs for their supervision session. She expects them to complete the 'Signs of Safety' proforma which articulates any concerns and SNA2 reminds them of the terms of reference for the group. When questioned if she observes the HVs preparation she stated,

> *"I can see that they have come prepared, and I can see the framework but there are others who are sort of writing (during the session). I would say come some prepared, some don't, and I notice as well at the end of every supervision I've always got to say, 'right, are you clear with the plan to write up?'* (SNA 2 ICHB).

Each HV also signs a supervision contract in the ICHB which is stored on a shared drive. SNA1 also keeps a paper copy.

Within the ICRHB when questioned about HV preparation SNA3 was unsure if preparation takes place stating,

> *"I don't know, I think they are prepared, I just think sometimes people don't want to share, some do, some don't."* (SNA3 ICRHB).

Health Visitors in the ICHB were sent a 'terms of reference' which included information about Kolb's model of structured reflection (Kolb 1984). Safeguarding Nurse Advisor three (SNA 3, ICRHB) was unsure of the content,

> *"I've forgotten what it is called now, I'm just going to have to check myself, but it is based on a model of reflection I think."* (SNA3 ICRHB*).*

Safeguarding Nurse Advisor three (SNA3 ICRHB) was six months into her role. She was confident within her group supervision session and offered structured advice and guidance. Safeguarding Nurse Advisor four (SNA4 ICRHB) sent an email reminder out to her group members asking HVs to think of a case to bring to their safeguarding supervision session.

> *"So that's literally what their preparation is.... they've got the supervision policy as well, so you know (the HVs) .... the criteria from that."* (SNA4 ICRHB).

Questioning explored further the preparation and engagement of the HVs in the group supervision. It was observed that not every practitioner took a case to discuss. The types of engagement of the HVs was experienced and one type was referred to as, '*the active listener' by* SNA4 (ICRB).

> *"You can tell an active listener as opposed to somebody who is away with the fairies, thinking about what they were going to have for tea...if somebody seems like they're listening then to me they could be learning a lot more than the person who is taking the stage and doing all the talking."* (SNA4 ICRHB).

The observed sessions within this health board were one hour long (due to changes in policy caused by COVID-19) on Teams compared with three hours face to face in the ICHB or two/two and a half hours in the RHB.

Health visitors in the RHB, booked onto their sessions via a shared form held on a shared drive by the corporate safeguarding team. Their sessions were online at the time of data collection and lasted 2 – 2.5 hours. Safeguarding Nurse Advisor five (SNA5 RHB) reflected on preparation for previous one to one supervision and stated HVs were,

> *"...never prepared...the preparation that they were requested to do through policies didn't tend to happen and I ended up tending to that work on the one-to-one basis, filling out the forms whist we were there."* (SNA5 RHB).

In relation to group supervision,

> *"I would state it hasn't really changed...it's perhaps five/ten minutes before they come into a supervision session if they have time to do it then."* (SNA5 RHB).

Safeguarding Nurse Advisor five referred to the HVs wanting to prioritise it and there was a pro-forma in the back of their safeguarding policy they could utilise.

> *"I've never seen that filled for supervision session, so I don't believe that preparation is there."* (SNA5 RHB).

She felt concerned if cases were not discussed and felt concerned as she is cognisant that the HVs could have several vulnerable families but is allowed to bring one case to supervision. Safeguarding Nurse Advisor (SNA6 RHB) felt the HVs were prepared for supervision.

> *"I think they do; it depends on the group I suppose...I think it is important for us to remind people to prioritise."* (SNA6 RHB).

However, prepared or not the HVs have the potential to impact the facilitation of the safeguarding supervision session based on their input and engagement.

8.5 Safeguarding Nurse Advisor facilitation of safeguarding supervision

Across the health board's structure of the safeguarding supervision varied. Some commonalities occurred including updating on recent safeguarding events, updating on health board policy/practice, and using a risk assessment called 'signs of safety' although, this was used at varying levels.

Numbers of practitioners within each group varied, which is detailed in chapter five. In general, SNA2 (ICHB) related that groups were no more than four – six although there were times when groups were joined with a total of eight in a group, and during safeguarding supervision a group of eleven was observed. The observations were structured using dimensions of Spradley's (1990) nine observational dimensions in human interaction model and demonstrated the diverse and complex discussions brought to the safeguarding supervision space.

9.6 Recording and monitoring of Safeguarding supervision

Questioning explored how the SNAs thought the HVs recorded the supervision as well as how the SNAs record/monitor the safeguarding supervision. This appeared to prove challenging. Safeguarding Nurse Advisor (SNA1, ICHB) refers to:

> *"…. getting them (HVs) to do a safeguarding care plan at the end…. I always like them to do signs of safety because if you can write that down, that forms part of your plan, you can see where your plan is going, you can see what you need to be doing…….transfer that onto your safeguarding care plan….You've got it all electronic."* (SNA1 ICHB).

She found this challenging:

> *"I find that the hardest"* (SNA1 ICHB).

Safeguarding Nurse Advisor one (SNA1 ICHB) was able to reflect of a situation that day when a HV called to discuss an issue with a family. The HV said:

> *"Oh, do you remember that family? I discussed it at supervision with you, and I 'm going, 'Oh I can't remember that one, which one was it?' Because I had about ten phone calls beforehand, and I'll say ". ...oh, did you notify me what the plan was?'* (SNA1 ICHB).

On exploration with the HV the SNA discovered she had not written a safeguarding plan but a case note. This was discussed further with the SNA referring to that as health professionals,

> *"...the HV was responsible for completing their own documentation*." (SNA1 ICHB).

Conversation continued as to whether this had been discussed with the Head of Safeguarding. The SNA would be aware of what was brought to safeguarding supervision and put the identification number next to the family name in her written records following the supervision session.

> *"They (HV) should be recording a safeguarding plan because that is what would happen on a one to one…. you're there in dedicated time with them….and they would document their visit if they were out so they should be documenting what is discussed..."* (SNA1 ICHB).

This SNA had provided the HVs with guidance on how to complete the signs of safety risk assessment document and advocated notes to be taken in the supervision as seeing the risks on paper allows them to see the risks to inform any referral into the local authority. She referred to some of the HVs being *'fearful'* of Multi- agency Risk assessment forms, *'but they've got it all there'* (Information in signs of safety format.) It was unclear how the information on the paper record was transferred to the electronic record, there was some uncertainty.

Safeguarding Nurse Advisor two (SNA2 ICHB) felt assured that once HVs had attended supervision they wrote up their safeguarding plan and notified her via the electronic system in place. She was asked if she reviewed each plan.

> *"I'm scribbling away ...during supervision, main thing is the ….ID numbers and so usually if I have one (supervision session) on the same day or the day after ….some of them are really prompt and I can see notifications coming through...as soon as they come through I'll go and check, check with my records, a lot of the time I can remember the case, what the plan was and that it tally's up. If there's some changes, I tend to notify them for instance, 'we agreed that you'd discuss the wellbeing visit at the next visit, can you add this?' Other times …. I'd leave it to the next day and then I haven't had a notification, so I'll go onto (the electronic system) and send a reminder to them."* (SNA2 ICHB).

When asked if sending reminders was a regular occurrence SNA2(ICHB) reflected that the group observed were prompt in adding notification updates,

> *"...I would say in some other groups it's probably at least one in the group that I would have to prompt."* (SNA2 ICHB).

The SNA referred to the fact that all HVs sign a supervision contract and implied they *'should be'* aware of their responsibilities within safeguarding supervision practice as they sign that contract which includes that they are aware of the All-Wales safeguarding supervision guidance. Questioning was trying to ascertain if the SNA monitored safeguarding plans written by the HV and were they satisfied that HVs understood their responsibilities in recording the safeguarding supervision discussion. The ICRHB worked entirely with paper records and therefore the SNAs did not have access to written safeguarding plans at time of data collection nor do they ask to view a plan unless there is need to (for example during a record audit). The ICHB uses an electronic

health record as does the RHB they are different from an electronic platform perspective.

SNA 3 did not record what was brought to safeguarding supervision. She referred to HVs recording a safeguarding plan if one to one supervision occurred.

> *"Not for group, no... if people want to have more of a discussion around a specific case, then I always encourage them to follow it up with one to one and then you'd have that more formal plan"* (SNA3 ICRHB).

She confirmed that this 'formal' plan would be in the HV written record. This health board kept a record of who had attended supervision which was recorded centrally via the safeguarding corporate team. Attendance was monitored across all three health boards. Safeguarding Nurse Advisor four (SNA4 ICRHB) felt that she was aware of practitioner need from a supervision perspective. She was asked if she felt she 'had a handle on what was happening.'

> *"Yes, oh yes 100%"* (SNA4 ICRHB).

Safeguarding Nurse Advisor four (SNA4, ICRHB) stated that she doesn't really 'push' for one-to-one supervision compared to other SNAs.

> *"I let them come to me.... every six months or so I will email out.... I will make sure that people are OK."* (SNA4 ICRHB).

There was some reflection on previous one- to- one supervision and how the SNA would record lists of families discussed as well as what occurs if one- to –one supervision occurs now and how the SNA should trust the HV to record any discussion which progresses to a safeguarding plan.

> *"We do have paperwork we use, so we do the proper one –to- one session and I still keep my own records.... it's either in my diary or I've got my book where I'll document and I will say, 'please will you document in the records' (HV records) ...obviously capacity wise to be signing off records...you could be talking to anybody from any area...there is an element that you should be able to trust them. If you ask them to document, they should be documenting it....If I do go to do an actual one-to-one session, they keep a copy and I keep a copy as well (signs of safety document).* (SNA4 ICRHB)

The RHB also used a group supervision contract which listed who was in attendance and anonymised the cases discussed. This is completed by the SNA and distributed to

those in attendance at the supervision session for their records and learning. During the data collection phase, this was undertaken electronically and therefore those who attended were deemed to have consented to the supervision contract. It also acted as the attendance list for the safeguarding team to record. Safeguarding supervision attendance was also communicated to the HV line manager.

> *"Equally, if we have a practitioner who fails to attend one of the safeguarding supervision sessions.... we'll send an email through to the line managers to let them know they haven't attended.* (SNA5 RHB).

Discussion continued as to why HVs missed supervision and it was generally due to 'heavy' caseloads, an urgent issue or child protection meetings clashing with the session.

> *"I am very keen on making sure when I pick up people seeming overwhelmed, I will document it down."* (SNA5 RHB).

This SNA also felt that HVs 'should be' recording their safeguarding supervision session and any plan formulated. This health board also used electronic records but a different digital platform to the ICHB.

> *"Should they record? Yes, they should, it should be very clearly recorded. I know from audits or from looking into records...when I am producing a chronology... it isn't necessarily being recorded as it should be. It is something that has been flagged previously, there is the proforma to be able to do that even if it's just a case note they need to say 'discussed at supervision. Whether they do that is questionable."* (SNA5 RHB).

When a case is taken to supervision with a specific action, it is followed up and monitored by the SNA. SNA5 was able to reflect on a case discussed within the observed safeguarding supervision. The HV was requested to make a child protection referral which involved the completion of a Muli-agency referral form (MARF). Due to an electronic record system the SNA was able to track on the system via a 'MARF tracker.'

> *"When it reaches a threshold for protective action.... we would be following it through. Again, it's those cases where there's perhaps a little drift going on which we wouldn't necessarily be chasing up immediately."* (SNA5 RHB).

Safeguarding Nurse Advisor five (SNA5 RHB) also referred to the responsibility of the HV when if a case is discussed which needs escalation of a referral or challenge to another professional and how this is recorded.

> *"There is an element of responsibility however on the key professional, once they've accessed that supervision, they've told us what they need to do, (they) need to go with that escalation process... I can look back on every one of their supervision sessions and say we discussed it (an area of practice or a case), on such a date because I am very careful about making sure that anything like that I keep and document."* (SNA5 RHB).

The above process was repeated by SNA6 (RHB), she followed up practitioners after a supervision session and offered a one-to one discussion. She also referred to encouraging practitioners to record any case they brought to supervision.

> *"Well they're encouraged to document it I send them a copy of the record which they can do what they like with, whether they print it off or delete it... I do say make sure you document that you've talked about the supervision, or you've discussed it with the safeguarding team... "* (SNA6 RHB).

For context, the RHB supervision group was a mix of midwives and HVs. Midwives' documentation is on paper whereas HVs have an online platform. This proved a challenge in practice which SNA alluded to.

> *"So, I think health visiting would be more likely to document that (supervision)… on there (health record) ... whereas midwifery you're just jotting it down on the sheets (designated area) within notes. I've never been asked to document, I've never been asked to audit, it would be tricky to, but I am trying to develop a document for midwifery that would kind of translate into...(digital platform) so it's only just sort of writing everything down like a chronology on the continuation sheets the old-fashioned way."* (SNA6 RHB).

She sounded assured that practitioners record the safeguarding supervision later on in the discussion.

> *"I do think they're quite happy to document whether they've spoken to us or not because it gives them that extra layer of support and protection."* (SNA6 RHB).

The interviews with the SNAs alongside observing safeguarding supervision allowed deeper exploration to answer the research question and gain insight into their experience of delivering safeguarding supervision. I was particularly interested in the

education they received and or safeguarding/safeguarding supervision experience which impacted delivery of the supervision, their confidence, their engagement with HVs within the session but included how they felt the HVs prepared for the supervision. These data were extrapolated particularly from the one-to-one interviews.

Chapter 10 The impact on the delivery of Safeguarding Supervision during the COVID-19 pandemic

This chapter sets the context in which I explored HV and SNA perceptions of the impact of safeguarding supervision during the COVID-19 restrictions. The safeguarding practice of HVs was very different at the time of data collection, which was observed and captured in as much as describing the situations HVs found themselves in. Some of the data offered insight into the challenges brought about by restricted visiting, virtual visiting, virtual professional relationships and underpinned the context of the HVs experience, and the complexities of practice taken to safeguarding supervision. Their burden changed and this changed the narrative of cases taken to safeguarding supervision due to the additional responsibilities and concerns of not physically seeing babies, children, and their families. This has not been included into the chapter as it does divert from the research question although, data that explores the supportive nature and delivery of safeguarding supervision at this time has been included. I would argue that their burden changed due to the specialist restrictions that were put in place, so not only did they have safeguarding concerns, but their ability also to access and assess babies, children and families was challenging.

10.1 COVID -19 impact on safeguarding supervision

Access to safeguarding supervision was hampered during the pandemic. The SNA were moved into other areas briefly in some health boards. For example, they assisted in mass vaccination centres or health visiting hubs.

> *"I mean our safeguarding lead of course has been pulled off to cover other safeguarding areas"* (HV3 ICRHB).

The safeguarding teams were accessible, and HVs valued a face-to-face encounter rather than an online meeting.

> *"You know there's someone on the telephone, you know on the end of the telephone but one to one is obviously an hour, and it's online which I don't particularly like online, I would prefer meeting"* (HV3 ICRHB).

> *".. it's still there. I mean obviously they've been working from home, but they've been available, so no, no problem at all."* (HV1 ICHB)

> The regularity of safeguarding supervision was initially changed as health boards had to work in line with restrictions including, social distancing, ventilation, mask wearing and therefore finding adequate space to undertake a group meeting. *"...I think one (safeguarding supervision) was during COVID…. finding somewhere for everyone to socially distance"* (HV1 ICHB*).*

Supervisors did make themselves accessible during initial and subsequent COVID-19 lockdowns. One of the HVs in ICHB stated that she would:

> *"… email supervisor - "can I ring you; can you ring me? and I've got to be honest the supervisor she'll ring us"* (HV1 ICHB).

This was supported by another HV, from the same health board describing how well supported she felt,

> *"I think we were really, really well supported here in in this trust with the safeguarding supervision, they're always on the phone. Somebody will always ring you back. Yeah, and we've, you know, we've been facilitated with the group supervision twice during COVID"* (HV2 ICHB).

Within the RHB, HV5 felt that there was a significant impact on safeguarding supervision and would prefer face to face supervision delivery.

> *"COVID has had a massive impact on it (supervision) hasn't it? Even if we went to teams, teams so you did alternate (face-to-face/group safeguarding supervision) …. you know even that might work but I do think you probably do benefit more from a face to face."* (HV5 RHB).

She went on to say that peer support played a key role during the pandemic where they would discuss issues whilst walking for 20 minutes in a lunch break.

> *"...in the office, we're very good at calling into each other's office and just offloading as its needed and we contain each other that way."* (HV5 RHB).

With the move to online supervision, which was in a group format, one HV (HV6 RHB) reflected on the last time she received face to face, one to one supervision. Both HVs are based in the same RHB and reflect they would like a face-to-face session once more as well as some one-to-one sessions. Safeguarding supervision was priority to the heads of safeguarding within each health board and cascaded to the SNAs who facilitate each session. They were aware of the importance of their input which is to take an objective yet informing stance when providing advice and support to the HV. They understood HVs were not able to undertake a robust risk assessment. Despite this SNA

stating the priority of safeguarding supervision, in some areas, sessions were cancelled for the short-term.

> *"Well one thing that 'safeguarding' insisted was that we do continue on the safeguarding supervision, that was a priority, purely for those reasons because health visitors would be moved into cases they have no idea about, and we've got access to information that they probably wouldn't and rather than, because they have no idea and not only that they weren't visiting, couldn't visit so they weren't getting a full picture about what was going on.* (SNA1 ICHB).

This SNA also raised the issue of attendance at supervision within the pandemic and if attendance had been affected. Other challenges included finding a room to undertake the session as well as booking a larger room to allow for social distancing and good ventilation.

> *"Actually, it should have been my last couple of sessions should have been teams but a lot of health visitors are based in GP practices where they don't have the accessibility on the computers, so I had no choice but to make sure I tried to get a room so that it was the whole logistics of booking a room, so it has been really challenging getting the room booking. I think although I've just spoken of the benefits of being in the room, the fact that it is on teams allows people to pick up and join wherever they are,"* (SNA 3 ICRHB).

Opinion was varied around the move to online safeguarding supervision. It was particularly valued within the RHB and importantly accessible to all HVs in some format eventually throughout the pandemic, whether it be ad hoc one to one (online via teams or phone call) or online group supervision. There was one incidence of it being cancelled in the third wave for facilitators to staff the mass vaccination centre.
In the first lockdown attendance of supervision was hampered, reflected upon by SNA 5 in RHB as uncertainty in what to expect as the pandemic progressed and supervision was stopped. There was adjustment to setting up and establishing Teams meetings.

> *"… initially when I think everywhere, everybody thought what we are going to do, how are we going to do this. Initially we stopped supervision at one point in time just because we felt that it wasn't something that could be prioritised and of course at that moment in time we actually thought the situation was going to be a lot shorter (COVID-19) than it's transpired to be. It became very clear that we had to restart, we had to rethink how we were going to do this, and it came up through the Teams scenario. I would say that's taken people quite a little bit of getting used to"* (SNA5 RHB).

As familiarisation with the new interface and way of working became more digital, safeguarding supervision became regular practice once again with additional sessions to practitioners as needed. The SNAs found that other members of the health board were accessing them more often due to complexities of safeguarding exacerbated within the *pandemic*.

> *"Now I think we're back more than up to standard I would say, probably even this time last year we were back to facilitating as usual and as expected. Additionally, we were putting on added sessions for members of staff where they might be more affected."* (SNA5, RHB).

The SNA6 from RHB felt that once established online, attendance at safeguarding supervision improved. Being online made it more accessible and manageable for practitioners to attend especially in the RHB with no travel time associated to attending. The infrastructure and resources have been an issue and continue to offer some barriers to engagement during the supervision sessions. The HVs within the focus groups discussed the impact of the pandemic on their supervision. They were able to access it with a slight delay due to the setting up of online resources.

> *"One thing I found with COVID was I was off at the beginning; I shielded until I could get a computer at home which took forever, nine weeks it took I think that's a very long time for somebody who's able bodied and wanting to work so yeah I felt that was way too long."* (HV FG1 ICHB).

> *"…as I said before, providing we've got you know adequate resources, internet speeds, cameras, microphones at work."* (SNA6 RHB).

When practitioners had no camera, it was difficult for the facilitator to see how engaged they were. Also, some of the practitioners (observed) were at home, one with a small child was present (on camera). The SNA provided further examples of how practitioners can get distracted but acknowledge the difficulty in attending when self-isolation with other family members at home, pet distraction and doorbells being answered. This of course would not happen in a face-to-face session or if the practitioner had dedicated time and a place to focus.

> *"…well that's definitely the first time it's ever happened to me in supervision (a distracted practitioner), it's happened to a previous member of staff in a different meeting but not safeguarding and I think particularly with the sensitive nature of*

> *the content, you know that you're discussing, it wasn't appropriate. It's difficult because you know you have got and particularly now we've got a number of practitioners self-isolating so they are encouraged to make sure they're accessing but if they're self-isolating at home it can be difficult sometimes but I think that you know having that conversation with a practitioner prior to, I mean the distraction part of it would be you know things happen, dogs bark, people ring the doorbell but having a child on your lap when you're chatting about domestic abuse wasn't appropriate really."* (SNA6 RHB).

Several HVs within the focus groups referred to this protected time to discuss safeguarding and sometimes if working from home or in a busy office environment it sometimes felt less protected and maybe not as effective.

> *"It's less protected isn't it so when you're in that meeting face to face that's a protected two hours, there's no phones going off, you've not got people in and out of the office, that is your two hours. Like on teams, there's just stuff going on around you, phones are ringing, people are in and out and it's not a protected time, you're not getting as much out of it because it's just not a safe time to talk and you've got to be careful of confidentiality as well, and the office people are buzzing in and out all the time and…it might seem less effective possibly over teams in the last year because it isn't as protected."* (HV in FG2 ICRHB).

The HVs within the focus group appeared incredibly supportive of each of each other and one recognised the importance in being in a room together rather than on Teams as the support is and was different especially in the height of the pandemic where there was limited team contact due to the restrictions. She stated:

> *"I think the other thing about it (online supervision) because...when you're all sat down together face to face it's protected. Child protection can be very, very sad, it can be traumatic alright but there's also a light-hearted side to it (discussion and support) and there is the support there (when online) so that if someone's upset, they can say go on out by there now and have a cup of tea... Whereas if they just leave, you don't know what's happened to them, you don't know whether they've got support or not, you don't know are they going to be alright. So that you know there's no sort of closure online either. Whereas when you're all together there there's closure."* (HV FG ICRHB).

Due to the nature of the health visiting role, there is a strong sense of community and networks of support. Due to pressures on resources, it took some time for HVs to be set up with appropriate equipment to work from home if shielding or isolating but, online supervision was set up and the consensus was that there was access to supervision in

several formats. Some barriers were presented within the findings relating to distraction of practitioners within the online environment. The aim of this findings chapter was to set context, based on the initial research question and to reflect the change in safeguarding supervision context brought about by COVID-19. It has included HV and SNA perceptions of the impact of restricted visiting on children and their families. It is these concerns that set much of the context of the safeguarding supervision and influenced the issues brought to discuss. It has also explored perceptions of a move to online safeguarding supervision. The research has been able to further explore and question the supportive nature of safeguarding for health visitors.

Overall the *'three findings'* chapters set out to answer the research question which was to ascertain whether safeguarding supervision was supportive for HVs working with babies, children, and families, many of whom were exposed to safeguarding circumstances. Data collection occurred mid COVID-19 pandemic and therefore this change in context could not be ignored. Despite the complexities that the pandemic posed, HVs were able to access safeguarding and they felt supported by the SNAs as well as their peers. The discussion chapter will further interpret these findings and generate further knowledge in the delivery of safeguarding supervision, identify there is a gap in research and practice, and make recommendations to enhance this area of specialist practice in health visiting.

Chapter 10: Discussion

10.1. Overview of study

The intensity for HVs working within safeguarding practice motivated me to explore and investigate HV and SNA safeguarding supervision experience, resulting in my research question which asked if safeguarding supervision supports HVs in their safeguarding practice. The aim of this study was to critically explore and interpret how HVs are supported within their safeguarding work, investigating the role of safeguarding supervision and the relationship with the safeguarding supervisor, in developing proficient safeguarding practitioners.

Objectives were set to investigate:

- The everyday work of HVs and their views about the safeguarding supervision process and whether context influences their individual practice.
- The practice of safeguarding supervisors.
- The perceptions of the safeguarding supervisors.
- The type and variance of supervision delivery.
- The quality of safeguarding documentation.

The title of the study uses a quote from data collection (*"Full to the brim"*), depicting how one HV felt in practice and when approaching a safeguarding supervision session. Safeguarding practice is challenging and often encountered daily by HVs. Health visitors' safeguarding experience in practice took a challenging turn as the COVID-19 pandemic evolved. The '*Full to the brim"* phrase became thought-provoking and allowed me to reflect and enhance my understanding of how the HV felt and how she just needed someone to tell her what to do in this instance.

Findings from the study aim to generate new knowledge at the forefront of safeguarding supervision practice. There is also a dearth of literature associated specifically with this type of supervision in health visiting. It became clear early on that to explore the effectiveness/supportive nature of safeguarding supervision, an ethnographic approach would allow for a holistic view of the HV role, the challenges they face, their access to families from birth and the safeguarding issues they are exposed to. My research is

unique in the sense that there was no other research which has taken an ethnographic stance in this field. The approach allowed immersion in the daily practice of health visiting as well as taking the viewpoint of the SNA to also gain a dual perspective. I also reviewed some of the HV documentation completed post safeguarding supervision, offering a triangulated approach to data collection. The research also allowed me to explore the HV preference, comparing the group and one-to-one formats. As detailed in the methodology chapter, this was accomplished by undertaking semi structured interviews, observations of practice and HV records and observations of safeguarding supervision.

I was very aware throughout the study of the concept of being an 'insider researcher' (Gray et al. 2017).This posed a challenge as I did not want to influence the data or the analysis with my opinion or experience as a previous safeguarding lead who delivered safeguarding supervision. Within that role, I was fortunate to undertake intensive safeguarding supervision training and I soon came to realise that the SNAs I observed and interviewed were not afforded that same opportunity. I consistently kept reminding myself of that as well as being alerted to the essential need of education on supervision, not necessarily safeguarding supervision, but a restorative approach to supervision which aims to reduce stress and burnout, and increase compassion satisfaction, essential in the field of safeguarding (Morrison 2005, Wallbank and Hatton 2011, Wallbank and Woods 2012, Wonnacott 2014, Wallbank and Wonnacott 2016). I considered how the financial climate within organisations had significantly altered in relation to access to training for staff and questioned, does safeguarding supervision take priority within organisations, across Wales and further afield? Is it embedded and acknowledged within organisational policy?

An essential part of the thesis was to include a chapter on the history and role of health visiting which was subsequently published in 2022 (Moseley and Phillips 2022). The HV profession appears to be in a constant struggle to justify its role within nursing as a specialist role, as well as demonstrating its importance in assessing public health and safeguarding risks within the early years. Its salutogenic approach to public health

practice has such potential for positive outcomes for children and their families. Yet, across some countries and regions in the UK, numbers of HVs are depleted or the role is being substituted (Institute of Health Visiting 2023). This replicates some of the issues within nursing of attraction, recruitment, and retention into the profession. Due the nature of the HV role and exposure to safeguarding situations, it is imperative safeguarding supervision is meaningful, supportive, and facilitated effectively to aid HV retention, enable continued professional development, to enhance compassion satisfaction and reduce stress (Wallbank 2012). Support via safeguarding supervision is particularly important within the context of a global pandemic, as well in day-to-day practice. External influences and workforce pressures can mean that supervision, whether it be clinical or safeguarding is postponed or cancelled. This occurred during my data collection. Being '*Full to brim'* depicts a HV who needs support and advice regularly which is effective and supportive, to prevent moral distress and subsequent moral injury. The concept of moral injury and distress has also been identified as an important consideration by nurse leaders (Johnstone and Edwards 2022). Moral distress occurs when an individual knows the right course of action/the correct thing to do but, this can be hampered or prevented by organisational constraints/pressures (Jameton 1984).

Johnstone and Edwards (2022) highlight three pre-requisites to moral injury. Firstly, relating to nurses sensitivity, when patients are vulnerable nurses face occasions where organisational pressures prevent them from delivering what they deem effective care and when nurses feel at a loss to instigate change, they feel a lack of control. This is also identified by Watts et al. (2023) who refer to the powerlessness of nurses' which incurs a feeling of ethical and moral dilemma. This brings me back to the '*Full to brim'* quote and as part of my questioning to HVs as to whether they could 'switch off' after work, they said 'no.' Therefore, this emphasises the need for availability of protected time and space to receive and reciprocate meaningful discussions with a safeguarding lead who guides, facilitates and supports an active, effective discussion to mitigate moral distress and subsequent moral injury. Safeguarding children is a challenging,

complex area of HV practice that, accompanied with the burden of complex cases, workforce pressures and a pandemic has the potential to cause stress.
Data collecting during COVID-19 pandemic altered my access to staff and the following section summarises my experience and observations which related to the data and in answering the research question. The themes established within the findings chapter are replicated and discussed in more depth within this chapter and include:

- The impact of COVID-19 on health visiting practice and experiences taken to safeguarding supervision.
- Health visitor perceptions of safeguarding supervision.
- Delivery of safeguarding supervision – The SNA perception.

10.2. The impact of COVID-19 on health visiting practice and experiences taken to safeguarding supervision.

There is continuing narrative of the population health and health inequality impact of the COVID-19 pandemic (BMA 2022, Afrashtehfar et al. 2023). The NSPCC (2022) published a briefing to outline its impact on children and their families. It recognises the significant impact on the mental health of children as well as their families/carers. Their data suggests an increase in child abuse with the pandemic enhancing pressure within families, which includes relationships, financial insecurity as well as the impact on physical and mental health. They also identified that professionals who would normally be a source of support and assess risk with referral to social services, if necessary, were not accessing children regularly and they were less visible (Institute for Government 2021). This was referred to and identified in data collection where HVs referred to having difficulty assessing families with restrictions in place. Health visitors implied that families used COVID-19 as an excuse not to see them and how the use of digital platforms did not offer a true risk assessment.

What became apparent very quickly was the shift and type of cases taken to supervision and the impact on the HVs with some experiencing major disruption of caseload work. The impact of COVID-19 was a dominant theme throughout my data collection. I particularly referred to how it impacted access to and experience of

safeguarding supervision and I experienced safeguarding supervision being cancelled once during the COVID-19 pandemic to allow for safeguarding advisers to assist in the mass vaccination centre. This posed a question as to how seriously that health board took the safeguarding supervision process whilst dealing with an unprecedented situation whilst trying to protect the population. As with clinical supervision, safeguarding supervision can be cast aside, postponed, and sometimes not prioritised within the workforce, which was observed during data collection. Health visitors, had to adapt quickly, as did other child protection professionals to provide a service in a vastly different environment. They faced personal and professional challenges to include risk (e.g. lack and use of PPE or visiting within a restrictive context/social distancing), fear (e.g. their own and their family's well-being), home issues (e.g. economic impact, finances, home education of children) (Katz et al. 2020).

Health visitors and the SNAs were re-deployed with a move to a HV hub model which centralised caseloads. Health visitor visits were significantly reduced then transferred to online meetings using mobile phone applications. This was concerning, particularly from a safeguarding perspective and considering the NSPCC (2022) report. Concern was escalating during late 2021/early 2022 (BBC Wales 2021a, 2021b) with BBC Wales (BBC Wales News 2022, Appendix 12) raising this within the national news. Health Visitors were worried about the welfare of the infants/children on their caseloads. A survey of parents (both new to parenthood and parents-to-be) reported that 47% of the 5,474 participants observed their babies wanting to be with them constantly and a quarter noted that their babies cried more often (Saunders and Hogg 2020). Despite this, the HV service was streamlined at the time. Another survey, which included individuals who work in nursery settings highlighted that the emotional well-being of younger children had been affected (Nelinger et al. 2021). Health visitors within this research were cognisant of this and discussed such cases within their safeguarding supervision.

Specialist Community Public Health Nursing experts and lead academics as well as national organisations such as the iHV, CPHVA and Women's Aid raised concerns

about accessing families' homes (Women's Aid 2020). Home visits stopped in the initial months and within the first 'lock-down' and as knowledge was enhanced about the virus, knowledge also was enhanced about the levels of PPE required to allow home visiting to restart. I observed all HVs visiting practice visits in PPE. It was hot, restrictive from a conversational and communication perspective and I questioned the potential barrier in building relationships with families. Throughout data collection I was genuinely concerned about children who were not being seen. I raised those concerns with Heads of health visiting services as well as the above organisations (iHV, CPHVA). It was no surprise to see the impact of COVID-19 on safeguarding children as well as their health and development post pandemic which I discussed as part of a BBC Wales report (BBC Wales 2021a, 2021b. Appendix 10).

An essential issue and impact on HV practice during the progression of COVID-19 (outside of relating to epidemiological data/findings) was the reality of service user access to/lack of access to the health visiting provision and potential long-term effects on the child and the parent which included identification of risk (Saunders and Hogg 2020, NSPCC 2022). This could be in terms of identifying physical issues, domestic abuse, developmental issues, and psychological issues (parent and child related). The BBC Wales news story (BBC Wales 2022) featured the voice of a new mother who had concerns; she was not visited by a HV for two months post-delivery due to the COVID-19 restrictions. She says it would have been reassuring to see someone to allay any concerns. This is just one family with no safeguarding concerns. It is essential to consider the families where significant harm was present who also did not have access to the service or, it was hampered with the introduction of virtual appointments (NSPCC 2022). Such issues were captured in my discussions with participants during my data collection phase. External data outside of this study is somewhat limited and potentially not entirely accurate referring to the increased incidence of child abuse during the pandemic, with child abuse often well hidden. English data suggested an increase in serious incident notification ((Department for Education 2021). When a child dies or serious harm inflicted. Serious incident notifications increased by 19% and serious harm notifications by 12% (Department for Education 2021). In early 2020 Great Ormond

Street reported on an increased number of children presenting with an abusive head trauma. This equated to 10 cases, a rise from 0.67 cases over the previous three years (Royal College of Paediatrics and Child Health 2020). Calls to helplines increased (Womens Aid 2020, Stop it Now 2021, Refuge 2021, NSPCC 2022). England and Wales saw increased reporting of domestic abuse (ONS 2021) with Womens Aid (2021) identifying through their survey, 'A Perfect Storm' more children seeing domestic abuse but also being exposed to abusive behaviour themselves with women reporting how domestic abuse had increased. As the NSPCC (2022) report states support services were reduced significantly. The pandemic affected parental health with reports of substance misuse increasing also (Aldridge et al. 2021, Public Health England (PHE) 2021).

With the provision of HV service being streamlined to support pandemic nursing allocations, this raised several concerns for me in relation to a true/efficient assessment of risk within families by the HV service. These concerns included how the home conditions were assessed, how interaction between parent and child was assessed as well as observation of child's physical state, development, health, and well-being. Bradbury-Jones and Taylor (2015) refer to the importance of early detection of risk. They refer to how small signs of risk are rarely one-off incidents. They are generally cumulative and equate to concerning and complex safeguarding experiences for children. Therefore having less contact and undertaking virtual contacts enhanced risk and these issues were discussed at safeguarding supervision. The HVs were worried how they could assess interaction between family members and parental well-being and other agencies were using the HV to report back to them, rather than them undertaking their own assessment which caused an element of frustration. Health visiting service provision at this time was a step into the unknown for the HV leads and Executive Directors of Nursing (EDoNs) and the concerns raised above were featured in the interviews with HVs and SNAs as well as within their supervision sessions. A UK wide survey of parents who had children under the age of two identified that only 11% of them had seen a HV between April and June of 2020 (Saunders and Hogg 2021). Unsurprisingly, child protection referrals were reported to be 10% lower over a 15-

month period between 2020 and 2021 in England (Department for Education 2021b). This lower referral rate resonated across the UK with Wales reporting a 50% drop in referrals compared to same time frame a year previously (Children's Commissioner for Wales 2020). Northern Ireland saw a 37% decrease (Department of Health 2021) and Scotland a 27% reduction (Scottish Government 2020). This reflects the move away from face-to-face home visiting and family's access to services.

The above issues/gaps in practice during the pandemic were explored within the practice environment during data collection. Health visitors described how some families would use the restrictions in place during the pandemic to avoid them and they felt at times that they were the only agency visiting the family. This caused frustration with agencies such as the local authority and some challenge did occur due to changing thresholds and lack of a multi-agency 'eye' on situations. The voice of the HV was clear, they did not want to be re-deployed, they wanted to stay within their own caseloads rather than them being allocated to another HV which caused frustration amongst the health visiting teams. During a safeguarding incident or identification of risk it is essential that a multi -agency approach is taken to inform an evidence-based risk assessment. The concept of professional curiosity and challenge is raised by Dickens et al. (2023) as they re-visit it by underpinning and relating the concept to recommendations from serious case reviews. Raising professional curiosity and challenge can be daunting with parents/carers and has been featured in overviews of serious case reviews for the past twenty years (Brandon et al. 2008, Brandon et al. 2012, Brandon et al. 2016, Brandon et al. 2020, NSPCC 2024). The concepts refer to raising concerns respectfully and professionally and relates to the underpinning authoritative practice traits (authority, humility, empowering) presented by Sidebotham (2013). It is about professionals working in safeguarding situations being objective when assessing risk and being honest about raising and escalating concerns to parents/carers (if it is safe to do so) and with professionals. If there are any concerns about decisions relating to the safeguarding of a child, it is the duty of the HV (or any practitioner) to raise this. The focus in practice must stay with the CYP. Dickens et al. (2023) refer to the terms often being raised, and it therefore can imply poor practice.

The more recent terminology of resolving professional differences is now featured in local safeguarding policies across the country. I observed a discussion around this during data collection with the concept being discussed as a briefing due to a local child practice review where it was raised as a recommendation. Working through the complexities of professional curiosity and challenge are well placed in a safeguarding supervision session.

Some of my data identified communication between agencies was hampered with a strain on professional relationships during the pandemic. Data identified HVs frustration on being asked to undertake visits and report back to a social worker. Health visitors also felt frustration with each other when they were moved across caseloads to a hub model and re-categorised the status of families as per Healthy Child Wales Programme (Welsh Government 2016). Lessons from serious case reviews, namely child practice reviews in Wales, report breakdown in communication and information sharing and lack of professional challenge, lack of supervision and poor record keeping (Brandon et al. 2020, Dickens et al. 2022, NSPCC 2023) and yet, the pandemic exacerbated such behaviours as staff were redeployed and depleted, with some breakdown in professional relationships identified which is not safe for a child/family at the centre of a safeguarding incident. As these complex situations in practice occurred the HV required access to an efficient and supportive safeguarding supervision process. Although the impact of COVID-19 did detract from the initial research question and I needed to capture its impact, not only on the HV and SNA but on the service provided to children and their families. Therefore two questions about the impact of the pandemic were included into the questions during the interview. The questions allowed me to explore the HV and SNA perceptions of the impact of COVID-19 on the safeguarding of children and young people and to explore the additional burden and exceptional circumstances HVs and SNAs found themselves in, which were discussed at safeguarding supervision. The HVs and SNAs felt the pandemic placed the children at risk of harm if underlying risks were already present. They felt that key danger/ harm factors could be missed and they brought such issues to safeguarding supervision. The hidden risk potential at this

time increased the burden in safeguarding children and families, this additional risk meant that HVs often felt '*Full to the brim.'*

10.3. Health Visitor perceptions of safeguarding supervision

Being alongside the HVs in practice allowed me to observe the complexity of the role, the way in which HVs communicated with a therapeutic approach to parents and their families, and the display of compassion and kindness to go over and above to support children within their caseloads as well as communicating with each other and the multi-agency team. This was the benefit of taking an ethnographic stance in the research. I was able to sit back, immerse and absorb the context of relationships (between the HV and family, HV and infant/child, HV and colleagues, HV and SNA), communication, surroundings, including home environments. These ethnographic observations of key interactions enhanced my data and brought the data to life. It also linked to the underpinning theory of risk assessment, child protection, taking an ecological approach to safeguarding and how supportive, restorative conversations have the opportunity to reduce stress and burnout. I was in a unique position and I had not found a similar research study which encompassed an ethnographic 'stance' methodology in observing safeguarding supervision in health visiting practice.

The ethnographic stance allowed me to revisit the day-to-day role of the HV, as indicated in my data and this was observed in their approach to the interventions they suggested, and the way they communicated with parents/carers and the children. This was a rewarding section of my research. Health visitors spoke to the children at their level. For example, they sat on the floor and utilised play to assess development or distract the child. They offered reassurance to parents/carers who need a friendly ear to listen, a smile, or a touch of the hand to comfort. I observed HVs who had built supportive relationships with the families. These traits were consistent across the four observations. They were also able to be professional and authoritative, showing authority, humility, and empathy (Sidebotham 2013), when there was a need to reaffirm an earlier expectation/action or follow up a referral from the nursery or local authority when an issue had been identified. All four HVs stated their passion for their role, and it was no surprise to me how protective they felt of their caseloads. The level of service

provision varies and HVs get to know families in depth from the birth of a baby until they start school. I was able to reflect at the end of the observations of my time as a HV, which I did with fondness and appreciation of the role and the reality that the role can make a positive contribution to the health and development of an infant/child whilst supporting their parents/carers. I saw delivery of the principles of health visiting in abundance. The search for health needs was clear, the raising of awareness of factors associated with the health needs identified, leading to the facilitation of health enhancing activities. This was observed within family homes, well child-clinics, and within multi-agency conversations. The experience also validated for me the essential role of the HV from an early intervention and prevention perspective and how they can influence policy affecting health with a salutogenic approach operationally (their day-to-day practice) and strategically (Antonovsky 1979, Cowley and Frost 2006).

During the observation of safeguarding supervision, I was able to observe the preparedness/lack of preparedness of the HVs for the sessions as well as the SNAs confidence levels in facilitating. Within the ICHB both supervision sessions were undertaken socially distanced with masks being worn throughout where the other observations were virtual, which was a challenge to see and a unique way of accessing supervision. The HV perception of safeguarding supervision data were divided into several themes which included:

- The positives of safeguarding supervision.
- Access to and variability of safeguarding supervision.
- Perceptions, comparisons, and access to one-to-one supervision.
- HV perceptions and feelings around group supervision.
- Safeguarding supervision enhancing critical thinking.
- Facilitation of safeguarding supervision.
- The duration and structure of safeguarding supervision.
- Preparedness for safeguarding supervision - the HV perspective.
- Recording safeguarding supervision.
- Preparation for home visits post safeguarding supervision.

The preparedness/lack of preparedness of the HV refers to preparedness to discuss pertinent cases within the supervision session. Preparation guidance was determined 'partly' by the clarity of the safeguarding supervision process within each health board. Where there was policy, it is assumed the direction would be clear, the reality was that HVs were unsure of process. The HVs were aware of the health board policy/guidance but were unable to articulate its criteria. They knew that they could take one case to discuss at a group supervision, and if they needed longer, or a more in-depth discussion, they could request a one-to-one session. The HVs were not aware of the PHW guidance (PHW 2017) as a national directive.

One of the health boards suggested HVs prepare by completing the Signs of Safety (SOS) risk assessment tool to structure the discussion and sent out a blank framework for HVs to complete and bring to the session. The other two health boards did not stipulate this although, one of the other health boards used it to structure their discussion. Although discussion within safeguarding supervision 'loosely' covered the four areas (key danger/harm factors, positive factors, grey areas, complicating factors (Turnell and Edwards 1997), a prepared discussion with SOS was not instigated by any of the HVs during the observations with no pre-populated frameworks observed being taken to the two face-to-face observations. The HVs were familiar with use of the framework, as it is used to structure multi-agency referral forms and level of awareness was varied. This implies a clearer process could be established to inform the HVs, which has potential to promote their commitment and motivation to the process. When exploring one to one supervision with the HVs, one implied about *'getting it over and done with*.' This highlights that HVs need the supervision to be meaningful, not just a tick box exercise (Knapman and Morrison 2008). The HVs also need to take responsibility in preparing for their safeguarding supervision. One of the HVs brought three cases to a supervision session, and she was allowed the opportunity to discuss these, which meant that time was reduced for other members of the supervision group to discuss their case. This is a potential risk if they feel they can only discus one case. They may not have the opportunity to raise all of their concerns in the group supervision space. This health board offers one-to-one supervision also as another available option.

Whilst reflecting on the observations, I contemplated how much time the HVs took to prepare, taking into consideration their varied caseloads and acuity within that caseload. I also pondered over their motivation to prepare and whether they are able to factor in protected time to think and focus on preparing for their safeguarding supervision. Some of the HVs were rushing into the session and I heard on occasions '*How long will this last? I have to be somewhere.'* The *'somewhere'* would be a family visit or meeting but, if the visit/meeting is not safeguarding related is it reasonable and best practice to utilse their safeguarding supervision session.

The importance of the preparation for safeguarding supervision is highlighted by Scullion and Robertson (2023). The HVs and school nurses in this study valued use of a risk assessment tool to prepare for supervision, which is similar to the assessment framework triangle (Department of Health 2001) which assesses parenting capacity, the child's health and development and environment with the child depicted within a circle at the centre. These keys areas also fit into the four Signs of Safety (SoS) domains discussed in chapter three. Interestingly, the HVs and SNs in this study (Scullion and Robertson 2023) were offered a mixed model of options for safeguarding supervision four monthly (one-to-one, peer and group supervision). The participants felt that group supervision offered them little support and was referred to as a 'tick box' exercise. The authors felt a need to raise the profile of group supervision to highlight its benefits from a peer support perspective (Scullion and Robertson 2023). Preparation for safeguarding supervision is referred to by Little et al. (2018), but there is no narrative to expand on the point. Scullion and Robertson (2023) and Smikle (2018) are the only researchers that offer more detail into the effectiveness of preparedness, with Smikle stating that if safeguarding supervision is going to be successful, staff have to be well prepared and have clarity around the roles and responsibilities of its action, the supervisor and their role as supervisees (Smikle 2018).

As part of the preparation process and to set the safeguarding supervision scene it is good practice to use a supervision contract (Knapman and Morrison 2008). All the health boards used a form of a supervision contract. It is recommended that the

supervisor formulates a basic contract/agreement, an example from one of the Health Boards is detailed in the Appendix 13. These contracts are ‘group contracts’ and used as sign in documentation to the supervision session. One health board received signatures as sessions were face to face and the other two used the sign up to the session as agreement to take part and reference was made to the contract when the supervision session began. The aim of the contract is to set expectations and boundaries to ensure a safe space is advocated for a productive supervision session (Knapman and Morrison 2008). This sets the ‘supportive space’ scene for a potentially productive discussion. Knapman and Morrison (2008) also refer to a breakdown in discussion/conversation being usually due to a lack of clarity and always advocates the development of written contracts. A supervision contract is also recommended within the existing PHW safeguarding supervision guidance (PHW 2017) which at the time of writing is being updated.

One health board added additional information on the contract which stated the type of supervision model to be used (Kolb 1984), with ground rules incorporated. These ground rules included a confidentiality statement and process to be followed if safeguarding practice issues were identified. The safeguarding teams in each of the health boards monitored attendance at the supervision session and reported any non-attendance to the HV line manager. The size of the supervision groups varied across the three health boards. Typically, the SNAs recorded the discussions and emailed the participants with anonymous reference to the key themes (Appendix 14).

The two face-to-face supervision sessions observed in the ICHB mirrored each other as the SNAs delivered the same educational material prior to the HV discussing cases. The face-to-face sessions were structured with the normative, formative, and restorative process (Proctor 2008), referred to as the supervision alliance model by Wallbank (2016). The first two group supervision observations were small but allowed for greater in-depth discussion. This health board had been part of an evaluation of safeguarding supervision I was involved in which formed the basis of this PhD (Moseley 2020, Appendix 1). They had moved to group supervision in 2018 and 2019 whereas

the other health boards followed much later (2021 onwards). The recommendations from my previous study were observed in part (Moseley 2020). They included: smaller supervision groups, at least one case discussed by each HV, use of a structured framework (Signs of Safety). I had also included recommendations pertinent to, educating the HVs on the supervision process, access to safeguarding education for the supervisor, longer sessions to allow for rich discussion and ongoing evaluation of the supervision. Therefore, the findings and recommendations from this pilot study were at the forefront of my mind when developing this study and when choosing the most appropriate method. Children at the centre of the safeguarding conversations were the most important consideration as the literature (Walbank and Wonnacott 2016, Little et al. 2018, Smikle 2018, Warren 2018, Guindi 2020) indicates due the increased risk to their safety at this time.

10.4. Delivery of safeguarding supervision – The safeguarding nurse advisor

I was able to progress my exploration and observations of the SNA within this study. My previous research had not allowed me to do this due to the type of study and its context. This section of the research was something I was looking forward to delving into although, I was mindful of the 'insider researcher' context. I saw this as an overall positive factor, as I had a more in depth understanding of the culture of health visiting practice and safeguarding supervision processes, although, caution prevailed (Saidin and Yaacob 2016).

I found that SNAs had varied supervision safeguarding experience and had to adapt very quickly to an online delivery of safeguarding supervision. Observing this online approach as a 'virtual ethnographer' (Given 2012, Gill and Baillie 2018) offered flexibility as well as being challenging and I too, had to adapt and embrace this new experience, which was unique and as already identified, there was no research available which took this stance in observing safeguarding supervision. This adaptation allowed me to continue my data collection and provide me with a virtual observation experience, which was enlightening and could inform future online safeguarding supervision practice as part of my recommendations. I encountered some issues whilst observing, which I expand in more depth outside of the methodology chapter, and as part of this

discussion. The online observation was complex and challenging as I tried to immerse myself in the virtual space whilst examining the safeguarding supervision practice.

Participants (HVs and midwifery colleagues present in focus groups) had switched their cameras off; some had poor connectivity and some appeared distracted (answering phones, talking to other colleagues in the room, knitting, cameras being turned on and off). It was clear, some were not paying full attention and did not appear fully invested in the supervision process. The distractions were noticed within the group with one of the HVs raising concerns with the head of safeguarding. I too raised the issues encountered with the safeguarding lead. I initially authored a report (anonymised within the appendices – Appendix 15) for the head of safeguarding in this area and subsequently met with her and one of her team to discuss further. To note, before data collection commenced, I had met with each individual health board head of safeguarding to discuss the data collection process and to advise I would contact them if any practice concerns arose. When I undertook the focus group in this health board, this issue was raised again and discussed with the HV stating that she would prefer supervision as a group of HVs rather than a mixed professional group.

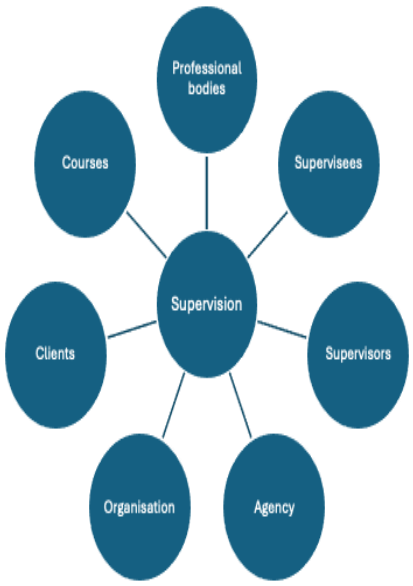
One of the health boards had cut down their supervision session to just one hour during the pandemic and it was difficult for all the HVs to partake in discussion. It felt like a tick box exercise, which I explored in interviews with the SNAs, and I identified that the SNAs had had minimal supervision training. One of the health boards had a mix of HVs and midwives in the supervision session. During one of the observed sessions, a practitioner was seen discussing a complex domestic abuse case with a young child present. I observed closely the reaction of the SNA, as well as the reaction of other members of the group. There was no challenge from the SNA to stop the conversation and it was something that I raised with the SNA immediately following the session. The SNA stated that she was going to speak to the practitioner to follow up on the discussion and inappropriateness of discussing the case with a child sat on her lap. I had another observation booked in to observe with this same SNA and after that session, I asked if she had followed up with the practitioner and she said that she had

not had chance yet and I felt at this point I needed to discuss further and raise my concerns with the head of safeguarding detailed in the appendices (Appendix 15). There were many positives observed in the group supervision process, which included peer support and active discussion and troubleshooting of cases. Being part of such a professional group with similar case examples and with varying complexities offers practical and professional sharing of information, advice, and support (Burns et al. 2020). This did make the HVs feel reassured not only from their peers but from the SNAs facilitating the discussion.

Some of the SNAs were more confident than others, which was based on the length of time in post, but this was also based on the type of training they had received in preparation for facilitating safeguarding supervision. From a health visiting perspective, based on observations, interviews, and focus group data, they felt that group safeguarding supervision is supportive, and they valued an objective eye on their cases from their peers. There was more of a mixed response relating to support and skills of the SNA, but in general they were felt to be supportive. Health visitors felt reassured that they were not alone with the complexities experienced on individual caseloads. Safeguarding supervision was embedded in practice and the HVs would value discussing more cases on a one-to-one basis, as well as having access to group supervision – they would like a mix of both models. This is also reiterated in the literature (Guindi 2020, Scullion and Robertson 2023).

When assimilating the observed safeguarding supervision, I referred to the seminal work of Proctor (2008) who describes group supervision as an “enactment” (Proctor 2008. p.3) and uses a ‘stage’ scenario stating that within a group supervision process both the supervisees and supervisor are ‘on stage.’ But there are other key players who are impacted by the supervision and take to the stage at varying times throughout the group supervision (Figure 7). This is something that I could relate to when revisiting the data.

Figure 8. Group Supervision stakeholders



(Proctor 2008)

The above diagram (Figure six) is similar to the components of the 4x4x4 model devised by Morrison (2005). He depicts the service user, staff, organisation, and partners at the centre encompassed by Kolb's (1984) learning cycle (Experience, reflection, analysis, and plans/actions, with four key supervisory criteria on the outer aspect of the model (management, development, mediation, and support). It is interesting that Proctor (2008) refers to a stage setting. I have seen supervision depicted in a professional role play where 'actors' used different masks to depict their situation/mood and demonstrated how as a supervisor/supervisee, masks are interchangeable dependent on the context of the given situation. This is an interesting analogy which is impacted by safeguarding supervision practice, and something I was cognisant of when observing the group supervision. Although, this issue was especially challenging within the online space. Using the stage/mask concepts, I was able to explore supervisor behaviour and practice within the group supervision relating to their experience and subsequent confidence in advising and supporting the HVs. This could be viewed one step further, if effective, supportive safeguarding supervision is in place within this field of practice, it could impact on job embeddedness and also could be significant when considering retention within the role. Burns et al. (2020) take an

ecological approach to explain workplace retention which could be applied to the importance of getting safeguarding supervision processes right. They refer to the worker at the centre surrounded by the outer constructs of work, community, financial and environmental areas. So, when we think of the worker (HV) attending safeguarding supervision, they could come with the burden of the complex case/impact on the child, as well as the burden of issues going on in their own lives. This also applies to the supervisor too. Hence the different 'masks', worn during the enactment of the safeguarding supervision. The supervisor needs to be cognisant of these factors in the planning and delivery of safeguarding supervision. Importantly, the process requires a critical reflection and analysis of the cases discussed to allow for professional curiosity and challenge, to be enhanced. Dickens et al. (2023) recognised that staff need resource and support if they are to develop their confidence and ability to professionally challenge and question safeguarding processes and practices and being courageous whilst focusing on the safety of the CYP. This includes effective communication across agencies as well as effective communication with children and families. They refer to improvement across learning in practice and at local level, providing staff access to *"good supervision"* (Dickens et al. 2023, p.7). This has to be established at a macro level, where governments recognise the recommendations from child practice reviews as essential in improving quality of child protection services, by delivering adequate resources, to allow safe staffing across agencies, a supportive culture where staff have protected time and space to balance,

> *"…skilful curiosity, astute yet sensitive challenge, and flexible high-quality assistance*"(Dickens et al. 2023, p.7).

Safeguarding supervision, therefore, can offer a safe space to educate and develop HVs in these skills but the resource (staff, protected time, protected space, education) has to be in place.

A key finding in relation to the SNA data were educational preparation, or lack of, that they had received to equip them to facilitate the safeguarding supervision process. The protected time element for supervisors and supervisees, as well as education for supervisor ,was also recommended in a scoping review of clinical supervision by

Masamha et al. (2022). Education for supervisors was found to be variable and as well as variation in skills/experience of the supervisor which relates to the findings within Warren's (2018) literature review. The aim of the Masamha et al. (2022) scoping review was to explore the barriers for nurses accessing clinical supervision as well as how it is provided and facilitated within organisations. They also scoped what skills nurses require to facilitate supervision. Despite this being focussed on clinical supervision, the findings relate to some of the barriers associated with the provision of safeguarding supervision, identified within the literature and this wider PhD study especially in relation to protected time (during the COVID-19 pandemic) and education for the supervisors.

Four of the six SNAs had received one day of training, which consisted of a national safeguarding service training day. They referred to it as a day to reflect on facilitation of types of supervision, rather than examining the theory behind effective supervision or types of models used in safeguarding supervision. It featured more about managing in groups or escalating practice issues. Just one of the six could refer to a safeguarding supervision model and they all had difficulty remembering 'general' reflective models (Gibbs 1988, Driscoll 2007). I was challenged (as an insider researcher) to think, was I expecting too much of them? But the SNAs are senior nurses/midwives with vast experience in the field; granted, some were more novice than others within the SNA role. The most experienced SNA had received 'training' eight years previously with no further updates, which led me to the question, who supports the supervisors and what continued professional development (CPD) is in place for them? The longer the length of time in role the more confident the SNA appeared.

The SNAs relied on the HVs to raise their concerns during case discussion. Sometimes, HVs did not bring a case. Within the online environment in particular, I found it challenging to understand whether the SNA had a grasp of the HV struggling in practice and how they facilitated, captured, and escalated any issues. The SNAs did make their own notes within the supervision session, which would inform the anonymised notes sent out to the HVs post supervision in one of the health boards. On analysis of the data, where the HV record is digital, the SNA can view the HV entry, although, the SNA

does not always check they have entered the information they rely on the HV to record. Where there were paper records (during time of data collection), the SNA did not review the safeguarding action plan agreed due to restrictions in place. The onus is solely on the HV to record the session. It was unclear as to how robust this practice was across the health boards. If the SNA does not record the conversations/overview of practice issue during supervision, how do they know the HV has recorded it, although the HV is an accountable practitioner and should be recording any information pertinent to the child/family (NMC 2018). There is potential to scope this further in practice to ensure the HV is writing up the safeguarding supervision discussion. There is also potential to consider an all-Wales format in recording safeguarding supervision.

In summary, all these objectives were explored in the study by examining the contribution of safeguarding supervision for HVs across the three health boards. It was concluded that the supervision was seen as supportive to the HVs although there was a variance in delivery, experience, and training of the SNA. These findings have been applied in the development of recommendations for practice, education, and further research. The data reflected the findings of research from within the literature review which although was not extensive, due to the limited amount of research undertaken within this field of practice, confirmed the reality and complexity within safeguarding (Warren 2018, Little et al. 2018, Smikle 2018, Guindi 2021). Key similarities include;

- The prioritisation of safeguarding supervision.
- The education of the supervisor.
- The experience and knowledge of the supervisor.
- Support and CPD opportunities for the supervisor.
- The safeguarding supervision offer of a mixed delivery format of one to one and group.

More recent research findings (Warren 2018, Little et al. 2018, Smikle 2018, Guindi 2021) reiterate the importance of the leadership qualities of the supervisor, as well focussing on the child at the centre of the process. This focus is prominent across macro, meso and micro levels of practice, with effective supervisors seen to be

perceived as offering a psychologically safe space. Psychological safety is defined as helping individuals to,

> *"...overcome barriers to learning and change in interpersonally challenging work environments"* (Edmonson et al. 2016, p. 65).

Safety can be categorised into four stages which include *'inclusive safety, learner safety, contributor safety and challenger safety'* and the display of these traits apply to the safeguarding supervision context. The supervisory space needs to be productive and feel safe both for the supervisor and supervisee. 'Group think' also needs to be avoided. This concept can disrupt a critical reflective discussion and needs early identification by the supervisor. Group think (Janis 1972) occurs when groups are cohesive and challenge within said group does not occur because members will not want to upset or cause unrest within group. This in turn affects decision making processes (Depierro et al. 2022). In terms of safeguarding children, this could have a detrimental effect on the safety of a child, affect professional challenge, and hinder an effective supervisory process. When a group think situation occurs, it is often generated by a directive member of the group and the group is generally working under pressure or stress. The three causes of group think explained by Janis (1972) are over-estimation, closed mindedness, and pressures towards conformity. Over-estimation refers to the group not realising their vulnerability which is shared by the majority of the group. This can lead to over-optimism in a given situation which can lead to risk taking. Closed mindedness is also risky as warnings are often discounted. If a group member challenges a decision or an idea this can be shut down by other group members if they collectively don't agree and then the person raising the issues bows to conformity (Janis 1972). It is important that supervisors are mindful of vocal leaders and team dynamics within the group setting (Depierro 2022). Setting ground rules and boundaries via a contract is a potential useful solution (Morrison 2007). Each health board was observed to be utilising safeguarding supervision contracts with HVs having access to a booking system. To avoid a group becoming 'too' cohesive, allowing practitioners to randomly book onto sessions could prevent the same individuals from attending every time together. This was observed to occur two of the three health boards. One health board supervised HVs in their already established teams. The concept of groupthink is an

important consideration and could be fundamental in the delivery of a successful group supervision. This further emphasises the need for safeguarding supervision training for the supervisors to include managing the group as well as the theory behind supervision models pertinent to safeguarding practice and therefore supports the findings from this study.

10.5. Recommendations

Based on the findings of this research the restorative safeguarding supervision model is recommended for use for safeguarding supervision practice to include the underpinning concepts of frameworks from Bronfenbrenner (1979) and McCance and McCormack (2021). Safeguarding supervision is more than a process, however the focus on the child and family is central to the development of a safeguarding supervision framework. The framework's delivery from a macro context has the potential to 'sit' within the PHW national safeguarding service, meso level responsibility with the organisations, and micro level responsibility with the HV and the SNA.

Therefore, a suggested framework should place the child at the centre. The lives of children are complex with many extrinsic influences. These influences affect their development and life outcomes and can constitute negative and positive experiences. This is the central focus of Bronfenbrenner's ecological model (Bronfenbrenner 1979, figure one) and this will feature as an underpinning model and be central to HV and SNA practice, influencing decision making within safeguarding supervision practice. An effective process is helpful, but the situation/experience and voice of the child is paramount (Dickens et al. 2022). This must feature across organisational context and be influenced from Government to practice level. Workforce supply and demand is challenging, the impact and 'shadow' (continued) impact of COVID-19 has been challenging and the wellbeing and support of HVs should not be compromised with the omission of safeguarding supervision which was demonstrated within this study when it was cancelled in one of health boards.

Safeguarding child practice reviews/ serious case reviews (England) often cause HVs to reflect on their own practice and recommendations from such reviews are shared within

supervision in some health boards as part of the education element of safeguarding supervision. There are often inter-professional/agency relationship barriers/challenges found. This would have a potential impact on the assessment of children who are at risk of harm. Poor co-ordination of services/inter-agency working, and poor information sharing are common findings in the serious case reviews/child practice review findings. Cases can drift, and findings have also included a break down in professional communication, lack of professional curiosity with challenge, and where the focus is on the process rather than the child. (Rees et al. 2021, Dickens et al. 2022). It is imperative that leaders within organisations recognise the impact of anxiety on staff (Laming 2009) and signs of moral distress as it affects practice (Johnstone and Edwards 2022), which could compromise the safety of children. I observed the complexity of cases brought to supervision, without careful, specialist supervisory support, there is potential for staff burnout, stress, and moral distress. Within Wales, there has been extensive scoping exercise undertaken reviewing clinical supervision provision across nursing practice. I worked within the CNO Wales team to develop a position and recommendations for career spanning support for nursing in Wales. Part of the scoping exercise explored the concept of a healthful culture with the final recommendations being underpinned by the person-centred practice framework. (McCance and McCormack (2021). The structure of this particular framework is considered in Chapter five in relation to exploring conceptual frameworks to underpin the methodology behind this thesis.

During the process of developing the clinical supervision scoping work, I was led to consider how applicable this would be for use in a safeguarding supervision scenario. The four constructs of the person-centred framework (McCance and McCormack 2021) relate to safeguarding supervision in respect of referring to the organisation, practice environment, supervisor, and supervisee – similar to the centre of the 4x4x4 model (Morrison 2005) and could be easily adapted to the context of safeguarding. I have developed a framework of safeguarding supervision which is transferrable across professions but in relation to this research the practitioner and supervisee are the HV and supervisor refers to the SNA. Of course, the baby, CYP and family must sit at the centre of safeguarding supervision and practice. In fact, it is the responsibility of

organisations to build supportive safeguarding supervision environments which are psychologically safe. Working from the inside out of my proposed framework for safeguarding supervision (child/family at the centre) and adapting to a safeguarding context, I have incorporated the conceptual frameworks and models suggested in Chapter three. Four areas will wrap around/encompass the child and family who are depicted by Bronfenbrenner's (1979) ecological framework. This will sit at the centre of the framework (Figure 9). I have aligned the framework to safeguarding supervision and made recommendations based on the literature findings and data from the study. By embracing the complexities of safeguarding babies and CYP, I have ensured they are central to HV/SNA practice, and by undertaking this research, I have been able to develop a framework, which offers an original contribution to knowledge and practice. It is actually relevant for any profession who accesses safeguarding supervision by applying a combination of the above evidenced based conceptual frameworks. The proposed framework constructs include the following:

The Practice Environment:

- The physical environment offering a safe, uninterrupted space within organisational systems.
- Promotion of relationship building which is multi-professional and inter-agency driven.
- Potential to be innovative and share best practice.
- A space for safe professional challenge.

Practitioner values:

- Professional competence.
- The development of inter-personal skills.
- Commitment to the role.
- Understanding of beliefs and values including self-awareness.

Supervisor/Supervisee centred processes:

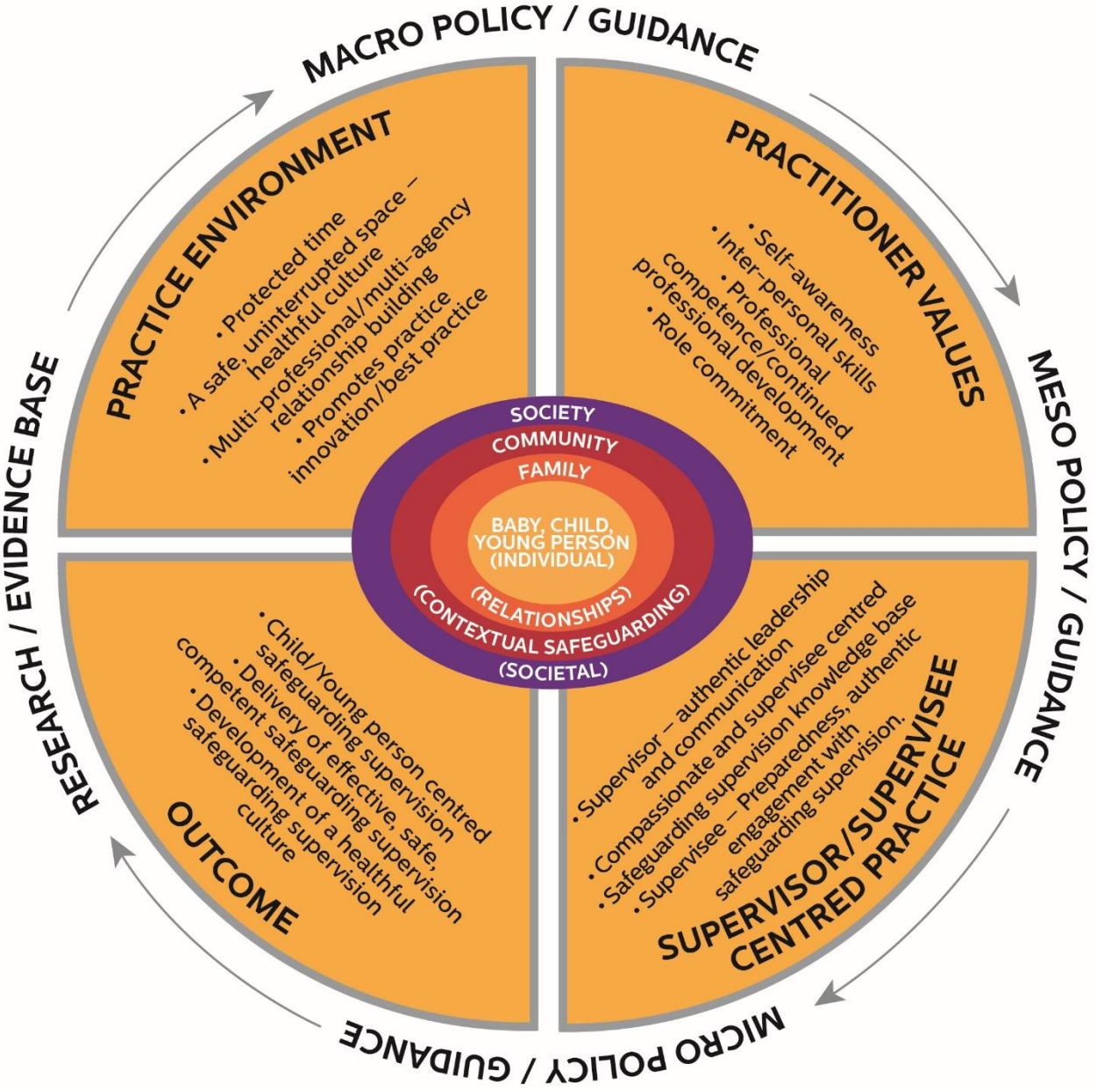
- A supervisor who engages authentically taking a restorative approach applying Kolb's model of reflection.
- Shared decision making.
- Supervisor and supervisee are sympathetically present.
- An ecological approach is applied to a child-centred discussion (consideration of child/family/community/society)
- Supervisee/supervisor beliefs and values are considered.

Outcome:

- Safeguarding supervision to be is supervisee centred.
- Focussed on the development of a child-centred/ healthful safeguarding culture.

Outside of these constructs sits the macro context, the policy, and strategic frameworks with relation to the support of staff and drivers to deliver effective safeguarding supervision practice.

Figure 9. A proposed safeguarding supervision framework



10.6. Implications for practice and service development

The results of the research have several implications for practice. The supervisors require training and education in the delivery of safeguarding supervision. However, there is no specific safeguarding supervision education or training available from a HEI or practice perspective in Wales. If the National safeguarding network approve these recommendations, there will be a need to consider how safeguarding supervision education is being delivered in Wales. Some existing programmes are already being commissioned outside of Wales (NSPCC or PNA programmes (England)). Consideration could also be given to a specific programme developed to meet the educational needs of this area of specialist practice. There is a cost implication and due to financial constraints could be a barrier to implementation. There will need to be further scoping across Wales of the type of training undertaken by all supervisors when assessing potential cost implications. Based on this study, four of the six SNAs had received only one day of training. An All-Wales approach will be recommended for equity.

The current Wales based safeguarding 'best practice' supervision guidance is currently being reviewed. Once standardised this will be shared across practice. Therefore, an all-Wales approach to education, record keeping/action planning/ supervision contracts could also be considered. Dissemination should include updating key multi-agency professionals and who can be informed at regional safeguarding boards.

Most of the HVs agreed that the safeguarding supervision they received was supportive with the majority enjoying the group format although, would like the possibility for one-to-one supervision too. Although this option is available if it is provided to more HVs this will have an implication to supervisor workload. All three health boards within this study offered group supervision. Other health boards in Wales offer one to one supervision, therefore a potential all-Wales stance on safeguarding supervision could offer clarity and equity.

Workforce issues are a challenge, it is essential that protected time and space is afforded to both supervisor and supervisee therefore, consideration could be given to mandating safeguarding supervision for the organisations to deliver.

10.7. Implications for education

The process of safeguarding supervision is recommended to be included into SCPHN post-registration programmes across Wales. An All-Wales stance is taken across many areas of nurse education. This same stance could be taken to promote awareness raising of the theory behind safeguarding supervision, use of reflective models, frameworks and role-playing safeguarding supervision are examples that could be included within the safeguarding module across SCPHN programmes. Health boards and Trusts could develop safeguarding supervision training including expectations, purpose, and the importance of preparedness to relevant staff accessing safeguarding supervision more often.

Further implications relate to the provision of safeguarding supervision education for safeguarding supervisors as detailed above. It appears the current provision could be enhanced further, as well as it being included as continued professional development in the form of safeguarding supervision updates. Supervisors need to explore models of reflective supervision with application to safeguarding supervision. They also need skills to enable critical analysis and reflection in group situations and use a structured approach/framework to facilitate discussion. They need a leadership style that is authoritative yet, compassionate and authentic.

10.8. Implications for future research

My initial plans and ethics application for this study were to accompany the HV to a home visit following safeguarding supervision. This was to allow greater insight into delivery of the safeguarding supervision discussion/action plan. Unfortunately, this was not approved by the ethics committee despite appealing and explaining the role of the HV. I was able to adapt and discuss the HV actions and observe four of six HV records to grasp application of the safeguarding plan. The ethnographic stance worked well in observing HV practice and the observations. The interviews and focus groups added

more depth to the data and reviewing HV records gave me a triangulated approach to deepen the breadth of knowledge gained from these different qualitative approaches to data collection.

A longer period observing HV practice would have given me greater immersion into their weekly practice challenges and oversight into their varying visits and conversations with not only parents/carers but other professionals. I was able to view this over four days in total, but a longer period would have enhanced this, and I would recommend further research to gain longer exposure to health visiting practice. Data collection was hampered by the pandemic and the research did take a COVID-19 *'slant'* due to restrictive access to HVs and families, use of PPE, interviews and supervision sessions moving to online. There were lessons to be learnt from this and the section on the impact of COVID-19 offered new insights into the pressures experienced by the HVs, the service as a whole and the access to babies, children, and families as well as access to safeguarding supervision. The emotional burden of the pandemic was clear observed within safeguarding supervision with different challenges and complexities discussed. Health visitors were unable to 'switch off' and carried the burden always associated with the role with them.

The type of research question sits well within a qualitative paradigm, and I answered the question that I set out to explore. It would be beneficial to consider the impact on the child/family in the future, and the impact on retention of HVs within the service. This could take a quantitative or mixed methods stance in measuring effectiveness for the practitioner as well as the service user although ethical approval could be an issue due the safeguarding context of the research.

If an All-Wales approach to safeguarding supervision is developed based on the recommendations from this research it would be pertinent to evaluate further its supportive nature and its impact on HV recruitment, resilience, and retention.

10.9. Recommendations

The recommendations consist of high-level priorities for action which are made more explicit for the operational delivery of a supportive safeguarding supervision process via specific breakdown of recommendations for the organisation, the supervisor, and the supervisee. I have set out a proposed definition of safeguarding which states:

> *Safeguarding supervision provides a structured discussion between supervisee and supervisor to support and advise on specific complexities and challenges within their caseloads. For safeguarding supervision to enhance safeguarding practice, accountability and responsibility is targeted to the organisation, the supervisor, and the supervisee. The aim is to develop competent, confident, professionally curious practitioners who are work across all relevant agencies to support the best interests of a baby/child/young person/individual and their families.*

The proposed supervision process/framework (Figure 8) is underpinned by data from this study, as well as Bronfenbrenner (1979), Morrison (2007), Wallbank and Wonacott (2015) and McCance and McCormack (2021).

10.9. High-level priorities for action

- Safeguarding supervision theory and practice to be included within safeguarding supervision SCPHN curricula. (***Responsibility****:* HEIs /Wales Council of Deans/ NMC)
- Develop an all-Wales approach to restorative safeguarding supervision to include its principles in a policy format rather than a ‘guidance.’ (***Responsibility****:* Welsh Government/National Safeguarding Network, PHW and Health boards/trusts).
- Ensure safeguarding supervisors have access to safeguarding supervision education, as well as national and local networks of support and continued professional development. (***Responsibility*****:** Safeguarding network/ Health boards/Trusts).

- Consider mandating safeguarding supervision in Wales, which is applicable to organisations to provide protected time, space for its delivery. *(**Responsibility:*** Welsh Government/National Safeguarding Network, PHW).
- Ensure regular impact evaluation/research of safeguarding supervision practice to understand supervisee/supervisor experience and enhance future practice. (***Responsibility*****:** National Safeguarding Network PHW , and Organisations).

Throughout operational delivery of safeguarding supervision, the recommendations are broken down further to reflect a proposed safeguarding supervision framework (Figure 9) and divided into responsibilities for the organisation, the supervisor, and the supervisee.

Organisation

- Focus on the child at the centre of any safeguarding practice service delivery and consider their voice in policy development.
- Allow for protected time and space to foster well-being and support for practitioners dealing with complex safeguarding practice challenges in the form of restorative safeguarding supervision.
- Develop organisational safeguarding supervision policy which is underpinned to the National Safeguarding Network policy directive.
- Ensure safeguarding supervisors are educated to facilitate safeguarding supervision efficiently with confidence and competence in restorative supervision either with the development of a specific education package, or the funding/commissioning of places to undertake the professional nurse advocate programme.
- Support the development of a network of support for safeguarding supervisors in building safe, supportive, healthful safeguarding practice environments.
- Consider a flexible mode of safeguarding supervision delivery (one-to-one/group/ad-hoc), with one-to one offered at least once every 12 months.
- Evaluate the impact of safeguarding supervision on the supervisee, supervisor, and service user.

- In future pandemic situations, re-evaluate the re-deployment of HVs and SNAs. They should not be being redeployed to cover roles elsewhere. Therefore, its importance should be established from a macro level/top down throughout organisations. It needs to be seen to support practitioners whose frontline working includes working with families where safeguarding issues exist and impact on the CYP. Support from organisations also needs to be considered for the safeguarding supervisors.

The Supervisor

- Be accountable in keeping up to date with contemporary safeguarding supervision research/evidence base.
- Undertake safeguarding supervision education to enable competent and confident facilitation of safeguarding supervision.
- Develop skills to foster a facilitative, critical discussion to advise, support, challenge and develop the supervisee.

The Supervisee

- Prepare for safeguarding supervision.
- Attend regular safeguarding supervision as set out by organisational policy.
- Prioritise safeguarding supervision as essential practice and if they access a virtual session ensure the camera on their device is turned on and the session is not interrupted and stays confidential.
- Record a safeguarding action plan following discussion at safeguarding supervision.

10.10. Dissemination strategy

10.10.1. Dissemination to date

Some initial findings from the research were presented in 2022 at a joint conference of the Global Network of Public Health Nurses (6th International conference) and the Japan Academy of Public Health Nursing (10th Annual conference), this was a virtual presentation as the conference was in Japan. My work was also presented at the RCN

International Research Conference in 2022 and the Unite Scientific Nursing Conference in 2023 (virtual attendance Rome). The presentations included the findings from the impact of COVID-19 chapter of the thesis as the theme and findings were pertinent to the conference criteria. I have also presented an update of my research to the National (Wales) Safeguarding Network who have consulted with me as their national safeguarding guidance is due to be updated.

One of the aims of my research was to investigate the role of safeguarding supervision and the relationship with the safeguarding supervisor, in developing competent safeguarding practitioners. In March 2024 I had the opportunity to spend two days with national safeguarding lead nurses (Wales). The purpose was to explore the future provision of safeguarding supervision across Wales. I was able share the knowledge gained from my literature review and findings to enhance discussion around safeguarding supervision and assist in shaping future policy for Wales. I have developed a working relationship with the network and look forward to working with them as the policy directive evolves. I have been consulted with on the latest draft of the National Safeguarding Supervision guidance which is being presented to the Wales National Network imminently.

I also currently provide an education session in the form of a practical face to face lecture to one university in Wales and liaise with HEI leads, HEIW and the NMC to update them on study findings.

10.10.2. Dissemination going forward.

I plan to present my findings across local, national, and international conferences as well as writing for publication in relevant nursing and relevant multi-professional journals. I am presenting at the RCN International research conference in September 2024 and I have submitted abstracts to two further conferences for 2025 – The Global network of Public Health nurses and the International Collaboration for Community Health Nursing research. I was funded by the Community Practitioner and Association Macqueen educational bursary and will provide an overview of my journey and findings via the Community Practitioner journal. I will pursue publishing within peer-reviewed

journals to include; Child Abuse Review, Journal of Advanced Nursing, Journal of Nursing Studies; RCNi Primary Healthcare and Health and Social care in the Community. I have also been approached to publish my work as book.

I will share my experience and knowledge gained with the Chief Nursing Officer (CNO) Wales, Executive Directors/Deputy Directors of Nursing and Midwifery (Wales), Royal College of Nursing countries/regions, HEIW, Institute of Health visiting, Florence Nightingale Foundation and Foundation of Nursing Studies due to their investment in nurses' support, wellbeing, workforce experiences and retention.

I will also disseminate my findings and recommendations to the three health boards involved in my research, the All-Wales Heads of Health visiting and School nursing as well as the SCPHN (Wales) HEI leads, UK Standing Council of SCPHN education leads and the NMC.

10.11. Limitations of study

Although the research question was answered, COVID-19 restricted access to observations of safeguarding supervision in two of the three health boards. It also changed my ethnographic view from a face-to-face format to virtual observations, focus groups and interviews in two of three health boards. There was a risk to be focussed purely on COVID-19 and although it has been featured it was contained within one chapter and considered a necessary finding.

Being an insider researcher could have potentially flawed data collection, analysis, and recommendations for practice if a subjective view was taken. I felt that it enhanced my research role and that I was able to remain objective whilst having a knowledge base of safeguarding terminology, processes, and a lived experience of receiving and delivering safeguarding supervision. When group supervision was launched in 2018 within the ICHB, I was very sceptical in whether it would function as well as being supportive for HVs. Another potential limitation relates to my previous involvement in teaching four of the participants previously.

The HV and safeguarding leads chose the participants to avoid bias and ground rules established with the choice for participants to withdraw at any time without explanation on the participant information sheet. I was very aware of my previous relationship with two of the four HVs selected due to me teaching them both when I had been their SCPHN programme manager. From my perspective, it was a welcome observation to see how they had developed in practice post SCPHN programme. It was as if I was seeing their progress with a 360-degree lens from interview and discussions pre SCPHN programme, observing them complete their programme, to graduating and now seeing them practice was a positive outcome and they were pleased to be involved. I analysed this and questioned were they pleased to be involved genuinely, or did they feel they had to be involved. I was very conscious of my feelings and therefore set out some clear boundaries in relation to my role as 'researcher.

10.12. A personal reflection

As I was concluding this thesis the child practice review (CPR) findings and recommendations were published about the death of Lola James in 2020 (Mid and West Wales Safeguarding Children Board (MWWSCB) 2024). They are a distressing read but this is the reality and example of the complexity of safeguarding CYP, and how access to families, and the ability to assess risk, be professionally curious and challenge come into delivery of effective safeguarding practice. Lola was 2 years and 10 months old and died at the hands of her mother's partner on the 16th of July 2020 (three months into the COVID-19 pandemic). She was found with over 100 injuries and subsequently died. The child practice review states that although the COVID-pandemic had affected delivery of services they found no direct evidence that it prevented direct access to Lola. I will focus on the health visiting service involved in this case, who had attempted to contact the mother between March and July (2020). The published learning points from this review are included in Table 17 and I have highlighted particularly learning points targeted at the HV service. There are also action points for each agency within the report. Multi-agency action points relate to further training on information sharing, improved multi-agency working together in multi-agency safeguarding hubs (MASH), and training/managerial support to be given to professionals when parents are failing to

engage as well as support in asking difficult questions. The final multi-agency action point relates to producing detailed records. There was one reference to supervision.

> *"For supervision sessions with relevant practitioners within the respective agencies to address the importance of using specific terminology when completing records/reports, and for professionals to be reminded of the importance of providing sufficiently detailed/ contemporaneous records. This is to include making it clear which individual(s) in or around a family are being referred to."* (MWWSCN 2024 p.30)

Table 17: Lola James Child Practice Review Learning Points.

1. To ensure relevant professionals are consulted during an adult needs assessment.
2. To ensure that an assessment regarding the needs of a child is undertaken and finalised in accordance with the relevant timescale by children's services prior to a case being closed in an appropriate way, and to ensure that robust systems are in place within children's services to attend to periods of absence by an allocated assessor.
3. To ensure that opportunities are not missed by health visitors to arrange home visits or escalate concerns (to management) if there is a failure by a parent/carer to engage, particularly where there is a history of child protection concerns within the family.
4. To ensure there is professional curiosity when suggested negative behaviours of a child is limited to parental report only.
5. To ensure that language used by professionals within documentation is not vague, and that there is, instead, specificity to appropriately assess risk.
6. To ensure that written documentation is sufficiently detailed and entered onto the electronic system as soon as practicable after an even. (Although, the health visitor service, in some areas, still operate using handwritten notes only).

The child practice review was reported across Welsh news channels with criticism directed at the social worker and the HV and reminded me of the findings of previous child death tragedies and how we can support practitioners in doing the best for CYP within their caseloads. The risks identified within the CPR included; domestic abuse, substance misuse, a new male partner with additional learning needs and previous history of perpetrating domestic abuse, as well as maternal mental health issues. These are common cumulative risks identified in already mentioned serious case reviews (Brandon et al. 2008, 2012, 2016, 2020). I wonder how these recommendations across all serious case reviews actually impact on improving practice for the long term. We move from one buzz word/terminology to the next. There were flaws in service delivery in this case – staff sickness, resources, and the pandemic. The authors of the review state that it did not affect access to services but, there were three children in a house, with COVID-19 restrictions in place, and a multitude of risks present.

I find the reference to supervision more focussed on a managerial supervision rather than supervision that is educational, restorative, and supportive with the onus on improving processes and training. Learning from these tragic events is never straight forward because, as we know, families and situations are complex and evasive. Therefore, the development of an all-Wales approach to safeguarding supervision is paramount to support frontline staff dealing with such complex potentially safeguarding situations within families.

Chapter 11. Conclusion

This doctoral study has explored how supportive safeguarding children supervision is for HVs. The HV and SNA experience of supervision received was explored to determine whether it was supportive, practical, and offered a process that enhanced critical reflection and analysis of safeguarding practice, as well as scoping perceptions of, and preference for, one-to-one and group supervision formats. I felt early on that chapters including the history of health visiting, safeguarding children and young people leading to descriptions of safeguarding and clinical supervision would help to set the scene for the thesis. It feels as if there is always a need to justify the role of the HV, we always seem to be fighting for our purpose which is to offer support and advice to parents/carers in giving their children the best start in life. The role has such potential in setting children up to grow and develop to reach their developmental milestones both physically and psychologically. To do this the HV service requires support especially when working with vulnerable families being exposed to ACEs or trauma. Parental need must be factored into the role also and, therefore, an ecological approach is needed when assessing risk. This is essential to offer proactive supportive solutions with the child always placed at the centre. Health visitors have a SCPHN qualification, never more has this specialist role been needed to promote health, challenge health inequality and be true to the salutogenic nature of the role. There is such potential to improve population health, safeguarding children and advice and support parents when they are faced with adversity.

I took an ethnographic stance in observing HVs in practice and within their group safeguarding supervision sessions. This gave new insights into the day-to-day role of the HV and the SNA when facilitating group supervision. The discussion chapter has allowed me to consolidate the thesis content as a whole and by incorporating the evidence base with the data and its analysis. I have been able to construct a framework for safeguarding supervision that is just not specific to health visiting but one that can be transferrable across professions. The whole research process has been challenging at times with a complex ethical approval process and global pandemic as part of my research journey. Overall, I have learnt so much about the research process, its

intricacies, its complexities which has made me love and hate it at varying times. I have developed as a researcher and enhanced my skills whilst also developing as a person, stepping out of my comfort zone in embarking on doctoral study and drawing on my own resilience factors, strength, courage, and hope. The research question was answered with a consensus that group safeguarding supervision was supportive and valued. Some HVs would like one to one supervision as well to debrief and explore cases in more depth and to seek an objective overview of the families they were most concerned about.

My focus is and will always be child-centred, this is an essential ethical and moral stance within health visiting practice. I have reiterated the importance of resource provision in the form of safe staffing in this specialist field of nursing. A key message based on my findings and experience is that all levels of practice (micro, meso, micro) need to believe and invest, have the motivation and resource (staff, safe environments, protected time and space, policy) to practice effectively. This will enable HVs to provide the best possible care to ensure CYP safety is paramount. To do this staff require support, time, space, and education. Therefore, for safeguarding supervision to be effective and supportive in Wales, Welsh Government via the National Safeguarding Network need to invest in the education of safeguarding supervisors, prioritise safeguarding supervision within their health board policies, and offer healthy workplace environments to nurture, recruit and retain health visitors. This is essential to enhance, support, restore, educate, enable, and empower the HV and safeguarding workforce, to ensure proficient and expert practitioners who are practicing to safeguard babies, CYP and whilst ensuring their practice remains contemporary, evidenced based and pre-dominantly child centred.

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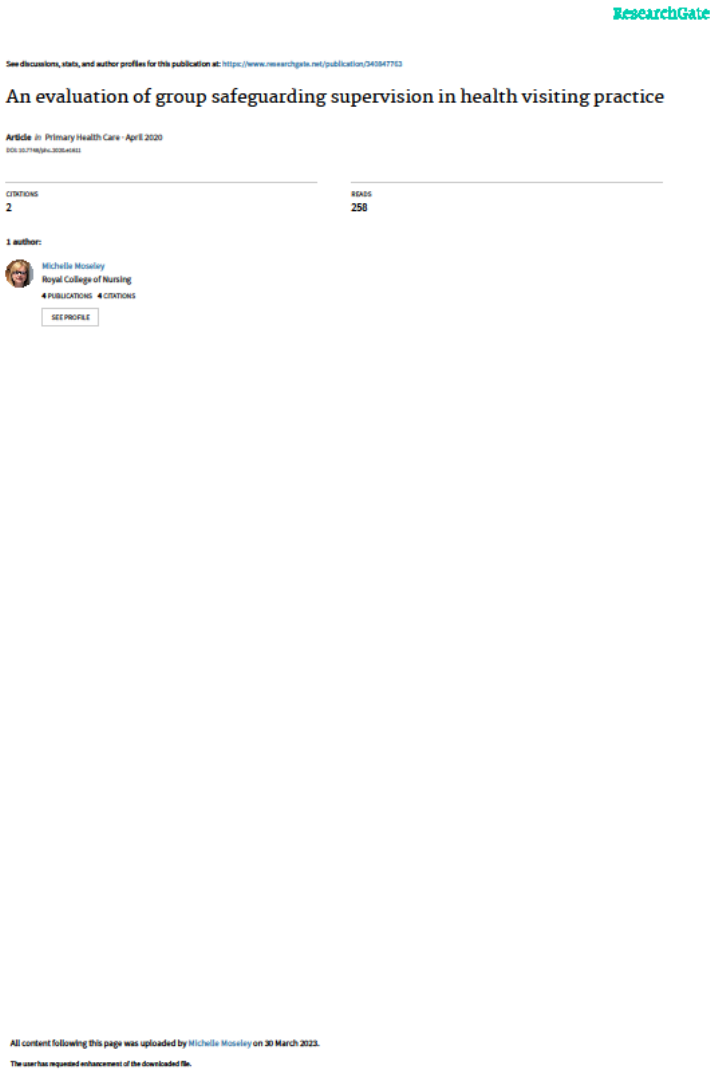
Appendices Pilot study

Appendix 1



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Appendix 2 Initial general overview/appraisal of literature

Author/Year	Population	Methodology	Sample Size	Ethics	Comparison/Intervention	Findings	Recommendations
Austin and Holt (2017)	Public health nurses. Social work line managers. Ireland	Qualitative Constructivist paradigm, focus groups, semi-structured interviews, Purposive sample – selected by managers.	10	Yes, limitations identified.	No.	Two themes: Stress and vicarious trauma associated with CP and welfare work. A new role – embracing change.	Public health nurses need access to 'appropriate' supervision when working with vulnerable families. PHNs are a key protective factor in the protection of children in Ireland. The need to develop new role to support the wellbeing of PHNs.
Bradbury-Jones (2013)	Child protection practitioners	N/A not research.	N/A	N/A	N/A	N/A	Acknowledges the complexities of child protection work and its impact on stress development and burnout. They suggested a re-focus on the delivery of child protection supervision with use of the Peshkin approach to supervision. A reflective space to allow for an open, reflective discussion is advocated and a holistic, reflective approach by Peshkin (1988) suggested as a way forward in child protection supervision. The approach focusses on supervisee emotions rather than incident/process. It is underpinned by anthropology and takes a thoughtful stance towards the safeguarding

							supervision process with the supervisee at the centre.
Burns et al (2020)	Social Workers	Longitudinal Qualitative study 2 data collection points.	1st data point 2005-2007 35 social workers. 10 interviews with social workers who had left. 2014-2015, snowball sampling – 33 of original social workers found. Nineteen agreed to be interviewed.	Not clear.	Comparisons drawn around reasons for attrition.	Thematic analysis led to three dimensions of job-embeddedness theory: fit, sacrifice and links. Ecological framework applied to retention. (Worker at the centre)	Stark – no amount of resilience, well-educated and prepared social workers can prepare them for the intensity of high caseload working. There were no new worker induction processes in place. Lack of emotional support from the organisation. If retention in years is over five years, the reason behind this is the same and became a central component of their professional identity. A stronger sense confidence moving from novice to expert.
Griffiths (2022)	Nursing A-EQUIP/PNA	Narrative, not research	N/A	N/A	N/A	Nursing practice transformed during the pandemic.	Use of restorative element of AEQUIP model positively influenced nurses' resilience/anxiety levels. Staff comments included.
Guindi et al (2019)	Community nursing.	Qualitative – literature review. Thematic Synthesis	Systematic review 11 papers.	N/A	Explores what factors contribute to effective safeguarding supervision. What is helpful/unhelpful for frontline staff. Does the supervisee/supervisor relationship detract from the supervisory process.	Limitations to all papers in the review from a methodological perspective. Papers do offer opinion on what potentially could support effective SS. No national definition of SS, confusion between CS and SS.	SS is different to CS and must sit in a different space to CS. SS must ensure the focus remains on the child. SS should extend to those that are vulnerable not just those on a CP plan. SS must support practitioners to feel safe to discuss, challenge practice to ensure safe and effective care.

						Supervisee/supervisor relationship important. Safe space important. Lack of safeguarding supervision training.	
Guindi (2020)	Community nursing - HV, SN, LAC, family nurses.	Quantitative - survey	37	Yes	Survey - community nurses views on application on a model of safeguarding supervision. Perception of SS. Qualities supervisor. What is unhelpful about SS process.	**Most familiar model** – SoS (78.4%), the reflective model (70.3%), Family Partnership model (48.4%), resilience model (29.7%), restorative supervision (18.9%), Brearley model (16.2%), 4x4x4 model (13.5%), Peskin (10.8%). **Mode of supervision** – 35/37 prefer a mix of 1:1 and group. **Background of supervisor** – 34/37 responded, 24 felt they should come from same professional background. 5 unsure, 5 said not important. **Training and credibility of supervisor** – 78.8% felt supervisors	**Implications and Recs** - Mode of supervision not so important but critical reflection important for learning. Preferred mode – mix of 1:1 and group – needs more research. Qualities of supervisor need further exploration. Supervision training though was deemed important. Experience of practitioner a key factor – needs further exploration. Provision of safe environment/feeling safe important. Unsure if absence of this has an impact on children.

						should be trained in SS. 21/32 also felt a leadership course was not necessary. **Other factors** – most important to have time, space, 'safe environment' experienced supervisor. Less important – application of theory to practice and model used.	
Harvey and Henderson (2014)	Target audience – social workers	Discussion paper	N/A	N/A	N/A	Describes a model of reflective supervision using psychoanalytical theory. *Useful for discussion chapter *	"Supervision cannot be reduced to a tick box exercise with reflection or critical analysis being compartmentalised." Supervision must focus on the child's experience. Containment through supervision. Projection – impact on the worker
Hunt et al 2016	Social workers	Mixed method Online Survey design to collect workers experiences.	590 participants. 402 SW's. 423 worked in CP.	No mention	Survey To analyse and understand workers' experiences of supervision and management responses following interactions with	Opportunities for emotional attuning and reflection on cases cannot be tagged onto performance checks	Recs: National policy to support workers working with hostile families. Supervision and management support needs

		24 questions to collect quant data/demographic info, 7 questions were open ended for qual data. Nvivo used to analyse qual data and theme.	Invited to participate through community care website.		hostile and uncooperative parents. Analysis of data examined organisational responses to worker stress, and assessed support provided.	in a token way there needs to be clarity about the theoretical frameworks which support the delivery of supervision, and the varying response of orgs was inadequate in the form of supportive education and supervision which related impacted the protection of children. models to do so.	to be effective to support retention and empower workers. Improved training, resourcing with 'intensive' supervision/support.
Jarrett and Barlow (2014)	Health Visitors	RCT This paper is summary of qualitative element. Interviews.	15 HVs. purposive sample.	Yes	Clinical supervision delivered by a psychotherapist.	Interviews themed: Maintenance and boundaries. Reflecting on practice. Developing a better understanding. Challenging practice. Opportunity to share experience.	The HVs experience of clinical supervision were: They felt their practice had improved. They felt the advantage of having clinical supervision provided by a therapist. Organisations must be supportive of delivering clinical supervision.
Little et al (2018)	Community nursing service. (HV and SN (School Nurses))	Qualitative evaluation/grounded theory. 11 F2F interviews, recorded interviews. Online open-ended questionnaire	25 – 5 safeguarding nurse leads, 20 case holding practitioners	Yes	Previous literature informed interview questions. There are few studies that have evaluated safeguarding supervision.	Themes: Context and processes of SS Helpful and unhelpful aspects. Accountability issues Developing existing practice. The SS was viewed as child focussed, helpful, improved practice.	SS (Safeguarding Supervision) could include case discussions of those children who were deemed problematic but not necessarily open to CP. Better staff preparation, time limiting safeguarding 'interviews,' improvements in record keeping. SS supervision allows opportunity to reflect on

						Little negative comments and related to the SS 'intrusive, punitive nature, time, competing priorities.'	practice, share good practice, improve future practice.
Littler (2019)	School Nursing	Qualitative phenomenological	Across 5 NHS trust sites in England. Telephone interviews. 15 participants.	Yes	Interviews. For themed categories: Education. Safeguarding risks. School nursing role. Practice Support.	Within the school nursing role – there were higher number of child exploitation and mental health in adolescence.	School nurse's role is essential in supporting young people. Support via practices such as safeguarding supervision, working in effective teams were deemed key factors in supporting the role.
Masamha et al (2022)	Nursing	Scoping Review	87 Papers	Yes	Review of literature	Themes established: Definitions and models. Alternative parallel forums and support mechanisms. (Mis) Trust and the language of supervision. Time and cost. Skills required for CS.	Future research is required to be solution focussed in relation to: Factors underpinning persistent barriers. Considering missed knowledge areas e.g. agency nursing, IENs. Provision of culturally specific and effective approaches to support diverse staff. Acknowledge parallel CS forums rather than fight against them. See them as complimentary. Critical reflections on resistance to interprofessional CS. Policy and regulation should be responsive to the above. As a profession we need to examine us as critical

							reflective learners where reflective practice is expected – access and support to it by organisations is essential. Pre- reg nursing CS preparation.
McGarry et al (2018)	Healthcare Practitioners	Quantitative	142	Yes	Anonymous Survey	Overall practitioners felt confident, knowledgeable, and satisfied with their SS. Understood the difference between SS and managerial supervision. Lower bands less positive about SS in relation to how enabled they felt to explore safeguarding concerns, how they felt equipped to deliver/receive SS and their understanding of the differences between management and SS.	What makes a successful Safeguarding supervision framework (SSF) relationship? Preparation of supervisors and supervisees in the SSF. Clear distinguishing between managerial and SS. Review current SS guidance and develop a best practice guide. Attention to lower grades/bands support on safe guarding practice. Ensuring equity of hours and frequency of SS for equity across the workforce.

McPherson et al (2016).	Social Workers	Qualitative	In depth interviews	20 Purposive from a pool of 90 previous students. 10 SWs 10 SW supervisors.	Yes	8 themes which the author's state reflect "ontogenic, micro, exo and macro levels of analysis, corresponding to the context of individuals" the supervisee/supervisor relationship, orgs, and wider community – Belsky (1980). Themes: Safety, responding to emotional impact of work, learning and growth, leadership, integrity and justice, balancing supervision functions, organisational processes, community understanding and valuing practice. Refers to the neuroscience of trauma – relational neuroscience.	Safety is essential and important to the participants due to the very nature of the work. Safety was described as the "foundational requirement for effective supervision." A calming supervisory presence attuned to the supervisee is required to reduce stress, burnout and promote good, safe practice to empower staff. This study and supporting literature within it suggest "supervisors who present as empathetic and well-regulated enable their supervisees to move from an internal state of distress to calm through this contagion, creating space for supervisees to reflect, practice and learn." (p76)
Moseley (2020)	Health visitors	Qualitative, phenomenology	16 HVs 2 SNAs	Yes	Focus groups and questionnaire	Themes of questions in FGs: The importance of safeguarding supervision. Willingness to try group supervision. Maintaining one to one supervision.	Group supervision to be offered with the option of adhoc and one to one if requested. SNAs to receive specific Safeguarding supervision training.

						Benefits of group supervision. Group supervision structure. Use of Signs of Safety. Training for SNAs. Record Keeping. Group vs 1:1	Smaller groups of 4-6 to enable time for each person to discuss a case. The same, planned structure employed across the health board. A model such as SoS used to facilitate discussion within the session. Longer sessions to be offered (up to 3 hours). Regular evaluation of group supervision.
O'Neill et al (2022)	Community maternal and child nurses.	Qualitative	26	Yes	In depth interviews	**Themes:** 'Understanding what to do' (Governing, Local arrangements, engaging supervisors, purpose). 'It's gathering the nurses' (Nurse needs, practice demands, group agreements). 'Bringing a case' (Supervision sessions, group facilitation).	MCH capacity to use CS could be enhanced by wider education of the workforce on CS in practice as well through leadership to build a culture of change. Organisations have a responsibility to strengthen CS in practice.
Peckover and Appleton (2019)	Health visitors	Narrative – not research .	N/A	N/A	N/A	N/A	Role of HVs in safeguarding and child protection is unquestioned. Offers an up-to-date RV of HV work in safeguarding and CP. Challenges in HV practice in relation to social and welfare

							austerity and huge change to commissioning (England).
Rankine and Thompson (2022)	Child protection social workers	Quantitative Data from an 'action research' study	10	Yes	Online survey	Frequency of supervision, functions of supervision, engagement in reflection, supervision changing practice, resilience, and longevity in social work careers as well as the supervision of supervisors.	Social workers showed increased confidence as they built reflective capacity, resilience in practice. Demonstrated the importance of safe learning spaces to enhance reflective supervision for supervisees and supervisors.
Rooke (2015)	Health Visitors	Qualitative	10 HVs	Yes – University Ethics Comm	Focus Groups x2. Thematic Analysis	Mechanisms for support were prominently colleagues and then supervision. Support to manage emotions within the CP Role. Feeling safe and effective in practice. Time to reflect.	HVs exposure to anxiety within their CP practice when working in isolation. Newly qualified HVs and students should be supported in CP practice. (Robust preceptorship) Development of forums for peer discussion
Sagoo et al (2013)	Health visitors	Not research. Audit data shared. (Annual audit)	N/A	N/A	N/A	Introduction of lead role to supervise HV's. Quarterly supervision.	Effective supervision linked to supporting standards of practice, enables early intervention and prevention, empowers the most vulnerable families. Supports retention. Supports RTP staff. Protected time allows for effective, protective practice.

							Introduced to student HVs in 3rd semester. Maintenance of this level of supervision requires regular evaluation. Laming (2009) - supervision needs to be open and supportive, enabling decision making with a focus on driving safe and effective care for CYP instead of focussing on targets.
Scullion and Robertson (2023)	Health Visitors	Qualitative	14 HVs and SNs	N/A	Semi-structured interviews	Themes include: **The need for supervision** to promote safe and effective care, to reassure and guide, offer support system mechanisms. **The supervision process** underpinned by policy, preparation for supervision, skills of the supervisor. **Value of the supervision:** Safe place, stress management, helpfulness, and positive aspect of supervision.	Preparation for supervision key – refers to the risk analysis tool. Alignment to Signs of Safety. Consideration of protected time – 3 hours. Networks of support mechanisms. Further work to QA process.
Smikle M (2018)	Nursing - reference to health visitor	N/A Not research.	N/A	N/A	N/A	Safeguarding supervision, reflective models, SCR's, NSPCC, RCPCH referred to.	SS needs to be offered protected time and delivered by a trained supervisor who is experienced and knowledgeable.
Wallbank (2011)	Health visiting and	Quantitative	Commissioned, ethics not mentioned.	22 HV/SN	Participants had received supervision prior to commencing the study.	Baseline results identified 41% had had no previous	National, regional, and local recommendation are detailed

	school nursing				ProQUOL questionnaire completed.	training in supervision despite being in leadership roles. Any training available was variable. Professionals who had received training were unable to identify a model of supervision. Burnout and stress were at clinical levels. Post supervision burnout was reduced. Compassion satisfaction high deemed a protective factor.	to support restorative supervision.
Wallbank (2012)	Health visiting	A review of evaluation rather than pure research. *Discussion paper	Confusing	N/A	RCS delivered to over 600 HVs over 18/12 – pilot. 942 Hv's in total, led by clinical psychologist/assistant psychologists and clinical supervisors (HV Background) Evaluation of Delivery of restorative supervision UK wide.	Themes: Description of participants. Violence experienced. Supervisory and organisational support. Procedures, guidelines, and protocols (hostile/un-coop families). Impact on children. Overview of themes associated with what HVs are experiencing,	Leadership development is key in retaining staff. Themes identified: Operational issues: Open communication about what needs to change. Workload pressures encourage ineffective ways of working. How does RCS help? It is one tool that has been evaluated as to support management structures and supporting improved outcomes for families.

						trying to resolve, and how supportive RCS is. Restoration of capacity to think, improved decision making.	
Wallbank and Woods (2012)	HVs	Results from an RCS programme. Questionnaire (Professional quality of life scale (PROQUOL) Compassion satisfaction, Burnout, Compassion fatigue measured	As per study results – RCS rolled out to 246 HVs (1800 UK wide) Quant data		Drew some comparison to CS literature but deemed not enough evidence on positive impact of CS. Pilot study roll out 2007 (Obs and Gynae nurses, midwives, Drs)	RCS increased levels of compassion satisfaction and reduced burnout and stress by 40%. Delivery then rolled out across West Midlands area. Lack of training in CS identified in baseline results and high burnout and stress scores effecting the individual's capacity to critically think. Qual results – valued CS, restored thinking, model of cs helpful, decision making,	Continuing research
Wallbank and Hatton (2011)	Targeted to SCPHN (HV & SN)	Evaluation	22 HV/SN undertaking a leadership programme. **Quant** questionnaire (PROQUOL)	Not included	Baseline questionnaire pre supervision. Professional quality of life scale (PROQUOL)	HV & SN a vulnerable group due to "complex, frontline, clinical work they are involved in." HCP programme recognition of the crucial role HVs play in safeguarding	**Lord Laming 2009 - "Managers must recognise anxiety undermines good practice. Staff supervision and assurance of good practice must be elementary requirements in each service."**

					Measures compassion satisfaction. Burnout Compassion fatigue 128 sessions delivered to 22 participants over 6 months. 41% of participants had had no prior training in the delivery of supervision. (They were deliverers of safeguarding supervision.)	practice requiring "effective leadership to provide a holistic, co-ordinated service that is tailored to individual needs." Burnout and stress were at clinical levels for most of the participants with slight variation within the group suggesting it was a common experience. Post supervision burnout reduced by 36%. Stress reduced by 59%. 76% indicated their psychological wellbeing was poor or ok with only 24% reporting good. Compassion satisfaction was high and considered a protective factor.	National recommendations. Regional recs Local recs.
Wallbank and Wonnacott **(2015)**	Health and Social Care	Narrative, refers to previous Wallbank research findings	Refers to 3094 sample.	N/A	N/A	Discussion and justification of RSS incorporating RCS and 4x4x4 model	Yes – Macro, meso, micro embedding of RSS to enable effective delivery of SS.

Warren (2018)	Targeted to safeguarding supervisors – not explicit.	Literature review	N/A	N/A	N/A	Role of leader in SS. Robust definition of safeguarding supervision. A literature review. Exploring the role. Of the leader in effective safeguarding supervision. Links were found. Where there was a positive leadership behaviour style. Which equated to the delivery of effective supervision. The literature also highlighted the positive impact. On the well-being of staff when he was supported by leaders who were compassionate. 2 themes, safeguarding supervision, and leadership behaviours.	Implications for practice listed – Macro, meso, micro awareness of importance of SS. Governance frameworks/safeguarding champions. R/V of existing policy. Leadership development for Safeguarding supervisors. Protected time. Regular evaluation of SS. Supervisor feedback tool.
Warrick et al (2022)	Social workers	Qual – Ethnography 15-month longitudinal study. Observations of supervision. England, 2 sites 2016-2018 402 days of field work observed, 271	Case study of one SW who features in 3/15 long term cases observed	Yes	Observation over 15 months. Table of observation included referred to as a 'star' case. Interviewed 59 times. 'Sh' stayed in the team for the whole 15/12 whereas 42 others left during that time.	Supervision processes reflected the organisational culture of both areas. Typically, austerity, funding issues, performance management focus move to bureaucratic and managerial supervision practice.	Recommends a more "humane approach to social work supervision" rather than "dominant managerial themes that have increasingly burdened the profession." The case study demonstrates the true nature of supportive supervision and how it contained a situation and retained a staff member.

		practice encounters social care staff and service users. Staff supervision observations, practice observations. Semi structured, informal ethnographic interviews carried out. 54 staff supervisions.				Sheena overworked had previously been off with stress (manger issues), worked well with current manager however hi manager left at month 2 or research commencing. New manager month 3. Service manager gave an incorrect description of Sheena to ne manager. Sheena personal and professional challenges – Sheena decides to leave the team. New manager reflects on Sheena's practice, liaises with research team, changes tack. Sheena stays due to effective supervision.	Active listening, empathy and security provided.
White (2023)	School Nursing	Not research, short opinion piece. .	N/A	N/A	N/A	N/A	Key point made how SN's are being asked to forgo their safeguarding supervision due to workload pressures. Supervision key in keeping child at the centre of practice. Supervision should allow a safe space to explore safeguarding practice, share feelings, enable challenge, allow critical reflection.

Appendix 3:COREQ (Consolidated criteria for Reporting Qualitative research) Checklist

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	Title
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	Title
Occupation	3	What was their occupation at the time of the study?	ii
Gender	4	Was the researcher male or female?	Title
Experience and training	5	What experience or training did the researcher have?	Title 2, 78
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	86
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	86
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	2, 3, 81
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	79
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	85, 86
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	86
Sample size	12	How many participants were in the study?	85
Non-participation	13	How many people refused to participate or dropped out? Reasons?	N/A
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	88, 89
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	N/A
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	80, 257
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	88, 264, 265
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	N/A
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	89, 98, 100, 1
Field notes	20	Were field notes made during and/or after the inter view or focus group?	84, 96
Duration	21	What was the duration of the inter views or focus group?	00, 101, 104,
Data saturation	22	Was data saturation discussed?	N/A
Transcripts returned	23	Were transcripts returned to participants for comment and/or	N/A

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	109
Description of the coding tree	25	Did authors provide a description of the coding tree?	111 - 112
Derivation of themes	26	Were themes identified in advance or derived from the data?	113
Software	27	What software, if applicable, was used to manage the data?	N/A
Participant checking	28	Did participants provide feedback on the findings?	N/A
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	114 - 145
Data and findings consistent	30	Was there consistency between the data presented and the findings?	113, 177
Clarity of major themes	31	Were major themes clearly presented in the findings?	113
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	172 - 177

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Appendix 4: Combined Health Boards completed HV Demographic Questionnaire results: an overview

HV	16
Length of time as HV ≤ 5yrs	3
6-10 yrs	5
≥10 yrs	8
SNA	2
Length of time as SNA ≤ 5yrs	2
Group Safeguarding supervision rating: extremely important	12
Important	4
Neither	1
Not important	0
1:1 supervision rating: Extremely important	4
Important	12
Group safeguarding supervision preference	10
1:1 supervision preference	2
One to one supervision outside of group	4 (Ad-hoc) 4 (Regularly)
Both modes of delivery preference	14
Supervision contract signed - Yes	2 (SNA's) 4 (HV)
Supervision contract signed – No	12*
Aware of HB Safeguarding supervision policy - Yes	16 (HVs) 2 (SNAs)
Aware of HB safeguarding supervision policy – No	0
Aware of all Wales supervision policy - Yes	2 (SNAs) 5 (HV)
Aware of all Wales supervision policy - No	11

Appendix 5: Participation information sheet (PIS) and consent forms.

Participant Information Sheet – Health visitor Interviews
(Version 3.0: 25.03.2020)

Title of Study: An ethnographic evaluation of mandatory safeguarding supervision for health visitors HVs working with vulnerable children and families.

Name of Researcher: Michelle Moseley
I would like to invite you to take part in a study that I am undertaking for the purpose of a PhD at Cardiff University, into what health visitors HVs feel about the safeguarding supervision process. Before you decide whether to take part, I would like you to take as long as you need to read this information to understand why the research is being done and what it would involve for you. I will explain the information sheet further if required with you and answer any questions you have. Talk to others about the study if you wish. Please contact Michelle Moseley (email address) if there is anything that is not clear.

What is the purpose of the study?
The purpose of this research is to explore how supportive safeguarding supervision is. As health visitors you will be key to study as I want to explore your safeguarding supervision experience by observing a safeguarding supervision session followed by a focus group. Two health visitors HVs will then be chosen to be interviewed in more depth following a visit you have undertaken with a family discussed in supervision. The study aims to incorporate health visitor HV and safeguarding lead nurses' views on the supervision process (The safeguarding lead nurses will be interviewed too). The overall aim is to establish if it is supportive and whether the mode of delivery is satisfactory in building proficient safeguarding practitioners. In summary, I will be interviewing you and observing you within a safeguarding supervision session, conducting a focus group with the safeguarding supervision group (health visitors) and interviewing 2 health visitors HVs from your area (who are part of the focus group).

Why have I been invited?
You have been invited to take part because you have been involved in the safeguarding supervision process.

Do I have to take part?
Whilst your contribution would be valuable, it is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason, and will not result in any disadvantage or detriment. If you withdraw from the study, this will have no effect on your relationship with any organisation or agency. The interviews will be audio recorded. If you withdraw and have been involved in the focus group and been recorded, your contribution will remain intact within the recording but will not be analysed or referred to within the study.

What will happen to me if I take part?
You will be contacted by Michelle Moseley to arrange a mutually convenient time to take part. This part of the study involves six individual interviews (2 per health board). You will be involved

in one of these interviews. Following a visit with one of the families discussed in supervision, an in depth semi-structured interview will take place within health board premises. As part of the study Your safeguarding plan will be observed within your records. All the interviews will be digitally audio recorded. The audio recording will be turned into a written transcript, which will be analysed using social science methods.

Audio recordings will be deleted from the audio recorder as soon as they have been saved on a password protected Cardiff University computer to which only the research team and the Data Custodian at Cardiff University have access. All information gathered will be kept confidential, except where disclosure may affect patient or staff safety. In that case, the information will be disclosed to the area safeguarding nurse advisor, the line manager, Head of Safeguarding, and the Deputy Executive Nurse Director. The transcripts will be kept for 15 years on a password protected Cardiff University computer to which only the research team and the Data Custodian at Cardiff University have access. Transcripts will be anonymised with a study number. Participants' names will not be stored with the transcripts.

Expenses and payments
Participants will not be paid to participate in the study. Time taken to be involved in the study has been agreed with the Health Board.

What are the possible disadvantages and risks of taking part?
There are no known risks to participation in this study. It is important to know that the researchers will not disclose any names or issues you may wish to be kept confidential unless this affects issues that have the potential to affect client or staff safety.

What are the possible benefits of taking part?
You will get the opportunity to express your views on the new supervision process and the structure of the sessions. This information will inform your Head of Safeguarding, the local health board, and Public Health Wales safeguarding team. The research has the potential to shape future safeguarding supervision practice in Wales.

What if there is a problem?
If you have a concern about any aspect of this study, you should speak to Michelle Moseley, School of Healthcare Sciences, Cardiff University. Tel:**********: Email **********Or, you could email Michelle's PhD supervisors: Dr Judith Carrier Tel: ********** Email: ********** **********Professor Daniel Kelly Tel: **********Email: **********

If you wish to express concern to someone not involved in the project, you should contact the Director of Research Governance at Cardiff University School of Healthcare Sciences. You can write to (Address), or contact her by either telephone on **********or by Email: **********

What will happen if I do not want to carry on with the study?
Your participation is voluntary, and you are free to withdraw at any time, without giving any reason, and, and will not result in any disadvantage or detriment. If you withdraw from the study, this will have no effect on your relationship with any organisation or agency. If you withdraw then the information collected so far may not be able to be erased and this information may still be used in the project analysis. If you wish us to destroy any previous interview material collected, please email us to this effect and we will try do so.

Will my taking part in this study be kept confidential?

The procedures for handling, processing, storage, and destruction of their data meet the requirements of the Data Protection Act 2018. The identity of your organisation will not be known, and your identity will be protected. We will follow ethical and legal practice and all information about you will be handled in confidence. Anonymous transcribed data will be securely stored in a file using a coded identification number. This will be held on a secure drive accessible only to the named researchers. Audio recordings will be deleted from the audio recorder as soon as they have been saved on a password protected Cardiff University computer to which only the research team and the Data Custodian at Cardiff University have access. All information gathered will be kept confidential, except where disclosure may affect patient or staff safety. In that case, the information will primarily be disclosed to the area safeguarding nurse advisor, the line manager, Head of Safeguarding, and the Deputy Executive Nurse Director. The transcripts will be kept for 15 years on a password protected Cardiff University computer to which only the research team and the Data Custodian at Cardiff University have access.

How will we use personal data about you?
Cardiff University will need to use information from you for this research project. This information will include:

- your name;
- your contact details;
- your job title.

People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.
Cardiff University will keep all information about you safe and secure. Once the study is finished, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?
You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we have already collected. We need to manage your records in specific ways for the research to be reliable. This means that we will not be able to let you see or change the data we hold about you. If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study.

Where can you find out more about how your information is used?
You can find out more about how we use your information:

- by asking the researcher (Michelle Moseley) or contacting Michelle's supervisors.
- by visiting the Cardiff University Data Protection webpages: https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection
- by contacting the University's Data Protection Officer: inforequest@cardiff.ac.uk

What will happen to the results of the research study?
The research findings will be submitted for PhD thesis, for publication within academic/research journals and at academic conferences. The results are likely to be published by 2022/3. You will not be identified in any report/publication. The research findings will have the potential to impact on the future safeguarding supervision practice. A final report will be produced for the Local Health Board. Academic papers will be developed from the research study and submitted for publication in prestigious academic journals. No one will be able to identify you from any publications or presentations.

Who is organising and funding the research?
This study has been funded by the Community Practitioner and Health Visitor (CPHV A) education development trust as well as a research fellowship award from the School of Healthcare Sciences, Cardiff University. It has been designed and will be conducted by an academic from Cardiff University. The study sponsor is Cardiff University.

Who has reviewed the study?
The study has been reviewed by the research and governance department at Cardiff University where university sponsorship was granted prior to obtaining NHS approval via the Health Research authority. This allows the researcher access to health board staff within health boards and families specific to this study.

Please contact the researcher (Michelle Moseley) by email or by telephone on ********** within one week of receipt of this information sheet.

CONSENT FORM – SNA Interviews

(Final Version 3. 20.01.2020)

Title of Project: An ethnographic evaluation of mandatory safeguarding supervision for health visitors HVs working with vulnerable children and families.

Name of Researcher: [Michelle Moseley] **Please initial boxes**

1. I confirm that I have read and understand the participant information sheet dated 25th March 2020 v 3.0. ☐
2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
4. I understand that confidentiality will be maintained, unless anything is disclosed that may impact on client or staff safety when it will be escalated to the relevant line manager. ☐
5. I would like to be contacted about taking part in future work that develops from this study. ☐
6. I understand any involvement in future work will be optional for me. ☐
7. I agree for secondary analysis of data to be undertaken in any future, follow on study. ☐
8. I agree to take part in the above study. ☐
9. I agree to the interviews being digitally recorded. ☐
10. I agree to anonymised verbatim quotes being used in any written outputs. ☐

Name of Respondent……

Date……..

Signature …….

Name of Person receiving

consent……Date……..

Signature receiving consent ……...

When completed: 1 for participant; 1 for researcher site file.

Appendix 6: Health visitors' focus group example questions

- Do you all have group supervision?
- If not, how many have just 1:1?
- What works well within the type of supervision you receive?
- How many cases to you bring to supervision?
- How do you prioritise the cases you bring?
- Are you able to transfer knowledge gained from the discussion and apply it your practice?
- What happens if you can't discuss your case?
- What do you think about the structure of the safeguarding supervision?
- How many of you have accessed 1:1 supervision outside of the group supervision?
- What were your reasons to access 1:1? For example, was it an adhoc issue?
- How does the structure of your supervision enhance your safeguarding practice?
- How does it enhance it?
- What works well?
- Is there anything that doesn't work well/could be improved?

Appendix 7: Health visitor interview example questions

- How do you prepare for a home visit with a family you have taken to supervision (Time of day, risk factors, review of supervision notes, consideration of the aim of the visit?
- Describe the environment? What were the home conditions like?
- Who was present at the visit (anonymously)
- How did the family members behave?
- How did you respond to them?
- Were you able to apply the advice and subsequent action plan devised from the safeguarding supervision session?
- Does the above question apply to all families discussed?
- Overall, how do you feel the home visit went?
- Does the safeguarding supervision aid your safeguarding practice? If so, how? If not, why not?
- Does it aid your critical analysis? If so, how?
- Does it evoke an element of professional curiosity?
- Have you heard the term authoritative practice? If so, what is it? How can it be applied to safeguarding practice?
- Do you seek 1:1 supervision as well as group? (Or, if receiving 1:1 only – what would you think of group supervision?)
- Have you experienced both types of supervision?
- Which do you prefer and why?
- What do you include in your safeguarding plan and subsequent records post visit? How is the plan and visit record structured?
- What is the feedback mechanism to your supervisor?

Additional questions (COVID-19 related)

How do you think the pandemic has affected the safeguarding of children?

How has the pandemic affected your access to safeguarding supervision?

Appendix 8: Data Analysis excerpt: generating keywords

190904_234021

HV views

Potential key theme

Int: Thank you for being my last interviewee, which is great, before I pull all this together. Thank you for the consent form, I received that this morning and again thank you for your time because I really know how precious your time is. I really do appreciate it you know, your group supervision and listening to you know our focus group conversation, I do appreciate your time because I know it's really busy out there. So, I'll make a start on the questions, it's a semi structured interview, I've got a whole list of questions which I've asked the same questions but sometimes they differ based on your answer, I might just throw in a few more different questions, see how that goes. Is that alright?

Resp: Yes, that's fine.

Int: So, my first question, how do you prepare for a home visit with a family you've taken to supervision? (Preparation post-supervision)

Resp: I suppose I'd have to look at the plan that we discussed at supervision and work out how I'm going to address that as a family. I'd need to sort of yeah, just make sure that I was clear in my mind what I wanted to say and how I wanted to proceed with the visit really before I even went in. (Safeguarding supervision plan)

Int: Okay

Resp: and just ensure that I've felt confident enough to bring up what I needed to bring up with them. (Competent/proficient practitioner)

Int: Based on what you discussed at supervision is it.

Resp: Yes, what the plan was with the **specialist nurse** yeah.

Int: The case you brought to supervision, the one that I observed, the supervision session I observed which was a very complex situation, I won't give too many details away, it was around domestic abuse but it was more than that, there were, there was no recourse to public funds for this lady was there and the complexities of getting her into a refuge and keeping her safe and in that refuge, you know, so did you use any of the information given. Have you visited her since I want to get to, I suppose?

Resp: No because she went into the refuge, I kept in contact with her, it took a lot longer to get her out of her property than we thought because of the complexity with the money and then when she went into the Refuge ,the health visitor HV takes over then so I've not seen her since. I've had the MARAC information through so I know what was going to happen but I've not seen her no.

Int; Okay, who did you say takes over when they go into BAWSO?

Resp: The health visitor HV that's linked to BAWSO, they take the case then.

Int: Sorry the sound just dipped out then, that's fine. What I was going to do initially as part of my PhD was hopefully come out into practice with you and observe the person that you would have, you know,

taken to supervision and just observed your interaction. Of course I can't do that now (COVID-19 restrictions). So you know going back to that person, or a case that you've brought to supervision, does it impact on your critical thinking, your critical analysis when you're going to, into a situation, a complex situation? How does group supervision, group supervision affect your critical thinking, I suppose that's what I'm getting at.

Resp: I suppose it just gives you a different, different ideas really on how to approach the situation, I think with this case it wasn't, because it was so new I felt quite clear with what I had to do anyway but I suppose there's some cases if they're drifting, like I've had cases that have gone on for years and years and years and you wonder if you lose sight sometimes so to have supervision can sort of clarify things a little bit. With this case I felt quite clear with what I had to do and what my role was but it was just good to talk about it because it was really, a really upsetting case, (Support)I've not had anything quite like it before. But I think with the critical thinking part yeah it's just about, it's about reflecting on what you have and haven't done really and of course more experienced professionals who you're in supervision with and how they would approach the situation and how they would deal with it because sometimes you just, you need somebody else to come in and just look at it from a different angle, (SNA Objective view) someone who is not involved with that family as well. So, it definitely does help critical thinking because you are, you can just look at it from a different angle and may just change the way, your assessment even, you can look at it from another point of view. (Critical thinking)

Int: Do you feel it pushes you, in a positive way, your practice, challenges you? (Challenge)

Resp: Definitely, definitely because yes you know we, you think you know what you're doing and you try and do your best but actually some other person may come and just say well have you tried this, have you tried that and you think oh gosh I hadn't thought of that or no I haven't approached it that way so it is really positive. (SNA Objective view)

Int: Okay, okay, that's great. I suppose we've sort of covered my next question, you haven't visited, I've removed the next chunk of my questions but that's absolutely fine, so my next question is does the safeguarding supervision aid your practice and you're saying that it does.

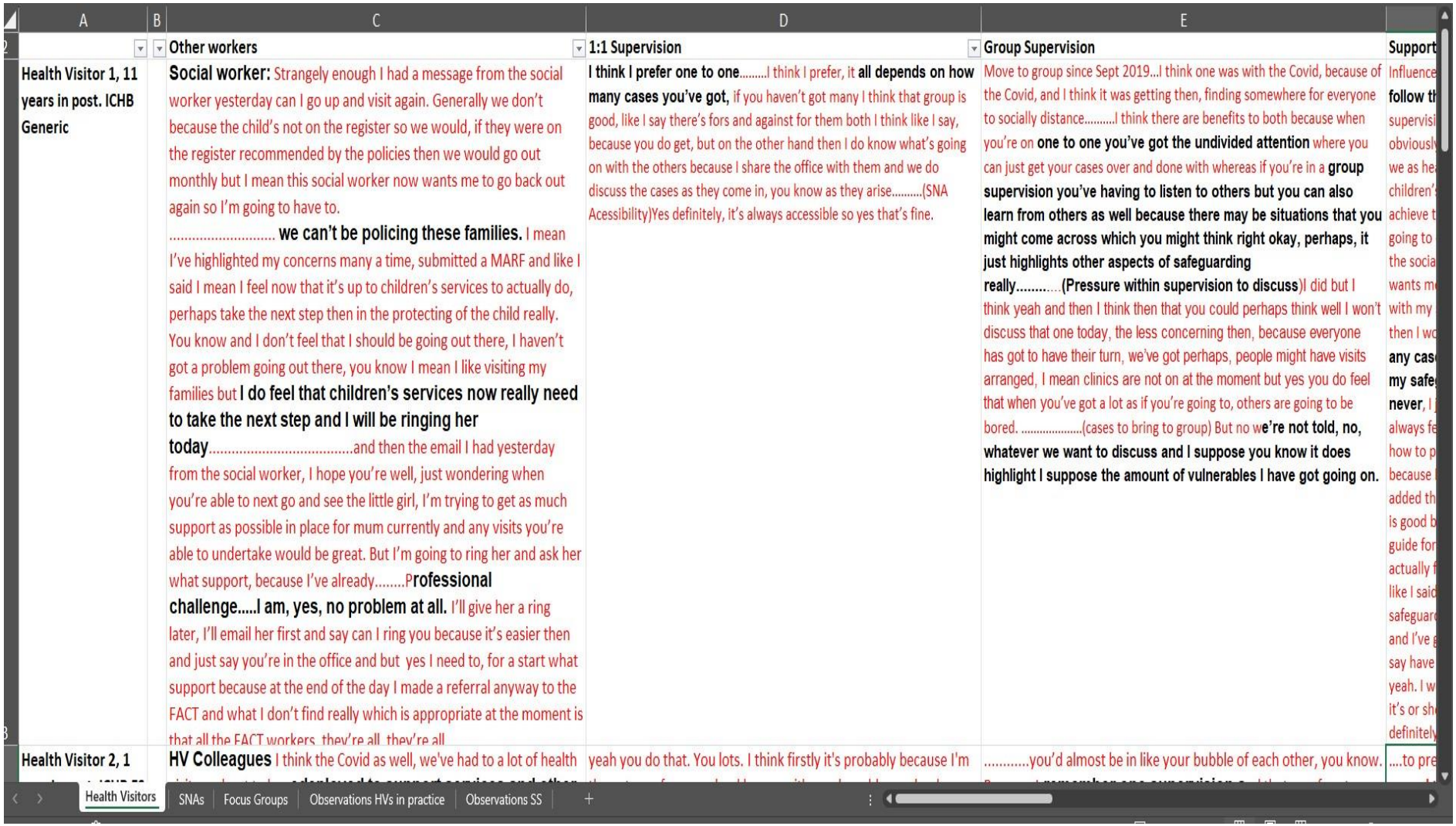
Resp: Mmm

Int: and if so how… and you've sort of given some examples of that as well. Can you expand on that at all, a bit more in depth, you know how does it aid your safeguarding practice? How helpful are the facilitators of those sessions, that sort of thing really.

Resp: Yes okay, I think it depends who's facilitating the session, (Effective/non effective facilitator) I've had sessions where, that's awful, where the facilitator has not with my case in particular but other cases, and so someone has brought a case in to discuss and they've gone back, so this child-could be two years old and the case, there have been no concerns until now, then sometimes they've gone back to look at, which is fine because it's all part of the process, but looking at the first visit and even asking who the health visitors HVs were for the first visit, wasn't this picked up then well actually because there was no problems then and I find that quite critical, that isn't a good supervision because it's critical of somebody

else who may have been involved years ago when there were no concerns and then I've come out and I've think oh gosh that wasn't, that wasn't useful because you're picking holes in somebody else's practice (negative aspect – facilitation) here rather than trying to look how to and I know we have to do that, of course we do, we have to be critical we have to look at how we improve things (Critical analysis) but then there's ones that, the one when you were there, it was really supportive, really good, in fact afterwards she sent me an email afterwards with more information on resources (Positive facilitation) and where to go and what to look, because obviously we hadn't been working with a longer term, well she'd obviously gone away and tried to support me with a little bit of resource which was really, really useful and I've not had that before actually, no one has done that before so that was quite a new experience. (Supervisor going over and above).

Appendix 9: Data analysis theming and coding data example.



	Other workers	1:1 Supervision	Group Supervision	Support
Health Visitor 1, 11 years in post. ICHB Generic	**Social worker:** Strangely enough I had a message from the social worker yesterday can I go up and visit again. Generally we don't because the child's not on the register so we would, if they were on the register recommended by the policies then we would go out monthly but I mean this social worker now wants me to go back out again so I'm going to have to. ..... **we can't be policing these families.** I mean I've highlighted my concerns many a time, submitted a MARF and like I said I mean I feel now that it's up to children's services to actually do, perhaps take the next step then in the protecting of the child really. You know and I don't feel that I should be going out there, I haven't got a problem going out there, you know I mean I like visiting my families but **I do feel that children's services now really need to take the next step and I will be ringing her today**.....and then the email I had yesterday from the social worker, I hope you're well, just wondering when you're able to next go and see the little girl, I'm trying to get as much support as possible in place for mum currently and any visits you're able to undertake would be great. But I'm going to ring her and ask her what support, because I've already.....P**rofessional challenge.....I am, yes, no problem at all.** I'll give her a ring later, I'll email her first and say can I ring you because it's easier then and just say you're in the office and but yes I need to, for a start what support because at the end of the day I made a referral anyway to the FACT and what I don't find really which is appropriate at the moment is that all the FACT workers, they're all, they're all	**I think I prefer one to one**.....I think I prefer, it **all depends on how many cases you've got,** if you haven't got many I think that group is good, like I say there's fors and against for them both I think like I say, because you do get, but on the other hand then I do know what's going on with the others because I share the office with them and we do discuss the cases as they come in, you know as they arise.....(SNA Acessibility)Yes definitely, it's always accessible so yes that's fine.	Move to group since Sept 2019...I think one was with the Covid, because of the Covid, and I think it was getting then, finding somewhere for everyone to socially distance.....I think there are benefits to both because when you're on **one to one you've got the undivided attention** where you can just get your cases over and done with whereas if you're in a **group supervision you've having to listen to others but you can also learn from others as well because there may be situations that you might come across which you might think right okay, perhaps, it just highlights other aspects of safeguarding really**.....**(Pressure within supervision to discuss)**I did but I think yeah and then I think then that you could perhaps think well I won't discuss that one today, the less concerning then, because everyone has got to have their turn, we've got perhaps, people might have visits arranged, I mean clinics are not on at the moment but yes you do feel that when you've got a lot as if you're going to, others are going to be bored. .....(cases to bring to group) But no w**e're not told, no, whatever we want to discuss and I suppose you know it does highlight I suppose the amount of vulnerables I have got going on.**	Influence follow th supervisi obviously we as he children's achieve t going to the socia wants m with my then I wo **any cas my safe never**, I always fe how to p because added th is good b guide for actually f like I said safeguard and I've g say have yeah. I w it's or sh definitely
Health Visitor 2, 1	**HV Colleagues** I think the Covid as well, we've had to a lot of health	yeah you do that. You lots. I think firstly it's probably because I'm	.....you'd almost be in like your bubble of each other, you know.	....to pre

Health Visitors | SNAs | Focus Groups | Observations HVs in practice | Observations SS

Appendix 10: Documentary analysis criteria

Criteria	Yes/No	Comments
Is there a safeguarding supervision plan?		
Is the plan structured?		
Is electronically recorded?		
Is it handwritten?		
Is it legible?		
Does it refer to the supervision discussion?		
Post visit records		
Are they structured?		
What format is adhered to?		
Are they electronically recorded?		
Are they handwritten?		
Are they legible?		
Do they offer a true interpretation of the visit?		
Are they critical in design?		

Appendix 11: Safeguarding nurse supervisor interview example questions

How long have you been supervising health visitors HVs in their safeguarding work?
Did you undertake safeguarding supervision training? If so, what sort of training was this? Was it a specific course? In house or external to the Health Board?
If not, what experience do you have in facilitating safeguarding supervision?
Were you/are you involved in the development of safeguarding supervision?
How confident to you feel in the supervision of health visitors?
What are the challenges/barriers?
How do you structure your sessions? Do you use a certain format?
Do you feel the safeguarding supervision process enhances HVs safeguarding work?
If so, how, and why?
Do you think the sessions are long enough?
What works well?
What does not work well? How can it be improved?
Do you receive supervision? If so, who delivers it and how supportive to you perceive it?
How has COVID-19 affected the safeguarding of children?

Appendix 12: Media excerpts: impact of COVID-19, BBC Wales

Covid: Babies 'disadvantaged' by pandemic, charities say - BBC News

Covid: The devastating toll of the pandemic on children - BBC News

Appendix 13: Safeguarding supervision contract example (ICRHB).

Ground Rules

- The supervisor and group members must prioritise group supervision. They should attend prepared and commit to the whole session without interruption unless there is an emergency.
- If a member of the group is unable to attend, they should inform the supervisor prior to the session.
- Each member of the group will be respectful of other members and allow people to speak without interruption.
- Respect for other people's views is essential and all comments should be helpful and constructive.
- The group should be managed in a non-discriminatory manner, and all participants should challenge any practice which they feel is influenced by prejudice of any kind.
- If any disagreements occur during the session these should be dealt with at the time and in a professional and courteous manner.
- All individual practitioners are responsible for carrying out actions ascribed to them and for seeking advice if they are unable to complete them

Confidentiality and Accountability

- All participants are responsible for observing their professional codes of conduct and organisational policies and procedures.
- Confidentiality regarding issues discussed within supervision session will be maintained unless concerns arise regarding any unsafe, unethical, or illegal practice.

Appendix 14: Post- supervision record of safeguarding discussion (RHB)

Safeguarding group supervision agreement and record of supervision session.
Group supervision will be offered in line with the Safeguarding Supervision protocol (Link provided)
Ground Rules • The supervisor and group members must prioritise group supervision. They should attend prepared and commit to the whole session without interruption unless there is an emergency. • If a member of the group is unable to attend, they should inform the supervisor prior to the session. • Each member of the group will be respectful of other members and allow people to speak without interruption. • Respect for other people's views is essential and all comments should be helpful and constructive. • The group should be managed in a non-discriminatory manner, and all participants should challenge any practice which they feel is influenced by prejudice of any kind. • If any disagreements occur during the session these should be dealt with at the time and in a professional and courteous manner. • All individual practitioners are responsible for carrying out actions ascribed to them and for seeking advice if they are unable to complete them
Confidentiality and Accountability • All participants are responsible for observing their professional codes of conduct and organisational policies and procedures. • Confidentiality regarding issues discussed within supervision session will be maintained unless concerns arise regarding any unsafe, unethical, or illegal practice.

Professional group	**Health visitor HV and Midwifery**			
Date of session	**24/11/21**	**Platform used**	**Skype/Teams**	**Face to face**
Name of Supervisee	**Designation**	**Signature**		**Line Manager**
	MW	**yes**		
	MW	**yes**		
	MW	yes		
	MW	yes		
	MW	yes		
	HV	yes		
	MW	Off sick		
		DNA		
	MW	yes		
	MW	Yes		

Theme Discussed	**Main Discussion Points**
Lessons from reviews discussed	Challenge of LA outcomes/lack of progress if unhappy, - resolution of professional differences. Need for professional curiosity. 'The myth of invisible men.' The child safeguarding practice review panel.
Documents/policies	Resolution of professional differences Threshold documents Wales safeguarding procedures – neglect categories including educational neglect, nutritional neglect etc.,

	Was Not Brought		
Case study	Neglect, non-engagement/non-compliance. Pre-birth assessment positive outcome		
Agreed Action		**Date to be completed**	**Action to be completed by:**

Safeguarding Supervisor		
Signature		
Copied to:	**Name**	**Date**
Safeguarding team		**24/11/21**
Participants		**24/11/21**
Line managers		**24/11/21**

Appendix 15: Raising concerns report.

PhD Observation de-brief

Michelle Moseley, PhD Student

Supervision observation 2 – Date **** (detail from PhD notes)**

Supervisor: (SNA)

Present: 2 HVs and 4 Midwives

Positives: Session facilitated well in general, with supervisor including all participants into the discussion.

Main issues:

- Supervisor unsure as total number of participants (admin was off)
- Some varied technical issues, cameras off, internet dropping out.
- A midwife towards the aim of the session raised an issue with one of her families with a history of domestic abuse, her camera was on and off. There was child in the room with her as she was dialling in from home. Provide detail of case on and off camera with child heard in background. When off camera heard walking around. Child heard asking midwife something, she stated will "need to get crisps to distract" "Can I have crisps too, what was I saying?" The SNA needed to re-cap. Midwife went into detail of MARAC – violent behaviour. She stated around threshold for referral – "it's like them all – the DV's, find it confusing to support." The midwife's child asked questions during the meeting – natural to try and get mum's attention it seems he had a sore bottom. Not an ideal situation having a child present during safeguarding supervision. It was distracting for the midwife who was unable to focus and probably assimilate the advice given. Unfair to discuss in front of child as well as being a distraction to other members of the group.
- I raised the above issue with the SNA at the end of the session who stated she would raise this with the midwife involved.

Supervision observation 3 – Date and detail from PhD notes.

Supervisor: SNA

Present (by end of session) – 4 HVs 7 Midwives

Positives – as above with involvement of all present on the call.

Issues:

- The majority of participants had their cameras on. Some participants sat in office together and both adding into the conversation. It was clear some of the offices were busy, people talking in the background, telephones ringing, printers printing, midwives moving from one desk to another during discussion. I am curious as to how much focus is applied to the session when this occurs. I appreciate that time is precious in both fields of practice as is dedicated time though for safeguarding supervision.
- The midwifery participants seemed the most distracted throughout.
- One midwife was on and off her phone throughout the session. She left her camera on and was speaking via loudspeaker. I assumed she was at home as had an informal; background (background: inside some sort of tent). She added some brief comments only during the session. There were a number of phone calls taken after this, two I believe, and I remembered her in my notes as 'telephone midwife.' Towards the end of

the session, she stood up and had something on her lap and then started knitting, looked up and turned her camera off.
- I raised my concerns about the midwife knitting with the SNA who stated, “it was good that she was here…. she’s retiring soon.”

Main concerns:

- The prioritisation of safeguarding supervision especially within the midwives on the call.
- The behaviour observed distracting practitioners from their own supervision.
- The assimilation of advice following supervision.
- The presence of a child when discussing complex, abusive cases.

Date – Email from Head of Safeguarding due to same concerns raised by a HV attending the supervision on the ******, arranged face to face meeting for later that day with Head of Safeguarding and Line manager. Action was to place detail of observation in writing and email to Head of safeguarding by ******

Date – De-brief report emailed to Head of Safeguarding/Dep Nurse Director.