Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

SAFEGUARDING CHILDREN SUPERVISION POLICY

POLICY

Reference	*CPG-TW-SG-SCSP*		
Approving Body	*Safeguarding Steering Group*		
Date Approved	*20th November 2025*		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	x		
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Date of Environmental Impact Assessment (if applicable)	N/A		
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Target Audience	Trustwide		
Review Date	December 2028		
Sponsor (Position)	Lisa Nixon – Head of Safeguarding & Vulnerabilities.		
Author (Position & Name)	Rebecca James – Named Midwife Safeguarding Children		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Safeguarding		
Position of Person able to provide Further Guidance/Information	Named Midwife Safeguarding Children		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Safeguarding Children & Young People Policy	August 2025
Template control	April 2024

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APPENDICIES

1.0 INTRODUCTION

The requirement for Trust employees to have access to safeguarding children supervision was explicitly set out in Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (Royal College of Nursing, 2019) stating:

"It is the duty of healthcare organisations to ensure that all health staff have access to appropriate safeguarding/ child protection training, learning opportunities, safeguarding/ child protection supervision and support to facilitate their understanding of the clinical aspects of child wellbeing and information sharing"

"Supervision is a process of professional support, peer support, peer review and learning, enabling staff to develop competencies, and to assume responsibility for their own practice. The purpose of clinical governance and supervision within safeguarding practice is to strengthen the protection of children and young people by actively promoting a safe standard and excellence of practice and preventing further poor practice."

2.0 POLICY STATEMENT

The trust recognises that Safeguarding Children supervision is integral to providing an effective child centred service and that it has a responsibility to provide clinical supervision for staff. Safeguarding children supervision is provided in addition to clinical supervision and does not replace it.

The involvement of key health professionals with children, in particular where there may be unresolved safeguarding issues, means that they have a major role in the identification of abuse and neglect. Many of the inquiries into child deaths and serious incidents involving children have demonstrated serious failings in professional practice which have been attributed to a lack of effective supervision and support for professionals involved in the care of vulnerable children, including those in the "Looked After System".

Safeguarding Children supervision supports and promotes individual members of staff in achieving best practice in circumstances that are both professionally and personally challenging and stressful.

It is underpinned by the principle that each member of staff [supervisee] remains accountable for their own professional practice and that supervisors are accountable for the advice they give and any actions they take.

Safeguarding supervision is underpinned by four primary functions:

- The **management** (or normative) function is primarily to provide accountability to the organisation. This involves overseeing the quality of practice through the monitoring of professional and organisational standards, for example, by ensuring that policies and procedures are adhered to.
- The **educational** (or formative) function is primarily to address the professional development needs of the supervisee. In this aspect of supervision practitioners are assisted to reflect on their work, deepen their understanding and develop new skills.

- The **supportive** (or restorative) function recognises the emotional impact of safeguarding work. This provides support for practitioners and explores strategies for coping and self-care.
- The **engagement/mediation** function which engages the individual with the organisation.

This clinical document applies to:

Staff group(s)
- All staff
- Particularly health professionals employed by the Trust who work primarily with children, young people and pregnant women including staff from agencies and all students during their clinical placements in paediatric/maternity areas.
- Anyone employed by the organisation can request safeguarding supervision in relation to a child at any time irrespective of their area of work.

Clinical area(s)
- All areas where staff may recognise a safeguarding children concern.

Patient group(s)
- All patient groups – adults (who may be parents/ carers of children), pregnant women, paediatrics and neonates.

Exclusions
- None

3.0 DEFINITIONS/ ABBREVIATIONS

Trust:	Sherwood Forest Hospitals NHS Foundation Trust
Staff:	All employers of the Trust including those managed by a third party on behalf of the Trust
Child:	Means anyone who has not yet reached their 18th birthday. "Children" therefore means children and young people throughout.
Named Professionals:	Means the Named Doctor, Professional and Midwife for Safeguarding Children; they have specific roles and responsibilities for safeguarding within the Trust.
Designated Professionals:	Means the Designated Doctor and Nurse for Safeguarding Children; they provide professional leadership across the Health community and support and advise the Named Professional in health organisations.

4.0 ROLES AND RESPONSIBILITIES

Safeguarding Children Supervisors will:

- Undertake Safeguarding Children Supervision training.
- Be available to staff as an important source of advice, expertise and support.
- Review Safeguarding decisions/actions undertaken by the supervisee.
- Have supervision provided for them by the Named Professionals.

Supervisees will:

- Undertake Safeguarding Children supervision as and when required by their role i.e. individual or group, ad-hoc or regular (see Appendix A).
- Ensure Safeguarding Children decisions/actions are recorded in the medical record and acted upon.

Named Professionals will:

- Undertake Safeguarding Children Supervision Training.
- Provide supervision for Safeguarding Children Supervisors.
- Have supervision provided by the Designated Professionals or an agreed appropriate experienced supervisor.

5.0 APPROVAL

This policy has been reviewed and approved by the Trust Safeguarding Steering Group.

6.0 DOCUMENT REQUIREMENTS

6.1 Aim of safeguarding supervision

The primary aim of safeguarding children supervision is to ensure that clinical practice safeguards children and promotes their welfare. This will be achieved by the following elements:

- To ensure professional practice remains child focused, thus ensuring the needs of the child are considered as paramount.
- To allow the exploration of how the practitioner can work effectively to prevent the child from suffering harm.
- To allow the practitioner to explore and develop ways of working openly and in partnership with children and families.
- To allow the practitioner to explore and develop ways of working openly and in partnership with other professionals and other agencies.
- To create an opportunity for the practitioner to reflect and discuss individual practice and organisational issues that may impact on their practice.
- To ensure the practitioner fully understands their role, responsibilities and scope of their professional discretion and authority.
- To enable and empower the practitioner to develop skills, competence and confidence in their Safeguarding Children practice.
- To provide a forum for the practitioner to discuss the emotional impact on them of working within this challenging area of practice.

- To reduce the impact of stress on the practitioner working with families where there are Safeguarding Children concerns.
- To identify the training and developmental needs of the practitioner so that they have the skills and knowledge to provide an effective service.
- To identify, in partnership with the practitioner, any difficulties in ensuring policies and procedures are adhered to.

There is an expectation that doctors involved in child protection work will have access to support and supervision to practice confidently and competently in this difficult area of work. The importance of supervision has been highlighted in several Serious Case Reviews both locally and nationally. In the RCPCH model, job descriptions for Named and Designated doctors both support and supervision are identified explicitly as tasks to be undertaken.

6.2 Outcomes of Supervision

The aims of supervision should achieve the following outcomes:

- The practitioner's professional practice becomes child focused, ensuring the needs of the child are paramount and thus safeguarding the child.
- The practitioner has a clear understanding of their role and responsibilities when working with vulnerable families where abuse and neglect of a child can occur, with due regard to legislation and confidentiality.
- The practitioner's response to safeguarding children concerns is appropriate to the child's needs and ensures the safety of the child.
- The practitioner recognises their own values, beliefs and prejudices and work to ensure that these do not adversely impact on their ability to work with families to keep children safe.
- The practitioner ensures that they do not discriminate against families and children because of age, gender, race, culture, religion, language, disability or sexual orientation.
- The practitioner works in partnership with parents and carers, respecting their right to privacy and dignity.
- The practitioner works in an open and honest way with families and carers, when concerns about a child's welfare are identified.

In addition:

- The supervisor ensures that the practitioner is aware of and adhering to policies and procedures.
- The supervisor may inform the line manager of any identified training needs.
- The supervisor should inform the Trust Named Professionals of any areas of concern or risk to ensure that the Trust is able to fulfil its responsibility in safeguarding children.

6.3 Supervision Process

Safeguarding children supervision should be offered on an individual or group basis as needed.

It is the responsibility of each practitioner to identify which children and families should be considered as part of the supervision process.

Both the supervisor and the supervisee will have prepared for each session, in terms of what they wish to be discussed.

There is no set criteria in regard to which type of cases can be brought to Safeguarding Children Supervision. Examples of issues which may need to be addressed as part of the supervision process may include:-

- Child Welfare concerns or risk of significant harm;
- Practice Issues;
- Emotional Support;
- Court Processes;
- Education and Development.

Concerns may include –

- Any child within a family considered to be at risk of harm or neglect.
- Parents/carers not engaging with services provided to meet the needs of children.
- Parents/ carers frequently requesting a change of worker.
- The impact of mental illness, substance misuse, learning disability and domestic abuse on parenting capacity.
- Girls who may be at risk of Female Genital Mutilation.
- Concerns where the professionals feel the case if drifting and not keeping the child from harm.
- Children involved in gang activity.
- Concerns around extremism.
- Concerns with exploitation.

6.3.1 Supervision contracts:

The purpose of this contract is to ensure:

- Clarity of expectations of both supervisor and supervisee.
- Roles and responsibilities are understood.
- Practical issues are agreed.
- A copy of the contract will be held by the supervisor and the supervisee. The supervisor will take responsibility for monitoring and reviewing the contract with the supervisee as necessary.

6.3.2 Record keeping

Key points, outcomes and decisions of supervision sessions, in relation to individual children/families, will be recorded on the Safeguarding Children supervision form and a copy of this will be sent to the practitioner for their records. Where necessary, a copy of the supervision form will also be added to the patient's hospital records behind a red safeguarding divider.

In Maternity services, supervision will be recorded on the electronic patient record

6.3.3 One to one supervision

This will be offered to staff working with a high number (more than three) of children who are:

- Subject to a child protection plan/child in need plan

- Who are considered at risk or with complex needs.

The supervisor and supervisee, according to need, will negotiate frequency of sessions. However, on average this will be three monthly, staff maybe more frequently supervised under special circumstances (e.g. new staff, anxious staff, and staff under extraordinary pressure); this will be at the discretion of the supervisor.

6.3.4 Group supervision

This will be offered to any teams who have common roles and responsibilities for safeguarding children, the decision as to the appropriate provision for individual teams will be negotiated by/between the Named Professionals for Safeguarding Children and Safeguarding Practitioner. An example of this, would be Community Paediatrician's attending regular peer review.

The focus of group supervision will be on identification of risk, need and vulnerability in families and clarification of processes and services to safeguard and promote the welfare of children.

6.3.5 Ad-hoc supervision

It is recognised that staff will often require advice or support in relation to Safeguarding children outside of the formal supervision session. In these instances, staff should approach the safeguarding children team as necessary, a trained member of the team will record the information discussed and the actions agreed on a supervision form and a copy will be sent to the supervisee for their records.

For all staff not directly involved with children and families, who are not having regular supervision, ad-hoc supervision will be available from a trained member of the Safeguarding Children team. This includes staff at any level from all disciplines.

6.3.6 Issues for supervisees

Whilst this document talks mainly about the role of the supervisor, it is acknowledged that supervision is a two-way process, and supervisees are encouraged to address any concerns they may have about the process. This should initially be with the person who supervises them. If that is not possible or should those discussions not alleviate the situation then the supervisee should approach their line manager or a member of the Safeguarding Team.

6.3.7. Dealing with poor practice

Issues of poor practice should as a matter of course be addressed initially with the practitioner and a plan of action agreed to address these concerns. The supervisor will need to make a professional judgement as to whether the matter is of such concern that the line manager will be informed. The practitioner should be informed of what, if indeed any action the supervisor intends to take.

6.3.8 Individual Case Management Advice

This is often timely in nature and indeed may need to be immediate. It may involve opinion on the injuries seen and likely causes, advice on whom to contact or which pathway of care to access, review of the paediatric report or advice on current research which may inform the clinicians' assessment. The discussion should be documented and any areas of dissent recorded, and the discussion should be documented in the patients' medical records.

6.3.9 Peer Review

Firstly, all paediatricians can learn from or provide valuable insight into cases brought for open discussion through a peer review process. Whilst there may be advice, opinions or suggestions which may be particularly pertinent to the case and should be recorded as above, the wider learning issues can be recorded by individual clinicians within reflective proformas and form part of their CPD for Safeguarding.

6.3.10 Good Practice Points

Terms of Reference for the peer review support group should be drawn up and agreed stating the purpose, objectives, membership and process for undertaking peer review.

The purpose of peer review is to develop a pro-active culture of learning about the process, procedures and evidence base underpinning the diagnosis of child abuse and in so doing, to provide support regarding opinions reached and benefit from the experience of peers who are doing the same work. However, Peer review is NOT a formal second opinion which should be formally requested and agreed.

Cases for review should include all cases both hospital and community with a maximum of 20 cases per session. These in practice will mostly comprise of cases of physical abuse and neglect cases with occasional discussions about sexual abuse. Consideration should be given to particularly reviewing cases which have gone through court for learning on the outcome of the case. The sessions should be held a minimum of monthly.

Meetings should be face to face with an identified Chair. Initially this will be the Named or Designated Professional but in time the Chair will rotate amongst the Consultant Body.

Peer review should be attended by all doctors involved in child protection cases and the Named Professionals for Safeguarding Children. Minutes of the review should be recorded with attendance and apologies; key themes discussed arising from all cases, action points and name of the responsible person for these actions. These should then be distributed to all invited professionals.

6.3.11 The Peer Review Process

The aim is to be open, honest and informal. The doctor presents the case including dilemmas and issues, the chair facilitates the discussion. In all cases where there is photo-

documentation available this should be reviewed first by participants at the peer review and then the history subsequently discussed.

This is particularly important to avoid any bias regarding the interpretation of the physical findings. Notes of the discussion are made on a peer review discussion sheet, but no comments are attributed to a particular doctor. The discussion sheet is then filed in the patients' health records. The peer review group should seek to achieve a consensus statement however, it is recognised that consensus is not always reached.

The presenting doctor has the responsibility of ensuring that areas of agreement and disagreement are recorded on the peer review discussion sheet. Names of specific doctors should only be recorded on the discussion sheet to be included in the health record if they give specific permission to do so. This also applies to any subsequent reports prepared from the case. Actions to be taken forward after peer review should always be recorded.

Individual actions relating to the case will be recorded on the discussion sheet with the presenting doctor taking responsibility for completing these. Actions which relate to the peer review membership as a whole, e.g. organising training on a particular issue, will be documented in the minutes with a named individual identified. The Chair is responsible to monitor these actions to ensure they are completed.

6.3.12 Safeguarding Supervision for Named Professionals

As important as it is for those health professionals involved in child protection work to receive support for their work and have an opportunity to develop their work, it is doubly so for the Named Professionals. The caseload is often more complex and challenging and there are issues relating to the extended safeguarding role implicit in the job description which need to be discussed and addressed. There are also issues which may be confidential to these particular roles which cannot be discussed in a peer review setting.

Supervision sessions for Named Safeguarding professionals including Named Doctors/ Designated doctor for Looked After Children (LAC) should be undertaken on a three-monthly basis by the Designated professionals. There are two aspects to this supervision: firstly, the majority of clinical discussion of cases will be best facilitated in the Peer Review setting, with the exception, already identified of difficult, complex or politically sensitive cases. Secondly, there is supervision of the role of safeguarding leads particularly with respect to working relationships within and between agencies, interagency issues, management issues within the context of the roles and responsibilities of the Named Professionals.

A supervision contract will be completed by the professionals and records kept as a summary of those meetings. In this way, the trust board can be assured of the close and efficient working of the leads for Safeguarding within the organisation.

Named Professionals will also have access to national and regional networks of Named Professionals for Safeguarding Children.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Attendance at supervision sessions	Named Professional & Named Midwife Safeguarding Children	Audit	Quarterly	Safeguarding Steering Group

8.0 TRAINING AND IMPLEMENTATION

Staff will be informed of this guidance during mandatory safeguarding children training.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix B
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Safeguarding Child and Young People: Role and Competencies for Healthcare Staff, (2019), Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing
- Nottinghamshire/Nottingham City Joint Safeguarding Children's Partnership Safeguarding Procedures (2025), Welcome to the Interagency Safeguarding Children Procedures
- Working Together to Safeguard Children, (2023), Working together to safeguard children 2023: statutory guidance
- Nottinghamshire Safeguarding Children's Partnership website, Nottinghamshire Safeguarding Children Partnership
- Nottinghamshire Safeguarding Children's Partnership 'Bruising in Non-Mobile Babies Pathway', Bruising in Babies Pathway
- Nottinghamshire Safeguarding Children's Partnership 'Assessment of Subconjunctival Haemorrhage (SCH) in Infants, Subconjunctival Haemorrhage Guidance.pdf
- Nottinghamshire County Council – Pathway to Provision, Pathway to Provision
- NHS England, NHS Safeguarding Guide, NHS Safeguarding

Related SFHFT Documents:
Safeguarding Children & Young People Policy
Safeguarding Adult Policy

11.0 KEYWORDS

Supervisor, Supervisee, Peer Review

12.0 APPENDICES

Refer to contents table.

Safeguarding Supervision Matrix

Staff Group	Type of supervision	Supervisor	Frequency
Named Professional for Safeguarding Children Named Midwife Safeguarding Children Named Doctors for Safeguarding Children Named/ Designated for LAC	One to One	Designated Safeguarding Professional	3 Monthly
Specialist Practitioner Safeguarding Children	One to One	External Supervision with an appropriate level practitioner	3 Monthly
Midwifery Safeguarding Children Supervisors	One to One	Named Midwife for Safeguarding Children.	3 Monthly
Community Midwives	One to One	Midwifery Safeguarding Children Supervisors	3 Monthly
In-patient Maternity Ward	Group	Named Midwife Safeguarding Children	3 Monthly
Neonatal Intensive Care Unit (NICU)	Group	Specialist Practitioner for Safeguarding	3 Monthly
Ward 25	Group	Specialist Practitioner for Safeguarding	3 Monthly
Obstetrics Physiotherapy Team	Group	Named Midwife Safeguarding Children	3 monthly
Ward 14	Group	Named Midwife Safeguarding Children	3 monthly
Ward Leader (Paediatric Ward)	One to One	Named Professional for Safeguarding/ Specialist Practitioner for Safeguarding	3 Monthly
Ward Leader (Neonatal Intensive Care Unit)	One to One	Named Midwife for Safeguarding/ Specialist Practitioner for Safeguarding	3 Monthly
Ward Leader (Paediatric Outpatients)	One to One	Named Professional for Safeguarding/ Specialist Practitioner for Safeguarding	3 Monthly
Paediatric Lead Nurse (Emergency Dept)	One to One	Named Professional for Safeguarding/ Specialist Practitioner for Safeguarding	3 Monthly
Integrated Sexual Health Service (Nursing and Medical Staff)	Group	Specialist Practitioner for Safeguarding	3 Monthly

Specialist Paediatric Nurses Diabetes Epilepsy Respiratory Complex needs ADHD/ASD Outreach Sister - NICU	Group	Specialist Practitioner for Safeguarding	3 Monthly
Little Millers - Nursery	Group	Specialist Practitioner for Safeguarding	3 Monthly
Emergency Dept – KMH	Group	Specialist Practitioner Safeguarding/Named Doctor.	3 Monthly
Urgent Care Centre	Drop-in session.	Specialist Practitioner for Safeguarding	Monthly

APPENDIX B - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Equality Impact Assessment (EIA) Form (Please complete all sections)

EIA Form Stage One:

Name EIA Assessor: Rebecca James		**Date of EIA completion: 07/10/2025**
Department: Safeguarding		**Division: Corporate**
Name of service/policy/procedure being reviewed or created: Safeguarding Children Supervision POlicy		
Name of person responsible for service/policy/procedure: Rebecca James		
Brief summary of policy, procedure or service being assessed: **Safeguarding Supervision should be tailored to staff by aligning responsibilities with their roles, experience and training. Ensuring everyone understands their duty to protect and respond appropriately.**		
Please state who this policy will affect: Patients or Service Users, Carers or families, Stakeholder organisations		
Protected Characteristic	**Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)**	**Provide a brief summary of what data or supporting information was considered to complete this assessment?**
Race and Ethnicity	No	This policy replaces the previous Safeguarding Children Policy. Inclusive and effective safeguarding supervision was considered with a person-centred approach to ensure the child is prioritised.
Sex	No	
Age	No	
Religion and Belief	No	
Disability	No	
Sexuality	No	
Pregnancy and Maternity	No	
Gender Reassignment	No	

Marriage and Civil Partnership	No	
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	No	

If you have answered 'yes' to any of the above, please complete Stage 2 of the EIA on Page 3 and 4.

What consultation with protected characteristic groups including patient groups have you carried out?
This policy acknowledges the needs of patients that require care from an acute perspective. To ensure that it is compliant with all legislation it has been shared with senior medical/ nursing and safeguarding colleagues for consultation and feedback to ensure that it effectively meets the needs of all staff and patients.

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?
No

On the basis of the information/evidence/consideration so far, do you believe that the policy / practice / service / other will have a positive or negative adverse impact on equality? (delete as appropriate)

	Positive					
High						

If you identified positive impact, please outline the details here:

No negative impact identified; this policy promotes good practice around all equality aspects. Only positive impacts identified. No requirement for stage 2 EIA.

Signature:    *I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form*
Date: 07/10/2025