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| **Blog:**  Reflective Practice (September 2020)    **Title:**  As a safeguarding system leader, do I need restorative supervision in order to process that cases and programmes of work which make up my job?    **Article:**  **As a safeguarding system leader, do I need restorative supervision in order to process that cases and programmes of work which make up my job?**  In order to answer that, we must first explore what supervision, clinical supervision and restrictive supervision is.  Supervision is widely regarded as playing a vital role in the quality control of any professional services. Some have gone so far as to propose that supervision is a ‘signature pedagogy’ of the therapeutic and mental health professions. Supervision has been defined as ‘… a formal, independent process of reflection and review which enables practitioners to increase individual self-awareness, develop their competence and critique their work’. It has been identified as serving a number of functions that range from developing the practitioner to protecting the public from poor practice.< sup>3  However, while it is elevated to the heart of effective and ethical practice by many, actual knowledge of what constitutes ‘optimum’ supervision remains limited. Although there is a well-established body of knowledge concerning the needs of those receiving supervision, far less attention has been given to the necessary skills and credentials of those providing it. This places those seeking the services of a supervisor at a distinct disadvantage and may be a particular dilemma for dual-trained practitioners who are forging new ground in their efforts to apply psychological knowledge and principles to the coaching engagement. Critical and as yet unanswered questions include, who is best placed to supervise the work of this distinct group of coaching practitioners, and which supervisory formats, styles and interventions might be best for a profession still forging its identity and place in the wider market?  **The interface between clinical and safeguarding supervision**  Underlying some of the confusions in the supervision landscape within health organisations is the relationship between clinical and other forms of supervision. Clinical supervision is a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance patient/client protection and safety of care in complex clinical situations (CQC, 2013).  Literature reviews relating to ‘clinical supervision’ show that its use as a ubiquitous term may well be problematic as it is often an umbrella statement with little clarity around function and purpose (Berggren et al., 2010). The evidence of the effectiveness within health settings of clinical supervision has been scant and often limited to specialist groups such as mental health nursing. There is little literature dedicated to the use of app ropriate and specific strategies to be used within the clinical supervision session (Howard, 2008) leaving managers with a need to improvise as to best practice.  Interestingly, managers are often confident with the supervision provided being effective, but less so with the theoretical underpinnings of their supervisory method.  There continues to be confusion regarding models of clinical supervision particularly in health settings. There is little guidance from policy nationally or locally, where ‘supervision’ is often discussed as being imperative but not described in a way that supports a practitioner to understand what the content or purpose of supervision needs to be in order to be effective. The measures available to practitioners to determine whether their supervisory space is  effective have focused wholly on the experience of the supervisee. This misses the aim of supervision to improve or keep safe the care being provided, the experience of the superv isor and the role of the organisation in the function and purpose of supervision. This lack of clarity is reflected in the safeguarding context with child protection or safeguarding supervision (CQC, 2013) either being seen as one form of clinical supervision, or something  entirely separate. This is a false dichotomy with evidence suggesting that general clinical supervision is an important aspect of protecting children along with an opportunity to focus on specific cases (Lister & Crisp, 2005).  There is the potential for further lack of clarity and confusion between the terms safeguarding and child protection supervision. Safeguarding is a term used to describe a wide range of activities related to protecting children from maltreatment, preventing impairment of health and development and promoting their welfare. Child protection is part of safeguarding and promoting welfare; although the supervision activity may be referred to as "safeguarding supervision", the realit y is that it is often focused on a narrow group of children who have been identified as in need of a child protection plan. Given that many of the children who die as a result of abuse or neglect are not on a child protection plan this is an unhelpful approach (Davies & Ward, 2012). This paper therefore uses the term "safeguarding supervision" to refer to Wallbank / Wonnacott March 2016 supervision activity focused on the needs of children receiving services beyond universal provision.  With the absence of guidance, safeguarding supervision is vulnerable to becoming a space that is solely driven by an organisational demand to be assured that practice is safe. The need for management assurance through checking, challenging, and auditing can overtake the restorative, reflective and learning nature of the session without a strong and skilled supervisor.  Given the increase in newly qualified workforces such as Health Visiting the need for this space to remain supportive as well as hold organisational assurance is critical.  The process of conducting safeguarding supervision should not be a punitive one. However in the absence of a common understanding within and between organisations as to how the sessions should be conducted, at times this is how it can be experienced by health professionals.  **What is restorative supervision?**  *Restorative supervision contains elements of psychological support including listening, supporting and challenging the supervisee to improve their capacity to cope, especially in managing difficult and stressful situations* (Proctor, 1988).  The Restorative Supervision model was developed and designed to support the needs of professionals working with complex clinical caseloads. It is underpinned by the Solihull Approach, Motivational Interviewing and leadership theories and has been designed with the input of over 200 professionals. The model has been piloted, tested and rolled out with a wide range of professionals working clinically and we know that those professionals who are exposed to supervision within the model are more clinically effective, less likely to be off sick and develop better workplace relationships (Wallbank, 2012). It is known that when professionals undertake complex clinical work they move between anxiety, fear or stress about their work. If they can process these natural feelings about the work they are able to focus on their own learning needs and development and then they enter a creative, energetic and solution focused zone.  The model of Restorative Supervision allows staff to spend more time in a creative energetic and solution focused zone. The model has been delivered and evaluated with over 3600 professionals since 2007. The model has shown to be effective in reducing stress, burnout and increasing compassion satisfaction (the pleasure that one derives from doing their job) (Wallbank & Hatton , 2011), this is measured b y using the Professional Quality of Life Questionnaire (PROQOL) at points during the supervision programme.  Professionals undertaking supervision report that they are enabled by the model to increase their autonomy, build stronger relationships with their colleagues and employers and undertake their clinical or managerial caseload more effectively (Wallbank, 2012).  The approach uses ‘containment’ that describes the method of processing anxiety and emotions so that the ability to think is restored in the person.  Also, ‘reciprocity’ which focuses the professional’s attention on the quality of the interaction and relationship both between themselves and the families they care for as well as the individual members of the family. The third element, of behaviour management, is used in the context of boundary setting, contracting and time management both within and out of the supervision sessions.  Restorative clinical supervision has been evaluated and foun d to be a helpful in a range of ways, such as reducing stress and absence from work which can lead to an improvement in the services provided .  **What can restorative supervision provider you with?**   1. Protected time to reflect on your physical and emotional health 2. A safe and confidential space to explore the impact of work pressures 3. An opportunity to discuss the challenges faced and new ways of working 4. Time out to reflect on your work/life balance 5. A chance to explore feelings, concerns or worries 6. Someone to challenge your ideas and ways of thinking to help improve outcomes 7. Way to help reduce stress levels 8. Opportunity to encourage and enhance good working relationships both within the team and with families, children and young people 9. Clearer way of thinking, improvements to your general well being and the service you provide.   Restorative supervision is helpful in addr essing barriers to productivity and improving emotional well being at work. It has also been reported to help reduce sickness and absence and improve management and communication skills.  Some issues with restorative supervision to be mindful of ~   1. Anxiety was expressed over the introduction of restorative supervision at a time when practitioners felt their professional identity was already fragile; some felt the programme would contribute to added stress and burnout. 2. Many practitioners expressed a feeling that they must be seen to be busy, and that taking time for reﬂective practice meant they would not appear to be busy enough, regardless of the potential value of this practice. 3. Some practitioners felt suspicious of the motives behind the organisation’s offer of restorative supervision 4. Many practitioners felt it was normal that the emotional burden of health visiting work would be carried from one appointment to the next, without be ing processed or shared. 5. Some practitioners seemed to have a personal barrier that prevented them from permitting themselves the time and space to reﬂect on their work. 6. Many practitioners valued being given a safe space to express their anxieties, share ideas and think creatively about their work. 7. Some practitioners seemed to feel they needed permission from an unknown person within the organisation to allow themselves reﬂection time. 8. Practitioners’ roles have changed signiﬁcantly over a relatively short time, and many felt additional pressure as a result; speed and quantity of clinical work, rather than quality, is seen as the chief priority. 9. Quantitative results have shown signiﬁcant reductions in stress and burnout; the conﬂict many practitioners felt about participating in restorative supervision did not appear to interfere with its effectiveness   **My reflection is that every safeguarding system leader requires restorative supervision otherwise our work will burn us up.** |