Using supervision to protect vulnerable families

In this article...

- Identifying need at a health visiting service
- How a supervision model was introduced
- Annual audit of record keeping and care planning

5 key points

1. Regular, high-quality supervision is critical for professionals working with vulnerable families.
2. Vulnerable families with complex needs require a rapid response from health-visiting teams.
3. Protecting children from harm requires sound professional decisions to be made at the frontline.
4. Kolb’s reflective cycle helps professionals to analyse and understand situations.
5. By identifying which issues are more prevalent, health visitors can tailor training to each locality’s needs.

Authors

Mandy Sagoo is a professional lead for health visiting; Jane O’Reilly and Monique Rawlings are both supervision leads for health visiting, all at Sandwell and West Birmingham Hospitals Trust.

Abstract


Sandwell Health Visiting Service identified difficulties in recruiting and retaining health visiting staff and fully meeting the needs of vulnerable families. Following the Laming report, the decision was made to introduce health visiting supervision leads. This resulted in improvements in record keeping and care planning and in better protection and support for vulnerable families.

In 2009, Sandwell Health Visiting Service was facing pressures of vacant caseloads and difficulties recruiting and retaining health visiting staff. The high percentage of families with a child protection plan was among the reasons for the low retention rate, and many families under the health visiting caseload did not meet the criteria for children’s services but were still deemed vulnerable and with complex needs, which placed a greater demand on the health visiting service.

New paper records were introduced at the same time as an electronic database, causing standards of record keeping to drop and work to often be duplicated. In addition, care plans did not always reflect the most recent episode of care.

The Laming report (2009) states that regular, high-quality supervision is critical. In 2010, we introduced health visiting supervision leads to support health visitors (HVs) when dealing with vulnerable families – namely those identified as needing additional intervention or support from the service and a high level of skill and cognitive effort from the HV. Under the new family offer, as outlined in the Health Visitor Implementation Plan (Department of Health, 2011), these families fit into the “universal plus” category, meaning they will receive a rapid response from their health visiting team when specific expert help – such as support for postnatal depression – is needed.

The supervision lead’s key role is to support HVs in identifying and managing complex cases that require a high level of intervention, and to work with them to form an appropriate plan of action in line with the principles outlined in safeguarding children processes. It was decided supervision would be delivered on a quarterly basis to provide regular support.

Working Together to Safeguard Children (Department for Children, Schools and Families, 2013) acknowledges that ensuring children are protected from harm requires sound professional decisions to be made at the frontline. Feedback from frontline staff shows this process can be challenging so it is important for practitioners to have access to timely advice and support. The overall vision is for practitioners to understand the value of Universal Plus supervision, and for it to be embedded in the health visiting service and ethos.

Aim

The health visiting supervision leads were introduced to:

- Focus on the needs of the child and family;
- Promote good practice within the health visiting service and improve service delivery;
- Additional intervention or support from the service and a high level of skill and cognitive effort from the HV.

Supervision sessions can help health visitors better support families most in need.
that an action plan can be developed.

The supervision process helps addi-

tional questions to the supervisee,

and develops skills of professional curi-

The families discussed at 

Vulnerability needs to be followed:

We agreed that to support HVs working 

supervision needs to be followed:

» Supervision is offered to all HVs every 
 12 weeks;

» HVs must submit a list of all current 
  vulnerable families for discussion;

» HVs select the families for discussion 
  (usually those presenting with the most 
  challenging issues);

» Families selected are those that have 
  not reached the threshold for a child 
  protection plan;

» Children who are in the looked-after 
  system are not included in the process;

» Each HV is given a named supervisor;

» Supervisors must contact their allocated 
  HV to arrange supervision sessions.

Universal Plus supervision process
We agreed that to support HVs working 

with vulnerable families, the following 

process needs to be followed:

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  system are not included in the process;

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  HV to arrange supervision sessions.

Universal Plus supervision uses Kolb’s 
(1984) reflective cycle as a framework. This 

enables the HV to discuss complex cases and 

reflect on their early intervention, ena-

blng the theory of “conceptualisation”. Kolb describes this as being able to analyse 

and understand the situation; the HV is 

supported in drawing conclusions about 

their own practice and intervention.

We use a formal, structured process 
that allows for case discussion, care plan-

ning and the standard of record keeping to 

be assessed. The families discussed at 

supervision are the most vulnerable on 

HV’s caseloads. This type of structured 

supervision aims to address practitioners’ 

anxieties that they may have missed some-

thing and, with gentle questioning, the 

supervisor encourages analytical thinking 

and develops skills of professional curi-

osity. The supervision process helps addi-

tional support needs to be identified so 

that an action plan can be developed.

BOX 1. AUDIT RESULTS

- 94% of records audited had a 
  completed care plan (5% increase)
- 85% of the care plans reflected the 
  most up-to-date care delivered at 
  the last contact (8% increase)
- 72% of the healthcare needs analysis 
  on the child reference card tallied with 
  the care plan (5% increase)
- 84% of the children had been seen in 
  the previous six months (14% increase)

The action plan focuses on:

» **Support:** difficult challenges in the 
  HV’s work are discussed and explored 
  and time constraints are addressed;

» **Mediation:** communication and 
  engagement with the supervisee;

» **Education:** professional development 
  and learning from practice, as well as 
  feedback on performance;

» **Management:** overall performance in 
  line with policy and best-practice 
  standards.

A supervision pack was designed so all 

supervisors follow the same process and 

provide the same standard of supervision. 

This documents the process structure and 

has been a useful resource for supervisors.

The process has been supported by the 

organisation’s safeguarding team and 

senior management. Supervision has been 

rolled out service-wide; non-compliance is 

attributed to long-term sickness.

Outcomes
Several common themes have been identi-

fied from supervision sessions, including 

domestic abuse, maternal mental health 

factors, drug and alcohol misuse, housing 

problems and teenage mothers, children 

with a “child in need plan” in place, and 

developmental delay. Variations within the 

locality have also been identified: for 

example, some towns have a higher inci-

dence of drug and alcohol misuse while 

others have higher rates of maternal mental 

health problems. Domestic abuse was a 

common theme across each clinical base.

By identifying these trends, we have 

been able to deliver specific training to the 

different localities and negotiate further 

training to be commissioned and delivered 

by the local children safeguarding board, 

for example in female genital mutilation.

Identified training needs will also be 

included in the annual workforce plan and 

the training needs analysis so the most 

appropriate training can be commissioned.

Two supervision team members sit on 

the child death overview panel. It is vital 

we learn as much as possible from the pan-

el’s findings to try to prevent future deaths 

and to support health professionals. Exam-

ples of good practice have been high-

lighted and shared; lessons learnt have 

influenced our current practice.

**Audit**
Compliance is monitored and an audit 

undertaken with supervisees annually to 

find out their views on the supervision 

process. The audit has shown yearly 

improvements in the quality of record 

keeping and case plan writing (Box 1).

Assessments appear more robust and the 

supervision sessions allow for assurances 

that the supervisee is delivering a high 

standard of care and a quality visit has 

taken place. Where this appears not to be 

the case, an action plan is put in place.

**Conclusion**
Effective supervision has proved impor-

tant in promoting good standards of prac-

tice and supporting individual staff mem-

bers; it may also help retain newly qualified 

HV and others returning to practice. This 

has enhanced our health visiting service.

Early indications reveal the Universal 

Plus supervision model is embedded into 

the service and is being well received by 

experienced and newly qualified HVs. The 

protected time away from a busy office 

allows for reflective thinking and case dis-

cussion. Student HVs are introduced to this 

supervision model in their third semester.

The results show that HVs appreciate 

the support supervision provides. It ena-

bles them to continue to put early inter-

ventions in place and empower the most 

vulnerable families to safely parent their 

children. To maintain this standard of 

quality supervision, regular evaluation 

should be carried out. The Laming report 

(2009) recommends that supervision be 

open and supportive, focusing on decision 

quality and improving outcomes for chil-

dren, rather than meeting targets.

**References**