Evaluation of an evidence-based model of safeguarding clinical supervision within one healthcare organization in the United Kingdom

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ABSTRACT

Aim: Clinical supervision has been recognized as a valuable mechanism through which healthcare professionals may evaluate, reflect upon and develop their clinical practice within the context of safeguarding. However, while there is a general consensus with regard to the value of clinical supervision there are multiple approaches to utilization in practice. This brief communication provides an overview of an evaluation of one model of safeguarding clinical supervision which was explicitly developed to support healthcare professionals in their everyday practice.

Methods: The current study used a survey approach, which involved the development and administration of an online anonymous survey with clinical supervisors and supervisees working within the one service of the Trust.

Results: The survey results showed that individuals were overall confident, knowledgeable and satisfied with their safeguarding supervisions. However, individuals at a lower band were significantly less positive about supervision, particularly in relation to how much they felt enabled to explore their safeguard concerns, how much they felt equipped to provide/receive safeguarding supervision and about how much they understood clearly the difference between managerial supervision/clinical and safeguarding supervision.

Conclusion: A number of key recommendations arising from the findings of the evaluation are presented in this article and are considered in terms of the question 'what constitutes form the core components of a successful Safeguarding Supervision Framework relationship?'

Key words: clinical supervision, evaluation, evidence transfer, evidence-based healthcare, safeguarding

Background

Safeguarding vulnerable adults and children forms a core tenet of contemporary health care delivery across many geographical contexts and is explicitly addressed within the United Kingdom through national policy initiatives.1,2 It is therefore pivotal that those working in clinical practice, across a range of settings, are adequately equipped with the requisite knowledge and skills to be able to identify, support and work with patients/carers and their families where safeguarding concerns may arise.3 From this perspective, within the United Kingdom as elsewhere safeguarding has often been referred to within the literature as ‘everyone’s responsibility’4 and thus should arguably form an integral part of clinical practice.

One healthcare organization in the United Kingdom (National Health Service Trust) has recently developed a structured Safeguarding Supervision Framework (SSF). The model involves structured preparation and training for clinical staff alongside a clear structure of safeguarding supervision responsibilities across all grades of clinical staff. The rationale for the development of this initiative was based on the ambition to embed safeguarding clinical supervision as a part of everyday practice within teams and across services, rather than as a standalone activity predominantly supported by the safeguarding specialist team.

As this was a new initiative, prior to Trust-wide ‘roll out’, the SSF was the subject of a formal evaluation...
in one service within the Trust. It was anticipated that the findings from the evaluation and subsequent recommendations would have the potential to inform the utility and transferability of this initiative beyond the evaluation site.

**Aims**
The overall aim of this evaluation therefore was to examine the extent to which the SSF supported the delivery of a safe and effective safeguarding supervision process to practitioners within one discrete service.

**Methods**
The current study used a survey approach, which involved the development and administration of an online anonymous survey with clinical supervisors and supervisees working within the one service of the Trust. The study was approved by requisite authorities (FMHS REC ref no. 159–1711). Participants were individuals involved in giving and/or receiving safeguarding supervision within the service at the Trust and were aged 18 years or above. A total of 142 individuals completed the anonymous survey. Participants had a mean age of 45.7 (median = 47; min/max = 26/63) and were mostly women (n = 126; 92.0%). Overall, there was a balance in representation of individuals from all clinical grades (≤4, 5–6, 7–8) and the majority were in their current roles for seven years or more (n = 80; 58.4%).

**Materials**
Prior to the survey development, the researchers carried out several discussions with the senior members of the Safeguarding Team at the Trust and attended several of the safeguarding supervision preparation/training sessions to gain a better understanding of the safeguarding supervision process. From these meetings and events, a pool of topic items for the survey was created and refined within the research team. These items were then reviewed by senior members of the team leading the safeguarding and social care team. These topic items were then taken to one of the training sessions so that the attendees could evaluate the clarity and relevance of the items. These were then refined again based on the feedback received to improve understanding and responsiveness. The final group of topic items founded the basis for the survey.

The final survey version contained general demographic and work items (age, sex, current role, time in current role) and questions related to the safeguarding supervision (how often received safeguarding supervision, how often provided safeguarding supervision, whether also provided clinical supervision, whether attended the safeguarding supervision training). Twenty-five 1–5 Likert-scale items evaluated the individuals' perceptions about their safeguarding supervision in terms of knowledge, confidence and satisfaction. Finally, participants were given the opportunity to submit open-ended comments related to the survey or about their experiences with safeguarding supervision and/or training.

**Data collection**
The survey items were uploaded to a confidential and anonymous survey platform. The survey was carried out between April and June 2018 and individuals took on average 10 min to complete the questions. It was not mandatory that all questions were completed, meaning that participants could leave questions blank if they did not wish to provide an answer.

**Data analysis**
The survey data were exported from the survey platform to SPSS Statistics for Windows, version 22.0 (IBM Corp., Armonk, New York, USA). The data were analysed descriptively, with tables of frequencies, range, means and medians. Correlation and significance scores (Pearson Chi-square) were calculated for the Likert scales and sex, age, time in the current role and band groups to explore differences in knowledge, satisfaction and confidence regarding safeguarding supervision between these groups. A 95% confidence interval (P ≤ 0.05) was considered for all calculations.

**Results/Discussion**
The survey results showed that individuals were overall confident, knowledgeable and satisfied with their safeguarding supervisions. However, individuals at a lower band were significantly less positive about supervision, particularly in relation to how much they felt enabled to explore their safeguard concerns, how much they felt equipped to provide/receive safeguarding supervision and about how much they understood clearly the difference between managerial supervision/clinical and safeguarding supervision.

In addition, the high reporting levels of knowledge, confidence and satisfaction in individuals receiving more hours of supervision indicate that a high number of hours of supervision can be more beneficial in many ways, including building professional confidence and as such arguably will have a positive impact in clinical practice. Sex, age and length of time in current role do not appear to affect individuals’ appraisal of their safeguarding supervision sessions.
Conclusion
Given the key recommendations arising from the findings of the evaluation, it may be most appropriate to pose the question 'what constituents form the core components of a successful SSF relationship?'

(1) Preparation of SSF supervisors and supervisees – potential to review both the length and content of the current training. Possible inclusion of problem-based learning and case-based scenarios for supervisors alongside an overview of the SSF philosophy for both supervisors and supervisees.

(2) Clear demarcation between managerial and safeguarding clinical supervision – ensuring that the boundaries (and time) allocated to supervision are not blurred.

(3) Potential to review current guidance and incorporate into a ‘best practice’ resource guide.

(4) Greater attention/focus given to the individuals at lower grades so that their safeguarding supervision sessions can be more open, supportive and effective, and they can feel more equipped, satisfied and confident about it.

(5) Establishing equity of hours and frequency of safeguarding supervision so that individuals taking part can benefit from it more equally.

Acknowledgements
The authors would like to thank all of those who agreed to take part in the study and to the funders for their support. A full copy of the report may be obtained from the authors via email.

Conflicts of interest
The authors report no conflicts of interest.

References