Core Group Supervision/Reflection

The optimum context for effective supervision is within a broader learning and development culture, characterised by the following features:
- *Reviews of mistakes and problems provide opportunities for learning, not finding scapegoats*
- *There is organisational commitment to continuing professional development throughout workers' careers*
- *Room is found for professional autonomy and discretion, and practice which is not dominated by rule-bound proceduralism*
- *The emotional impact of the work is recognised with effective processes to mitigate the worst effects*
- *Individuals and teams make the time to review their effectiveness*

(Schon, 1983; Hughes and Pengelly, 1997; Davys and Beddoe, 2010)

Why?
The emotional impact of child protection work is well documented (Harvey and Henderson, 2014). In her review of child protection in England, Munro (2010, 2011) identifies that there can be a high personal cost to being exposed to powerful and often negative emotions involved in this area of work. A lack of effective supervision increases the risk of burnout, which can be defined as emotional exhaustion, cynicism and reduced personal accomplishment.
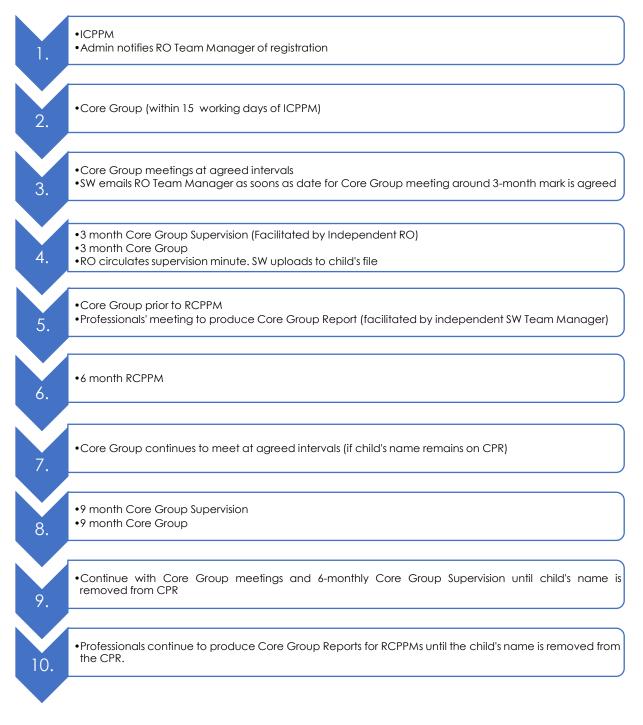
Evidence from Serious Case Reviews where children have died or been seriously harmed at the hands of parents or carers (Brandon et al, 2008; Vincent and Petch, 2012) indicates that inadequate supervision, or supervision that is overly focused on administrative aspects, risks losing the focus on the child, with the potential for fatal consequences.

Effective group supervision can result in faster, more effective problem solving by drawing on the expertise of a number of people. It provides the opportunity for learning from the diverse backgrounds and experiences of the participants who may provide different perspectives.

How?
1. This process is **NOT** a planning meeting without family members; it is designed to support practitioners undertaking complex case work gain knowledge and understanding from each other; discuss practice concerns; identify where cases have become "stuck" or practitioners are overly optimistic or pessimistic. Effective supervision provides a safe space for workers to reflect on their practice, as well as to develop skills and knowledge. This process is **NOT** about managing staff/administration or the facilitator telling the core group what to do or offering advice/solutions.

2. Core Group Supervision will take place 3 months after child protection registration and every 6 months after that. Supervision does not replace the need for a core group meeting.

3. Supervision will be facilitated by a Reviewing Officer who does not chair the CPPMs. The RO is responsible for
- Creating a safe space for multi-agency reflection and analysis;
- Creating an emotionally informed thinking space;
- Encouraging thinking before acting;
- Promoting respectful uncertainty and healthy scepticism;
- Encouraging open and honest professional conversations;
- Enabling professional thinking and challenge appropriately;
- Enabling professionals to embed trauma informed practice;
- Maintaining neutrality in the process;

- Facilitating group discussion to agree how the discussion will be shared with the family e.g. if the group decides that the plan's direction needs to change or other professional views or involvement should be sought;
- Recording (Appendix 1) and sending the supervision notes to the involved professionals;
- Identifying any themes and reporting them to the Lead Officer for Child Protection; and,
- Encouraging the group to escalate issues via their line managers if there is serious disagreement or resource issues.

1.
- ICPPM
- Admin notifies RO Team Manager of registration

2.
- Core Group (within 15 working days of ICPPM)

3.
- Core Group meetings at agreed intervals
- SW emails RO Team Manager as soons as date for Core Group meeting around 3-month mark is agreed

4.
- 3 month Core Group Supervision (Facilitated by Independent RO)
- 3 month Core Group
- RO circulates supervision minute. SW uploads to child's file

5.
- Core Group prior to RCPPM
- Professionals' meeting to produce Core Group Report (facilitated by independent SW Team Manager)

6.
- 6 month RCPPM

7.
- Core Group continues to meet at agreed intervals (if child's name remains on CPR)

8.
- 9 month Core Group Supervision
- 9 month Core Group

9.
- Continue with Core Group meetings and 6-monthly Core Group Supervision until child's name is removed from CPR

10.
- Professionals continue to produce Core Group Reports for RCPPMs until the child's name is removed from the CPR.

Where children's names are placed on the CPR pre-birth there will be an RCPPM within 3 months. Core group supervision will not start until 3 months after this review.

Appendix 1

Record of Core Group Supervision/Reflection

MULTI-AGENCY SUPERVISION RECORD	
All professionals should reflect on the question: *"What is life like for this child?"* paying particular attention to what they say and what their behaviour is telling us. Individual children should be considered if there is a sibling group.	

Date of Supervision:			**Facilitator**		
Attendees:					
Name of Child(ren):					

Do we agree that the risks identified at the ICPPM are current?	Yes/No
Have other risks emerged?	Yes/No
Is the plan working well? *Now we know the family better is the plan appropriate/proportionate? Is it working well because we are involved/doing the work? Has parental change happened? Has the child's situation improved?*	Yes/No
Are there complicating factors? *Are we stuck? Has progress stalled? What might be the reasons? Are there things that make it more difficult for the child to be safe/for us to know the child is safe? Are there issues about the child's behaviour/parental behaviour that we need to get expert advice on? E.g. from MH experts/justice services/medics/DASAT etc If parents are not engaging is that about the services we are offering – times/dates, too many of us? Parents unclear about our roles and purpose of involvement? Do we understand what everyone else's role is and the purpose of their involvement? Are the right services involved?*	Yes/No
Professional views of the family? *Experiences, observations, frustrations, concerns. Are there any attempts to undermine professionals/play professionals off against each other?*	
Are we overly positive? *Are we convinced by parental explanations or could something else be happening? E.g. Think the unthinkable. Is there a hidden man/woman? Are we open to exploring different hypotheses/explanations?*	Yes/No
Are we overly negative? *Is there progress but we cannot see it?*	Yes/No
Are we clear what we hope our interventions will achieve? *Can we measure progress? How will we know when the child(ren) is/are safe enough?*	Yes/No
Are we working well together? *Is communication adequate? Are there tensions in the core group? Is the family trying to undermine us?*	Yes/No
What is/are the child(ren) saying? *What does the child think of our involvement? What do they think will make them feel safe? Have we asked? How will we find out?*	
What is the family saying? *What does the family think of our involvement? Have we asked? How will we find out? Does the family have strengths we haven't considered/we could build on?*	
Is our contingency plan adequate?	Yes/No
Do we need to revise our plan with the family? *Do we need a new direction? How will we approach this with the family?*	Yes/No
Notes *Record anything of particular significance e.g. who is responsible for getting additional information/contacting an expert; particular concerns/worries/issues*	

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