Focus on: Vulnerable children and families paediatric workforce

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1. Introduction

This report focuses on lead roles concerning safeguarding, the child death service, looked after children (LAC)[i] and special educational needs and disability (SEND). Work in these sub-groups falls under the umbrella heading of work with vulnerable children and families.[1] This is a broad field including other sub-groups that are not included in the RCPCH census, and are therefore not within the scope of this report.

This report is part of a series using Royal College of Paediatrics and Child Health (RCPCH) 2017 census data to highlight key areas of the paediatric workforce. As the census focuses on the paediatric workforce, most of the lead roles discussed in this report are held by paediatricians. While outside of the scope of this report, the RCPCH acknowledges the important role of other health professionals, such as nurses and primary care doctors, in the care of vulnerable children and families.

Previous publications using RCPCH census data have focused on Specialty, Associate Specialist and Staff Grade (SAS) doctors,[2] and the workforces of the devolved nations.[3]

This report makes the following recommendations that relate to the vulnerable children and families workforce, the wider paediatric workforce, Governments and stakeholders in England, Wales, Scotland and Northern Ireland:

- Ensure that lead roles exist without exception
- Develop guidance for all roles in all countries
- Review the need for additional lead roles
- Ensure that holders of lead roles have appropriate competencies
- Recruit and train more paediatricians.

2. Acknowledgements

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Grace Brown, RCPCH Policy Officer, led the development and was the primary author of the report and Marie Rogers, RCPCH Workforce Manager, conducted data analysis. RCPCH Policy Lead Alison Firth also provided valuable input to this report.

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i LAC is the legal term that is most often used in national regulations and guidance. To reflect this LAC is used throughout this report. The RCPCH acknowledges that other terms are also used in the field, such as ‘children in care’.

3. Executive summary

3.1 Context

The roles described in this report are determined by the government within each nation. As such the lead roles are subject to variation between England, Scotland, Wales and Northern Ireland. Differences and similarities in the roles mandated for safeguarding, child death service, looked after children and SEND are presented in the appendix. The responsibilities of each lead role, associated standards and employer are described in section 5 of this report.

The vulnerable children and families lead roles are filled by paediatricians that deliver these responsibilities alongside other work, as part of their overall job plans. The challenges facing the paediatric workforce are therefore of high relevance to the vulnerable child and families workforce.

3.1.1 The paediatric workforce

As noted in previous RCPCH reports, the entire paediatric workforce is facing increasing levels of demand that they must meet with decreasing resources. For example, the RCPCH workforce census overview report concluded that demand for paediatric consultants outstripped supply by 21% in 2017.[4]

Furthermore, the paediatric workforce pipeline is not strong; across the UK 87.5% of ST1 posts were filled in 2019. This is a reduction from an already low fill rate of 89.6% in 2017. [4]

Workforce shortages are perceived by medical staff to be associated with increased risk for patients; 84% of 2017 census respondents said that paediatric vacancies and gaps in training posts pose a significant risk to their service or to children, young people and their families.[4]

The majority of lead roles discussed in this report, particularly those filled outside of hospitals, Trusts or Health Boards, are held by community child health paediatricians. Their workforce is therefore discussed in depth below.

3.1.2 The community paediatric workforce

Community child health (CCH) is the largest paediatric sub-specialty and lead roles supporting vulnerable children and families are a crucial part of CCH,[1] as their work safeguards the wellbeing of vulnerable young people, children and babies. They help to ensure that all children's needs are met and to protect wider society.

The 2017 State of Child Health short report on the community paediatric workforce concluded that the number of career grade community paediatricians must increase by 25% in order to meet current and anticipated demand, which is growing.

Rising demand is partly linked to trends concerning special educational needs provision. For example, between January 2018 and January 2019 the number of school pupils with an Education, Health and Care Plan (EHCP) in England rose by 17,500. This equates to an increase of 17,500 medical assessments that must be conducted by a medical professional, such as a CCH paediatrician. [5]

The challenges presented by increasing patient demand are compounded by a trend towards less than full time (LTFT) working. Additionally, the RCPCH census results show that the

proportion of consultants in CCH posts decreased from 18.5% of the consultant workforce in 2015 to 17.4% in 2017. [4]

The trends affecting the CCH paediatric workforce, and the wider paediatric workforce, are closely linked to the specific challenges facing the vulnerable children and families workforce.

3.2 Concerns surrounding the vulnerable children and families workforce

RCPCH census data shows that there are vacancies in vulnerable children and families lead roles across the UK. The cause of these vacancies is likely to be a complex mix of local, national and supernational factors, but UK-wide paediatric workforce shortages and increasing patient demand can be assumed to be major contributors.

In addition to widespread vacancies, some Trusts, Health Boards, Clinical Commissioning Groups (CCGs) and other employers have not yet developed roles that should exist in their organisation as per relevant guidance. For example, the lead roles for safeguarding in England, Wales and Scotland exist in over 90% of organisations. This is not the case for child death service, looked after children or special educational needs lead roles where the non-existence of roles (filled or vacant) appears to be a greater problem; in England, 23.1% of Trusts do not have a Designated Doctor for Child Deaths role (provided at CCG level), 45.1% of Trusts do not have the Named Doctor for Looked After Children role, and 36.2% of Trusts do not have the Designated Medical Officer for Special Educational Needs and Disability role (also provided at CCG level). The non-existence of roles, coupled with widespread vacancies where roles exist, leaves a concerning gap in service provision for vulnerable children and families.

Where roles do exist and are filled, the post holder is often awarded insufficient time to fulfil their responsibilities. These gaps and inconsistencies are part of a larger issue of variation among and within nations regarding lead roles. A lack of clear guidance from Governments and other decision-making bodies increases the risk of local misinterpretation and of vulnerable children and families not receiving the care they require. Guidance should clearly state the population that each role would serve, the person specification and job content. This should include suggested time allocation. Employers must align practice to the latest available guidance and ensure that healthcare professionals appointed to lead role positions are equipped with the necessary competencies and experience.

Some employers appear to have developed vulnerable children and families lead roles that are not stipulated in their nation's statutory guidance or code of practice. This may be in response to population need. Governments and membership bodies should explore whether new statutory roles for vulnerable children and families need to be developed across their nation to close existing gaps in service provision and to better care for the most vulnerable members of the population.

RCPCH census data also points to trends within the Speciality, Associate Specialist and Staff Grade (SAS) doctor group. SAS doctors hold vulnerable children and families lead roles to a variable extent across the UK; for example, it was reported that in Wales 16.7% of Named Doctor for Child Protection roles were filled by SAS doctors, whereas in England 3.1% of Named Doctors for Child Protection were SAS doctors.

The RCPCH census report on SAS doctors concluded that the number of lead roles held by SAS doctors increased by 0.6% between 2015 and 2017.[2] The number and whole time equivalent (WTE) of SAS doctors declined during this time, however, by 3.7% and 3.6% respectively. This drop is part of wider downwards trend; a fall in SAS doctor headcount and WTE has been

found in the results of every RCPCH census since 2001.[2] A continued reduction in SAS doctor headcount and WTE is likely to exacerbate existing vacancies in vulnerable children and families lead roles and to increase workload on post holders, especially in countries and lead role areas where SAS doctors hold the relatively higher proportions of lead roles.

In addition to the findings already outlined, qualitative census data reveals instances across the UK of long-term vacancies, a lack of strategic leadership, a scarcity of funding for backfill and cases of one individual possessing more than one role in an effort to meet demand. Role holders and employers should be commended for their hard work in the face of rising demand and relatively decreasing levels of resource. The clear commitment and compassion of the workforce should not be exploited to deliver a full service with only limited resources. Governments, employers and professional bodies must act to ensure that vulnerable children and families' safety is not compromised by the concerns outlined in this report.

4. Recommendations

4.1 Ensure that lead roles exist without exception

- Employers and commissioners must ensure that they have the full complement of lead roles appropriate for their country unless the guidance states that this would be inappropriate for their local context.
- Joint working between employer and provider organisations must ensure that roles are backed by appropriate recruitment practices, appraisals and recognition within job planning. This must meet standards set by model job descriptions and Government guidance.
- National-level workforce planners must collect data on the proportion of posts filled and aim to achieve a fill rate of 100% in their country.

4.2 Develop guidance for all lead roles in all countries

- Guidance must be developed for all lead roles in all countries, such as Government code of practice, competency frameworks or model job descriptions.
- Where possible, guidance should be developed in collaboration with other disciplines and professions. The 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' intercollegiate document is a good example of this.
- Guidance must specify who should fill the role, such as their grade and profession, and advise time allocation in job plans. Guidance must be as clear as possible to avoid the risk of misinterpretation by employers and to reduce unwarranted variation between employers.

4.3 Review the need for additional lead roles

- Governments across the UK must review the need for additional lead roles in areas where none currently exist in their country, but do elsewhere in the UK.
- This may involve the development of data collection systems to better gauge population need, or the better use of existing data systems and increased sharing of information across disciplines.
- Where lead roles and related procedures are due to come into existence, such as the Designated Education Clinical Lead Officer (DECLO) in Wales and Child Death Overview Panel (CDOP) in Northern Ireland, their establishment and appropriate resourcing must be a Government priority.

4.4 Ensure that holders of lead roles have appropriate competencies

- Employers must ensure that individuals appointed to lead roles possess the competencies outlined in the associated competency framework, where available. The frameworks should also be used to plan ongoing training for role holders.
- Employers must ensure that medical professionals appointed to vulnerable children and families lead roles have necessary experience and receive appropriate levels of support and training.

4.5 Recruit and train more paediatricians

- The UK Government and constituent nation Governments, as well as membership organisations and other professional bodies, must work to train more doctors, to recruit more paediatricians and to improve retention within the profession. As part of this work, effort must be made to ensure that the challenges facing the CCH workforce are also addressed.
- National medical workforce organisations must increase the number of paediatric postgraduate training places.
- The UK Government and constituent nation Governments must provide additional funding to support recruitment and retention drives for all medical careers, particularly in the paediatric specialty.

5. Lead roles: responsibilities and standards

The child protection system in the UK is the responsibility of the Governments in each of the UK's four nations: England, Scotland, Wales and Northern Ireland.[8] The lead roles covered in this report are therefore described below according to guidance relevant to each country. Guidance and standards are not available for every role or in every country.

Northern Ireland is absent from the findings (described in section 6 of this report) despite its inclusion in the RCPCH census distribution. This is due to concerns regarding the validity of the data provided in the nation. The census questions are under review, and the RCPCH plans to include data from Northern Ireland on these roles when we report on the 2020 census. For more information see section 6.

The appendix at the end of the report summarises the lead roles in each country according to the below.

5.1 Safeguarding

5.1.1 England

Designated Doctor for Safeguarding

The RCPCH model job description states that CCGs should employ a Designated Doctor for Safeguarding, also known as a Designated Doctor for Child Protection.[8] Designated Doctors act as clinical experts and strategic leaders, providing safeguarding advice and expertise to CCGs,

NHSE, the local authority/authorities within their scope, other healthcare practitioners and other relevant organisations and agencies.[9]

Government guidance states that 'NHS commissioners and providers should ensure that designated professionals are given sufficient time to be fully engaged, involved and included in the new safeguarding arrangements' but does not describe what might constitute 'sufficient time' (p61).[9]

The model job description for the role[ii] states that Designated Doctors for Safeguarding should be allocated 4.5 – 5 PAs per week to carry out the activities related to their role, according to the size of the districts that they are responsible for. The guidance also notes that designated doctors should hold 'consultant status or equivalent' (p2).[8]

Named Doctor for Safeguarding

According to the NHS Safeguarding Accountability and Assurance Framework (applicable to England only), providers must identify a Named Doctor in addition to a named nurse.[10] The Named Doctor for Safeguarding is also known as the Named Doctor for Child Protection. Named Doctors for Safeguarding are responsible for promoting good professional practice within their organisation, ensuring that safeguarding training is in place and advising peers as needed.[9]

The model job description for the role states that the Named and Designated Doctor for Safeguarding roles must be filled by separate post holders. The Named Doctor must 'hold consultant status or a senior post with equivalent training and experience' (p2).[11]

Named Doctors for Safeguarding should be allocated 2 – 2.5 PAs per week to carry out the activities related to their role, subject to the context of the local population.[11]

5.1.2 Wales

Designated Doctor for Safeguarding

All Designated professionals, including doctors and nurses, are part of the National Safeguarding Team. This team is accountable to the Board of Public Health Wales.[8] The Team sit outside and support the seven Health Boards and three NHS Trusts in Wales.[7] The Health Boards in Wales are commissioner and provider organisations.

Public Health Wales is responsible for employing Designated Doctor(s) for Safeguarding. These doctors have a comparable role to the previously described Designated Doctor position in England,[8] with the addition of looked after children as part of their role.[12]

Guidance states that Designated Doctors for Safeguarding should be allocated 4.5 – 5 PAs per week to carry out the activities related to their role, according to the size of the districts that they are responsible for. The guidance also notes that designated doctors should hold 'consultant status or equivalent' (p2).[8]

Named Doctor for Safeguarding

The model job description states that all providers of NHS funded health services should

ii The RCPCH model job descriptions for the named and designated doctor for safeguarding are adapted from the full fourth edition of "Safeguarding children and young people: roles and competencies for healthcare staff", an intercollegiate document published by the RCN in January 2019 (see reference 7).

identify 'a Named Doctor or Nurse' for Safeguarding Children, also known as the Named Doctor for Child Protection[11] and Head of Safeguarding children respectively (p1). Unlike in England, this guidance is not supplemented by a Framework that stipulates the appointment of both a Named Doctor and Nurse. The Named Doctor has a comparable role to the previously described Named Doctor position in England.[11]

Guidance states that the Named Doctor for Safeguarding must be filled by a separate post holder to the Designated Doctor for Safeguarding role and should be allocated 2 – 2.5 PAs per week, subject to the context of the local population. The Named Doctor must 'hold consultant status or a senior post with equivalent training and experience' (p2).[11]

5.1.3 Northern Ireland

Designated Doctor for Safeguarding

The Safeguarding Board Northern Ireland (SBNI) is responsible for employing Designated Doctor(s) for Safeguarding. This role is comparable to the previously described Designated Doctor positions in England and in Wales. [8]

Guidance states that Designated Doctors for Safeguarding should be allocated 4.5 – 5 PAs per week to carry out the activities related to their role, according to the size of the districts that they are responsible for. The guidance also notes that designated doctors should hold 'consultant status or equivalent' (p2). [8]

Named Doctor for Safeguarding

As in England and Wales, the model job description states that all providers of NHS funded health services should identify a 'Named Doctor or Nurse' for Safeguarding Children, also known as the Named Doctor for Child Protection (p1).[11] As in Wales, there is no Framework stipulating the existence of both a Named Doctor and Named Nurse although this does exist in England. These doctors have a comparable role to the previously described Named Doctor position in England.[11]

Guidance states that the Named Doctor role must be filled by a separate post holder to the Designated Doctor for safeguarding role and should be allocated 2 – 2.5 PAs per week, subject to the context of the local population. The Named Doctor must 'hold consultant status or a senior post with equivalent training and experience' (p2).[11]

5.1.4 Scotland

Lead Paediatrician in Child Protection

Each Health Board in Scotland must appoint a Lead Paediatrician in Child Protection. The responsibilities of this role are comparable to those of the Designated Doctor for Safeguarding in England, Wales and Northern Ireland, and the recommended time allocation according to RCPCH guidance is the same (4.5- 5 PAs).[13]

Paediatrician with a Special Interest in Child Protection

The Paediatrician with a Special Interest in Child Protection is employed by the Health Board. The model job description states that this role should exist in 'some larger Health Boards' (p1).[14] As noted above, the Paediatrician with a Special Interest in Child Protection and Lead Paediatrician in Child Protection roles must be held by two separate post holders.[13]

The responsibilities of the Paediatrician with a Special Interest in Child Protection role are comparable to those of the Named Doctor for Safeguarding in England, Wales and Northern Ireland, and the recommended time allocation from the RCPCH is the same (2 – 2.5 PAs). [14]

5.2 Child death service

5.2.1 England

Designated Doctor for Child Deaths

CCGs should employ a Designated Doctor for Child Deaths.[9] As with the Designated Doctor for Safeguarding role, the Designated Doctor for Child Deaths provides clinical expertise and strategic leadership to CCGs, NHSE, the local authority/authorities within their scope, other healthcare practitioners and other relevant organisations and agencies.[9] The Designated Doctor should also attend the Child Death Overview Panel (CDOP).[15]

As previously mentioned in terms of the Designated Doctor for Safeguarding role, Government guidance states that 'NHS commissioners and providers should ensure that designated professionals are given sufficient time to be fully engaged, involved and included in the new safeguarding arrangements' but does not describe what might constitute 'sufficient time' (p61).[9]

Intercollegiate guidance states that the Designated Doctor should 'hold consultant status or equivalent' (p82).[7]

5.2.2 Wales

There is no statutory lead role for paediatricians concerning child death in Wales. In the event of an unexpected child death the Head of Safeguarding (also known as the named nurse, described in section 5.1.2) will provide health information to the Procedural Response to Unexpected Death in Childhood (PRUDiC) process, ensure full liaison with the police and social care and consider the need to report serious clinical incidents to the Welsh Government.[16]

Some respondents in Wales reported the existence of a Procedural Response to Unexpected Deaths in Childhood Practitioner, a role held by a variety of clinicians (section 6.2.2).

5.2.3 Northern Ireland

There is no statutory lead role focusing on child death in Northern Ireland. Relatedly, Northern Ireland has not yet established a Child Death Overview Panel (CDOP). This was a requirement made by the Safeguarding Board Act (Northern Ireland) 2011.[17]

5.2.4 Scotland

Sudden Unexpected Death in Infancy (SUDI) Paediatrician

There should be a nominated SUDI Paediatrician for each Health Board. The role holder is responsible ensuring that a system is in place to investigate SUDI and that relevant staff are aware of it, including notification systems and planned feedback for supporting parents. They may also act as a link between those involved in the SUDI Review meeting.[18]

SUDI Paediatricians work with authorities in their area to best support and co-ordinate their work in relation to SUDI. [18]

In the RCPCH 2017 census this role was referred to as the Designated Doctor for Sudden Unexpected Death in Infancy and is termed as such in the findings (section 6.2.2).

5.3 Looked after children (LAC)

5.3.1 England

Designated Doctor for Looked After Children (LAC)

CCGs should employ a Designated Doctor for Looked After Children (LAC) or have a contractual agreement in place to secure the expertise of designated practitioners. As in the Designated Doctor roles for Safeguarding and Unexpected Deaths in Childhood, the Designated Doctor for LAC provides clinical expertise and strategic leadership to CCGs, NHSE, the local authority/authorities within their scope, other healthcare practitioners, and other relevant organisations and agencies.[9]

As previously mentioned in terms of the Designated Doctor for Safeguarding and Designated Doctor for Unexpected Deaths in Childhood role, Government guidance states that 'NHS commissioners and providers should ensure that designated professionals are given sufficient time to be fully engaged, involved and included in the new safeguarding arrangements' but does not describe what might constitute 'sufficient time' (p61).[9]

The model job description produced by the British Association for Adoption and Fostering states that the time allocation will depend on local context, but that 1 PA per week for a population of 100,000 where a local authority and health provider are co-terminus is recommended as a guide. The number of LAC in England has risen since the model job description was published, however, so the recommended time allocation per 100,000 population may now be an underestimate.

Intercollegiate guidance states that the Designated Doctor should 'hold consultant status or equivalent' (p51).

Named Doctor for LAC

Named Doctors for LAC are appointed by healthcare provider organisations to promote good practice and provide expertise to their colleagues. They should coordinate the provision of local health services for LAC and provide input into health assessments and reviews. The Named Doctor for LAC should also ensure the timeliness of such assessments and make sure that actions to implement the health care plan are tracked, as well as acting as a key conduit and contact point for the child and their carer where they have difficulties accessing health services.[22]

According to intercollegiate guidance, the Named Doctor for LAC should be allocated a minimum of 1 PA per 400 looked after children. The guidance also states that Named Doctor roles should be held by an individual with 'consultant status or a senior post with equivalent training and experience' (p45).[21]

Medical Adviser for Adoption/Fostering

The Medical Adviser for Adoption/Fostering provides medical advice to the adoption/ fostering agency and Adoption Panel. As part of their role, they assess and present the health of children and young people where adoption is in their care plan. They also assess the health of prospective parents and current and prospective foster carers, relating this to their ability to meet the needs of children currently or prospectively in their care.[23]

RCPCH members who work with looked after children note that the complexity of the Medical Adviser role and the breadth of its functions are not captured by national guidance. For example, the Medical Adviser answers all questions from social care and adoption agencies relating to risk to the child, their health and outcomes. They also share information with prospective adopters and contribute to the Fostering Panel in some areas. Their function may evolve further with the creation and development of regional adoption agencies in England.[25]

Government guidance states that local authorities are required to arrange for a registered medical practitioner to carry out an initial assessment of the child's state of health and provide a written report of the assessment, [22] and all adoption agencies are obliged to have a Medical Adviser.[19]

Intercollegiate guidance states that the Medical Adviser for Fostering and Adoption role should be allocated a minimum of 2 PAs for approximately 400 children.[21] The Medical Adviser for Fostering and Adoption is synonymous with the Medical Adviser or Adoption/ Fostering role asked after in the RCPCH 2017 census.

5.3.2 Wales

As stated previously, the Designated Doctor for Safeguarding, employed by Public Health Wales, also has responsibility for looked after children.

In the 2017 RCPCH census the questions regarding looked after children combine the two Medical Adviser roles into one: Medical Adviser for Adoption/Fostering. Some census respondents reported the existence of Designated roles for LAC in addition to the roles outlined below (6.3.2), although these are not Government statutory roles.

Named Doctor/Medical Adviser for LAC and Fostering

The Medical Adviser for LAC and Fostering fulfils a similar role to the Medical Adviser for Adoption/Fostering in England. All adoption agencies are obliged by the Government to appoint a Medical Adviser, who must also sit on their Adoption Panel.[26]

Guidance from the Looked After Children Health Exchange (LACHE[iii]) states that 'there should be sufficient and dedicated time for the Named Doctor/Medical Adviser to fulfil their responsibilities for all children living in their area' but does not provide further indication in terms of time allocation in job plans (p13).[12]

Intercollegiate guidance states that Named Doctor roles should be held by an individual with 'consultant status or a senior post with equivalent training and experience' (p47).[21] Further guidance states that the Medical Adviser for Fostering and Adoption role should be allocated a minimum of 2 PAs for approximately 400 children.[21]

iii The LACHE no longer exists but their guidelines, published in 2012, have not been updated or replaced.

Named Doctor/Medical Adviser for Adoption

Each Health Board is advised by LACHE to also appoint a Named Doctor/Medical Adviser for Adoption, fulfilling a similar role to the Medical Adviser for Adoption/Fostering in England. The role holder may be the same individual as the Named Doctor/Medical Adviser for Looked After Children and Fostering.[12] As previously noted, all adoption agencies must appoint a Medical Adviser that must sit on their Adoption Panel.[26]

The post holder should ensure arrangements are in place for Adoption Health Assessments, ensure Adoption Health Reports are prepared and presented at the Adoption Panel, monitor the health needs of children going through adoption and follow-up and provide advice to the adoption agency and prospective adoptive parents.[12]

Intercollegiate guidance states that Named Doctor roles should be held by an individual with 'consultant status or a senior post with equivalent training and experience' (p47).[21] Further guidance states that the Medical Adviser for Fostering and Adoption role should be allocated a minimum of 2 PAs for approximately 400 children.[21]

5.3.3 Northern Ireland

Medical Adviser for Adoption/Fostering

The Northern Ireland Government stipulates that adoption agencies must establish Adoption Panels. These must include a Medical Adviser that fulfils a similar function to the Medical Advisers for Adoption/Fostering in England and Wales.[27]

Intercollegiate guidance states that the Medical Adviser for Fostering and Adoption role should be allocated a minimum of 2 PAs for approximately 400 children.[21]

5.3.4 Scotland

Medical Adviser for Adoption/Fostering

The Medical Adviser for Adoption/Fostering in Scotland fulfils a similar function to that in England, Wales and Northern Ireland. The regulations regarding adoption agencies and local authorities in Scotland mandate the appointment of at least one Medical Adviser to the adoption panel.[28]

Local authorities must appoint as many Medical Advisers as necessary to provide advice to adoption panels, according to the level of demand in the locality. Large authorities that require more than one Medical Adviser are able to employ advisers with complementary areas of knowledge.[29]

Intercollegiate guidance states that the Medical Adviser for Fostering and Adoption role should be allocated a minimum of 2 PAs for approximately 400 children.[21]

As in Northern Ireland, some census respondents have also reported the existence of Named and Designated Doctor for LAC roles (section 6.2.4), although these are not described in Government guidance.

5.4 Special educational needs and disability (SEND)

5.4.1 England

Designated Medical/Clinical Officer for SEND

Government code of practice states that a Designated Medical Officer (DMO) should be appointed to support the CCG in meeting its statutory responsibilities for children and young people with SEND. The code of practice notes that this role would usually be filled by a paediatrician but is that it may be filled by a suitably qualified health professional who is not a paediatrician. The role would then be the Designated Clinical Officer (DCO) for SEND.[30] Some local authorities may choose to have both a DMO and DCO for SEND in place.[31]

The DMO/DCO should act as a point of contact for local partners when notifying parents and local authorities about a child that they believe may have SEND. Local partners should also seek guidance from the DMO/DCO on SEND as questions arise. The DMO can also support schools to fulfil their responsibilities to pupils with SEND and CCGs may delegate decision making to them.[30]

The DMO/DCO would not routinely be involved in assessments or planning for individuals outside of their clinical practice, but would ensure that these assessments, plans and health support are being provided by colleagues.[30]

The Government code of practice does not provide guidance regarding the number of the PAs that should be allocated to fulfil the DMO/DCO for SEND role.[30]

5.4.2 Wales

Designated Education Clinical Lead Officer (DECLO) – to be implemented from 2020-23

The Additional Learning Needs and Education Tribunal (Wales) Act 2018 refers to additional learning needs (ALN). This replaces special educational needs (SEN) and learning difficulties and/or disabilities (LDD). The stipulations described by the Act are expected to be implemented over a three-year period (September 2020 to August 2023).[32]

The Act requires health boards to appoint a Designated Education Clinical Lead Officer (DECLO). The DECLO will ensure that each health board is providing appropriate services to meet the needs of its population, serve as a point of contact for local authorities and facilitate co-ordinated working between different ALN professionals and partners. DECLOs are therefore anticipated to have a key strategic role in improving the collaboration between health, education and social care professionals in the delivery of services for children and young people with ALN. [32]

The DECLO will be a registered health professional with clinical qualifications and senior experience in an aspect of healthcare relevant to ALN. The DECLO therefore does not have to be a paediatrician but could be another primary or secondary care medic, a nurse, a midwife, or an allied or public health professional.[32]

It is expected that the DECLO role will be allocated one day per week per 40,000 children and young people. It is stated that this equates to each of the seven health boards in Wales having a professional undertaking DECLO responsibilities for approximately 2 days per week,[32] which is roughly equivalent to 4 PAs.

This role was not in existence when the 2017 census questions were asked, therefore no information is reported on them. However, census findings indicate that some Health Boards have developed a Designated Medical Officer for Additional Learning Needs role (section 6.4.2), although this is not a statutory role.

5.4.3 Northern Ireland

Northern Ireland does not have a lead role for SEND and community paediatricians provide input as required.

5.4.4 Scotland

Scotland does not have a lead role for SEND, also known as Additional Support Needs (ASN). However, some census respondents have indicated the presence of a Designated Medical Officer for Special Educational Needs and Disability in their Health Board (6.4.4).

6. Findings

This section below outlines the responses to questions in the RCPCH 2017 census about lead roles regarding safeguarding, looked after children, child death services and SEND. As previously described, lead roles vary between countries. Analysis therefore describes trends relevant to all roles across the UK before being broken down by UK nation within each lead role area.[iv]

As previously noted, Northern Ireland is absent from the nation breakdown of findings. This is due to concerns regarding the validity of the data provided. In the absence of census data, RCPCH members that work in safeguarding, LAC, child death services or SEND in Northern Ireland have raised concerns regarding widespread vacancies and under-resourcing of roles where they exist.

Across the UK, the free-text answer boxes in the census revealed instances of more than one person being responsible for a single lead role across a Trust or Health Board. It was also noted that one person sometimes held multiple roles. These instances of role sharing or one individual holding multiple roles suggest a lack of capacity within the Trust or Health Board.

"Designated dr and medical adviser for adoption fostering is same role - 3 people x 0.2 each (only 2 posts filled)" **–** Clinical lead census respondent in Scotland

Furthermore, clinical leads reported that some roles lack adequate support due to workforce shortages. This leads to vacancies that exacerbate workforce issues.

"No capacity to support designated doctor for looked after children. Other designated roles has [sic] heavily impacted clinical service as not backfilled." – Clinical lead census respondent in England

Concerns around organisational instability and a perceived lack of leadership were also described in free-text answers:

iv Lead paediatrician fill rates are not available due to misreporting. This is indicated by 'NA' in tables 1, 2, 3 and 4.

"Over last 2 years, HB [Health Board] safeguarding structure has been constantly fluctuating with several key roles vacant for months at a time. This has led to some unrest among those working in safeguarding with no visible leadership beyond their immediate department" – Clinical lead census respondent in Wales

The quotes given above have been selected from a pool of multiple free-text answers that express concerns of the same theme/s. These issues are therefore not isolated to single Trusts, Health Boards or other organisations.

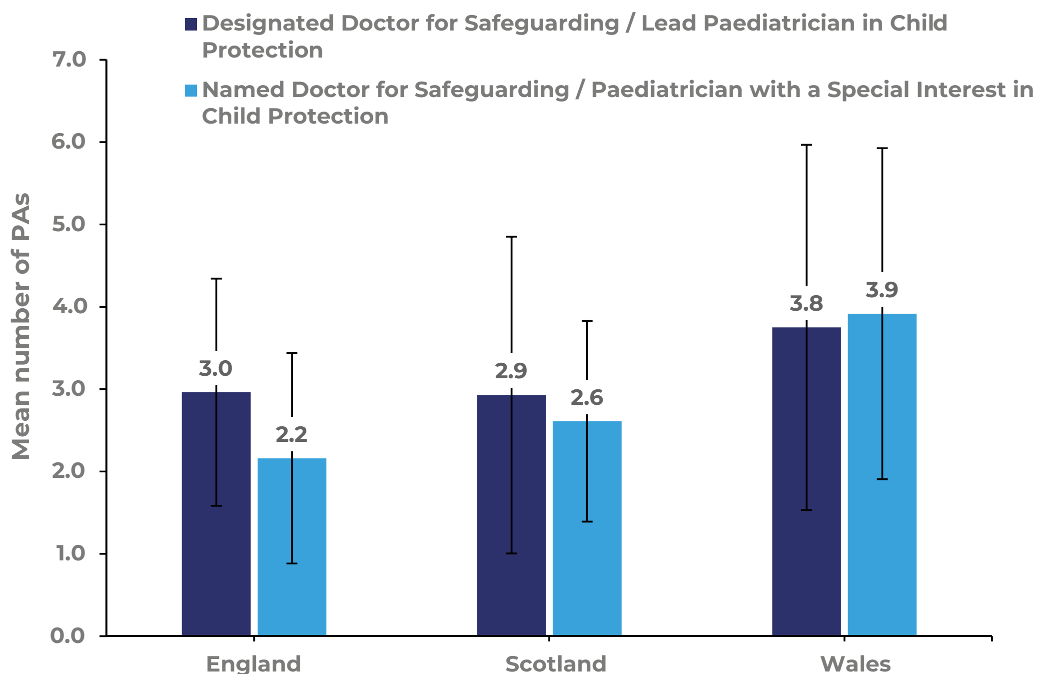
6.1 Safeguarding

Figure 1 represents the mean number of programmed activities (PAs) in job plans for safeguarding lead roles. [v]

On average, England, Scotland and Wales met the standard of 2.0 – 2.5 PAs for the Named Doctor for Safeguarding/Paediatrician with a Special Interest in Child Protection role. No countries on average met the standard of 4.5 – 5 PAs for the Designated Doctor for Safeguarding/Lead Paediatrician for Child Protection role.

Adding complexity to these national-level trends, the standard deviation shows widespread variation in PA allocation for both roles within all nations.

Figure 1. Mean number of PAs in job plan for safeguarding lead roles in England, Scotland and Wales. Error bars show standard deviation.



6.1.1 England

Almost all (97.3%) of Trusts in England had a Named Doctor for Safeguarding role and 94.6% of Trusts had a Designated Doctor for Safeguarding role (including filled and vacant posts).

v Safeguarding questions response rate: England 141/169 named doctor for Safeguarding, 74/169 for Designated doctor for Safeguarding; Wales 4/7 and 6/7; Scotland Lead Paediatrician for Child Protection 10/11 and Paediatrician with a Special Interest in Child Protection 9/11

According to guidance these roles should exist in 100% Trusts, with the Designated Doctor appointed at CCG level.

Table 1 shows that, where the Named Doctor for Safeguarding does exist, the fill rate was 97.1%. It also shows that more Named Doctor for Safeguarding posts (3.1%) than Designated Doctor for Safeguarding posts (1.5%) were filled by SAS doctors.

6.1.2 Wales

In terms of both filled and vacant posts, 100% of Boards in Wales reported that they have a Designated Doctor for Safeguarding post. Similarly, 100% of Boards reported that they have a Named Doctor for Safeguarding post and the fill rate for this role was reported to be 100%.

Table 1 shows that all Designated Doctors for Safeguarding in Wales were reported to be paediatric consultants, whereas 83.3% of Named Doctors for Safeguarding were reported to be paediatric consultants. The remaining 16.7% of posts were filled by SAS doctors.

6.1.3 Scotland

In terms of both filled and vacant roles, 100% of Boards in Scotland reported having a Lead Paediatrician in Child Protection role. Over ninety percent (90.9%) of Boards reported having a Paediatrician with a Special Interest in Child Protection role. Where the Paediatrician with a Special Interest in Child Protection role exists, the fill rate was 88.9%.

Table 1 shows that the Lead Paediatrician for Child Protection Role, where filled, was held by SAS doctors in 11.1% of instances. Similarly, filled Paediatrician with a Special Interest in Child Protection roles were held by SAS doctors in 12.5% of instances.

Table 1. Data on Lead roles for safeguarding in England, Scotland and Wales where the role exists

Lead Role	Role exists (%)	Fill rate (%)	Grade of person in role (%)			
			Consultant	SAS	Nurse	Other
England						
Designated doctor for safeguarding	94.6	N/A	97.1	1.5	0.0	1.5
Named doctor for safeguarding	97.3	97.1	96.2	3.1	0.0	0.8
Wales						
Designated doctor for safeguarding	100	NA	100	0.0	0.0	0.0
Named doctor for safeguarding	100	100	83.3	16.7	0.0	0.0
Scotland						
Lead Paediatrician in Child Protection	100	NA	88.9	11.1	0.0	0.0
Paediatrician with a special interest in child protection	90.9	88.9	87.5	12.5	0.0	0.0

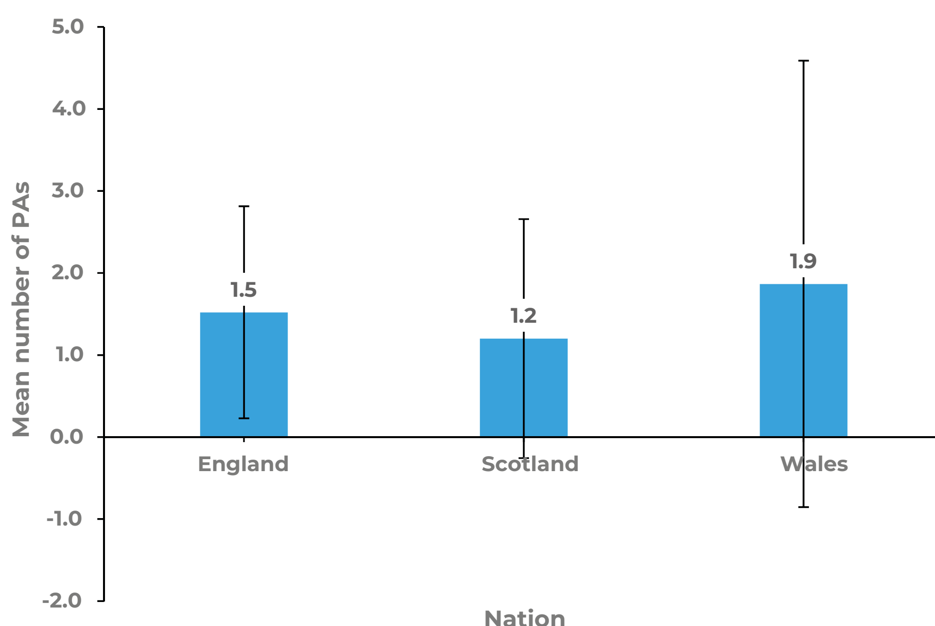
6.2 Child death service

Figure 2 shows the PA allocation for child death service lead roles reported to exist in each nation.[vi]

Child death is often covered across more than one provider, which can obscure the interpretation of data within nations. Figure 2 presents a comparison between England, Scotland and Wales, showing that all roles were allocated less than 2 PAs on average with large variation in each country. No child death service guidance advises on time allocation, which may account for the variation exhibited in each country.

The reported existence of Procedural Response to Unexpected Deaths in Childhood (PRUDiC) roles in Wales suggests that these have been developed to meet local need, despite not being statutory.

Figure 2. Mean number of PAs in job plan for child death service lead roles by nation.[vii] Error bars show standard deviation. Data not available for Northern Ireland.



6.2.1 England

Figure 3 shows that 7.7% of Trusts did not have a filled or vacant Child Death Overview Panel (CDOP) representative. Almost a quarter (23.1%) of Trusts in England reported not having a Designated Doctor for Child Deaths role (filled or vacant). This is also shown in Table 2.

The lack of a Designated Doctor for Child Deaths role is concerning, as this suggests a gap in service provision that should be provided at CCG level. This also increases the risk of clinicians being required to fulfil the Designated Doctor duties as needed without appropriate resources or training.

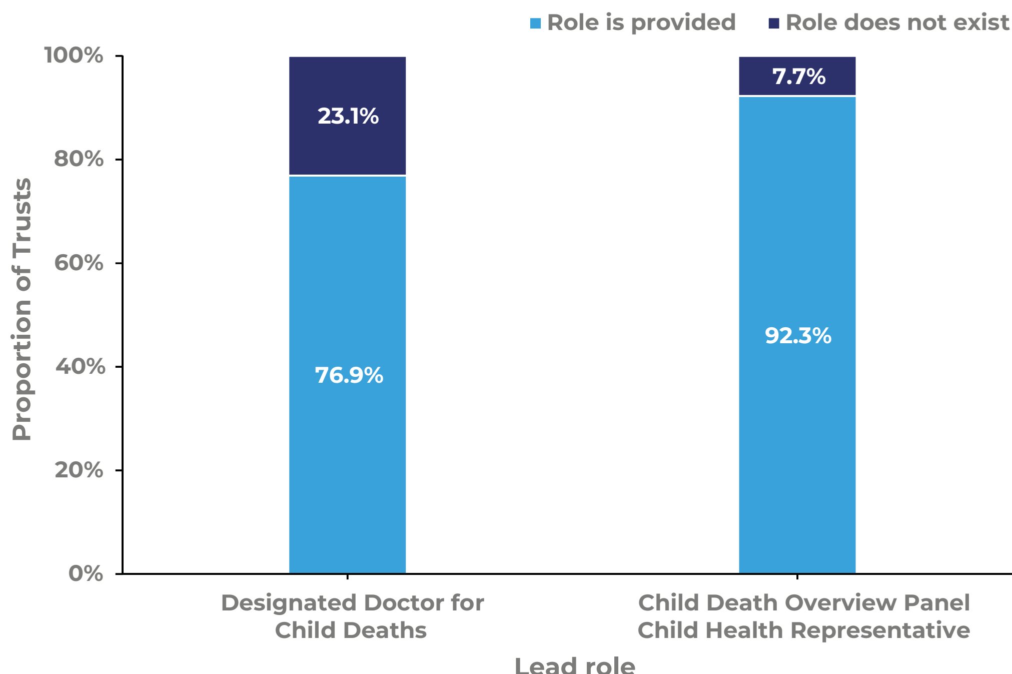
As described in section 5.2.1, attending the CDOP is a function of the Designated Doctor for

vi Response rate: 143/169 Trusts in England; 11/11 Health Boards in Scotland; 7/7 Health Boards in Wales

vii The title of child death service lead roles varies across each nation: Designated Doctor for Child Deaths (England); Designated Doctor for Sudden Unexpected Death in Infancy (Scotland); and Procedural Response to Unexpected Deaths in Childhood practitioner (Wales).

Child Deaths according to Government guidance. The findings indicate the possibility of the CDOP Child Health Representative function being separated from the Designated Doctor role. This may be due to capacity issues, meaning that Representatives are unable to commit to the full Designated Doctor role and that it has instead been divided among multiple doctors or nurses.

Figure 3. Proportion of Trusts in England reporting that the statutory lead roles for the child death service are provided in their area (including vacant posts).



According to Table 2, 97.8% of Trusts with the CDOP Child Health representative role reported that it was filled in their organisation. In 7.8% of Trusts the role was filled by a nurse and in 1.1% by another unspecified medical professional. Remaining filled posts were held by paediatric consultants (85.6%) and SAS doctors (5.6%).

In terms of the Designated Doctor for Child Deaths role, in 1.5% of instances this was filled by a nurse. The child death service lead roles in England are therefore filled by nurses to a greater extent than lead roles in Safeguarding, Looked After Children and SEND. This runs counter to guidance which states that a doctor should fulfil the Designated Doctor for Child Deaths role (section 5.2.1).

6.2.2 Wales

Guidance for Wales states that the Head of Safeguarding provides input to the PRUDiC process and does not mandate the existence of a PRUDiC Practitioner. Despite this, 85.7% of Health Boards in Wales reported that the Procedural Response to Unexpected Deaths in Childhood (PRUDiC) Practitioner role is provided in their Board, filled or vacant. This is shown in Table 2.

In Boards where the PRUDiC Practitioner role does exist, Table 2 also shows that the majority of roles are reported to be filled by nurses (50.0%), with 25.0% filled by paediatric consultants and 25.0% by other medical professionals; consultants of another specialty, for example. Similar to the child death service lead roles in England, the Practitioner role is filled to a greater extent by

nurses than lead roles in safeguarding, LAC or SEND.

6.2.3 Scotland

Just over ninety percent (90.9%) of Health Boards reported that they had a Designated Doctor for Sudden Unexpected Death in Infancy (filled or vacant), as shown in Table 2. Professional guidance states that all Health Boards should have a Designated Doctor for Sudden Unexpected Death in Infancy.

Table 2 shows that all Designated Doctors for Sudden Unexpected Death in Infancy roles were held by paediatric consultants.

Table 2. Data on Lead roles for the child death service in England, Wales and Scotland where the role exists.

Lead Role	Role exists (%)	Fill rate (%)	Grade of person in role (%)			
			Consultant	SAS	Nurse	Other
England						
Designated doctor for child deaths	76.9	N/A	92.3	6.2	1.5	0.0
Child death overview panel representative	92.3	97.8	85.6	5.6	7.8	1.1
Wales						
Procedural Response to Unexpected Deaths in Childhood Practitioner	85.7	80.0	25.0	0.0	50.0	25.0
Scotland						
Designated Doctor for Sudden Unexpected Death in Infancy	90.9	N/A	100.0	0.0	0.0	0.0

6.3 Looked after children (LAC)

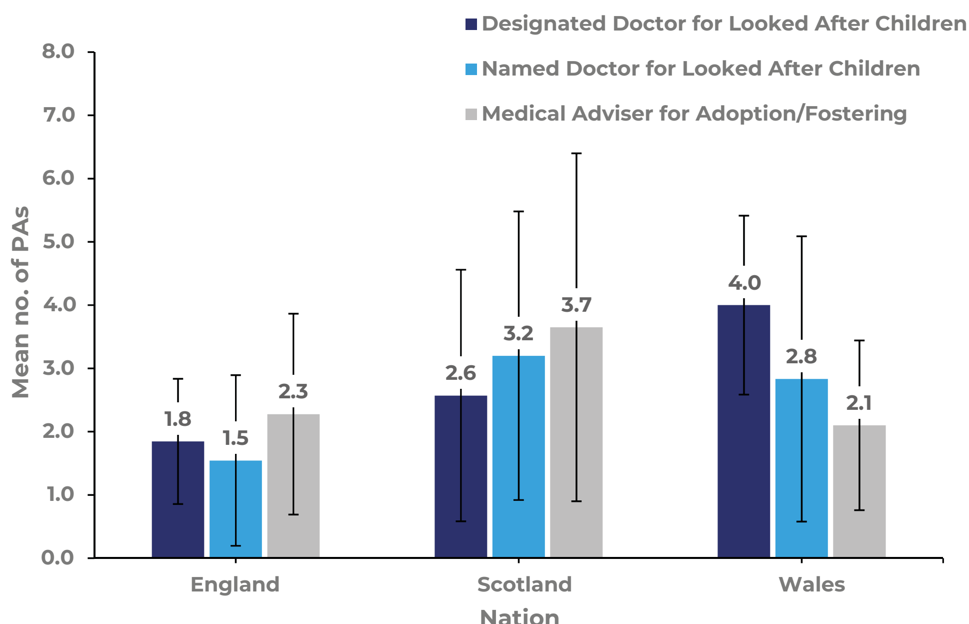
Figure 4 shows the mean number of PAs in job plans for looked after children lead roles by nation. The error bars show standard deviation.[viii]

As discussed in section 5, some respondents in Wales and Scotland have reported the existence of Designated Doctor lead roles in their organisations, although this role is only mandated by the Government in England. This may be indicative of a need within these nations for Designated LAC doctors, which some employers have chosen to meet by developing such roles.

As in the safeguarding lead role time allocation, Figure 4 shows high levels of variation within nations in terms of time allocation.

viii Response rate for Designated Doctor for Looked After Children, Named Doctor for Looked After Children and Medical Adviser for Adoption/Fostering: England 144/169, 142/169, 143/169; Scotland full response rate for all (11/11); Wales 6/7, 7/7, 7/7.

Figure 4. Mean number of PAs in job plan for LAC lead roles by nation. Error bars show standard deviation. Data not available for Northern Ireland.



6.3.1 England

Figure 5 and Table 3 show that 45.1% of Trusts in England did not have the Named Doctor for Looked After Children role (filled or vacant). Fifteen percent (15.3%) of Trusts did not have a Designated Doctor for Looked After Children role, which is employed at CCG level. This contrasts with Government guidance that advises these roles should be present in all Trusts and CCGs in England (section 5.3.1).

Respondents also indicated that almost 91% of Trusts in England had a Medical Adviser for Adoption/Fostering. This relatively high rate of existence may be due to local authorities' obligation to arrange for a registered medical practitioner to carry out an initial assessment of the child's state of health and provide a written adoption report to support the adoption panel or agency decision maker (section 5.3.1).

Figure 5. Proportion of Trusts in England reporting that LAC lead roles are provided in their area, including vacant posts

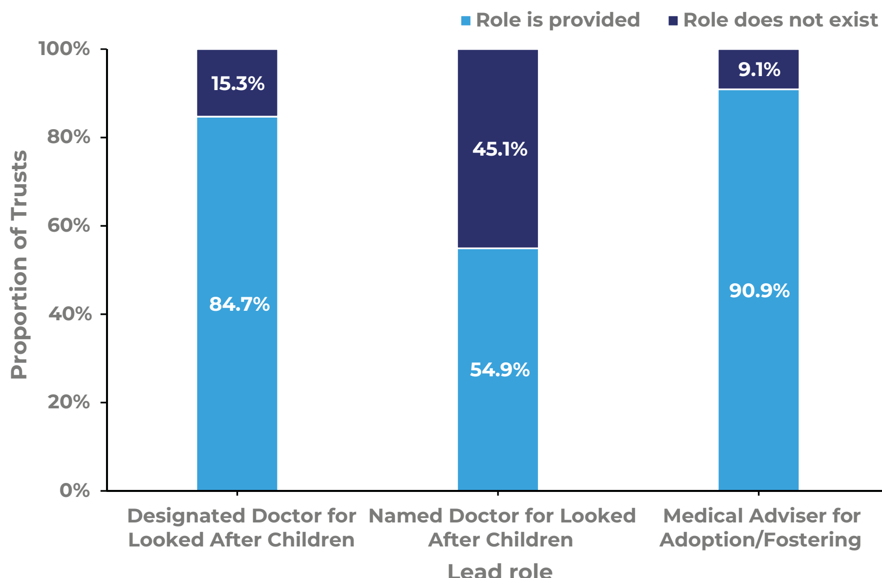


Table 3 also shows that over a quarter (26.2%) of Named Doctors for Looked After Children were reported to be SAS doctors, and that 16.1% of Designated Doctors for Looked After Children were SAS doctors. These are higher proportions than those shown in Table 1, which reflect the proportion of Designated and Named Doctor for Safeguarding roles filled by SAS doctors (1.5% and 3.1% respectively). More LAC lead roles were therefore filled by SAS doctors compared to safeguarding lead roles.

6.3.2 Wales

Figure 6 and Table 3 shows that all Health Boards in Wales had a Medical Adviser for Adoption/Fostering. This accords with the advice from LACHE described in section 5.3.2. Fifty percent (50.0%) and 71.4% of Health Boards had a Designated Doctor for Looked After Children Role and/or a Named Doctor for Looked After Children, respectively.

Figure 6. Proportion of Health Boards in Wales reporting that LAC lead roles are provided in their area, including vacant posts

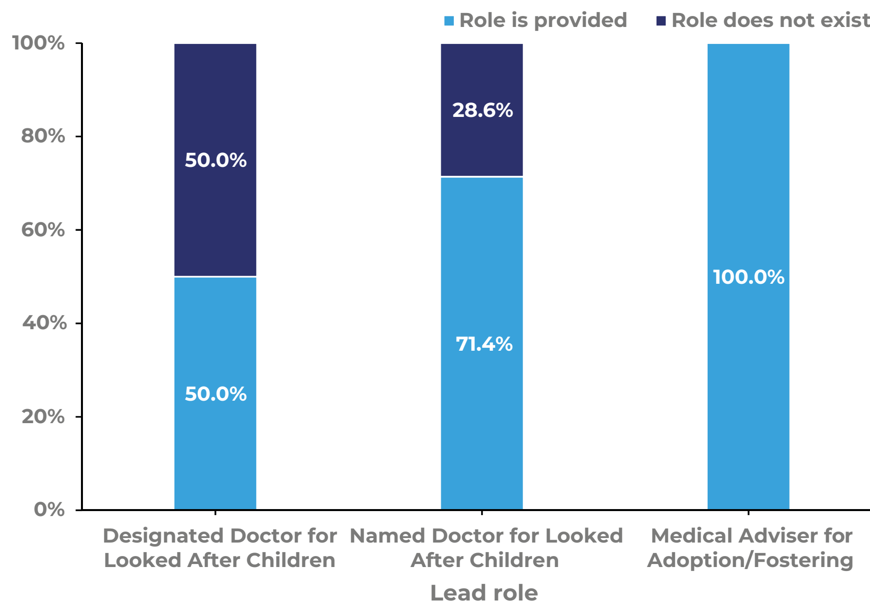


Table 3 shows that half (50.0%) of the Medical Adviser for Adoption/Fostering roles were filled by SAS doctors. Similarly, half (50.0%) of the filled Designated Doctor for Looked After Children roles are held by SAS doctors and a third (33.3%) of filled Named Doctor for Looked After Children roles. The relatively high reliance in Wales on SAS doctors to fill LAC lead roles is also true of safeguarding lead roles (Table 1).

6.3.3 Scotland

Figure 7 and Table 3 shows that the Medical Adviser for Adoption/Fostering role was the most common in Scotland of all LAC lead roles enquired after in the census, followed by the Designated and Named Doctor for LAC roles. Only the Medical Adviser lead role is advised in the guidance regarding Scotland LAC (section 5.3.4).

Figure 7. Proportion of Health Boards in Scotland reporting that LAC lead roles are provided in their area, including vacant posts.

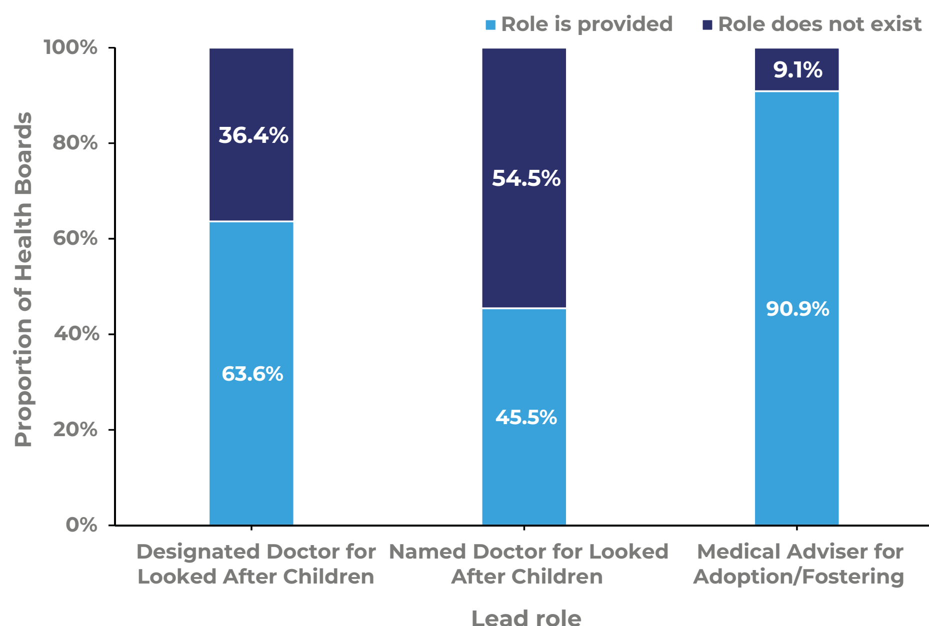


Table 3 shows that 57.1% and 60% of filled Designated Doctor and Named Doctor roles for LAC were held by SAS doctors respectively. 60% of Medical Adviser for Adoption/Fostering roles were held by SAS doctors and 10% were held by neither paediatric consultants nor SAS doctors. The remaining 30% of Medical Adviser roles were held by consultant paediatricians.

Table 3. Data on lead roles for LAC in England, Wales and Scotland where the role exists

Lead Role	Role exists (%)	Fill rate (%)	Grade of person in role (%)			
			Consultant	SAS	Nurse	Other
England						
Designated doctor for looked after children	84.7	NA	83.9	16.1	0.0	0.0
Named doctor for looked after children	54.9	96.9	73.8	26.2	0.0	0.0
Medical adviser for adoption/fostering	90.9	97.6	66.7	32.1	0.0	1.2
Wales						
Designated doctor for looked after children	50.0	NA	50.0	50.0	0.0	0.0
Named doctor for looked after children	74.1	100.0	66.7	33.3	0.0	0.0
Medical adviser for adoption/fostering	100.0	100.0	50.0	50.0	0.0	0.0
Scotland						
Designated doctor for looked after children	63.6	NA	42.9	57.1	0.0	0.0
Named doctor for looked after children	45.5	100.0	40.0%	60.0	0.0	0.0
Medical adviser for						
adoption/fostering	90.9	100.0	30.0	60.0	0.0	10.0

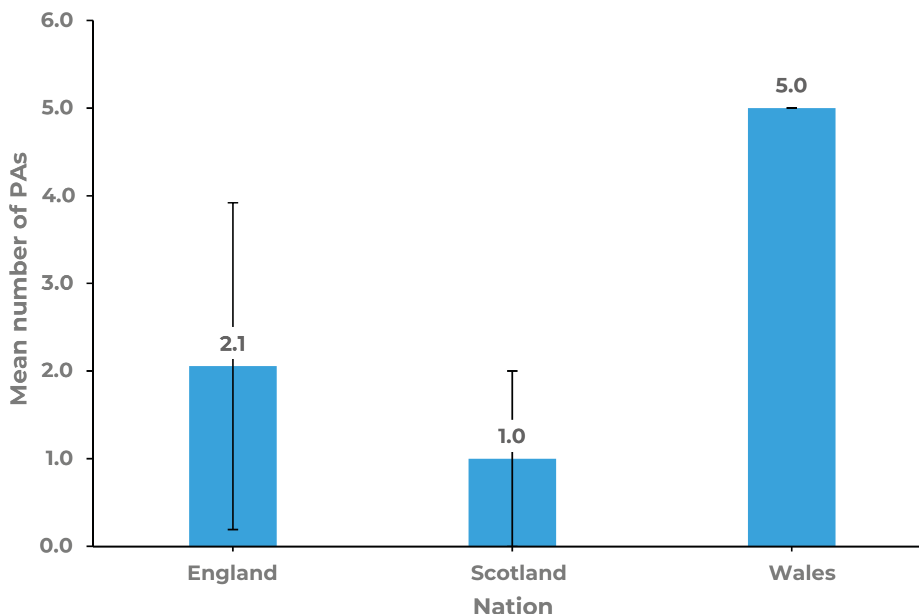
6.4 Special educational needs and disability (SEND)

Figure 8 shows wide levels of variation in England and Scotland for the Designated Medical Officer for time allocated to the SEND/Additional Learning Needs (ALN) role. This role is only described in Government code of practice relating to England and the code does not stipulate the time allocation that should be included in the holder's job plan.[ix]

As previously stated, the code of practice stipulating the existence of a DMO for SEND is only relevant to England. The development of the role in other nations suggests that there is need across the UK for the Designated Officer for SEND, which some employers have sought to meet in the form of a dedicated role.

In Wales the mean number PAs for the DMO for SEND lead role is relatively high (5.0 PAs). The standard deviation is zero and the findings in section 6.4.2 state that a minority of Health Boards have the DMO for SEND role. This suggests that the existence of the DMO for SEND role and the 5 PA time allocation is rare in Wales, and not replicated in many Health Boards.

Figure 8. Mean number of PAs in job plan for SEND/ALN lead roles by nation. Error bars show standard deviation. Data not available for Northern Ireland.



6.4.1 England

Two-thirds (63.8%) of Trusts in England reported that they have a Designated Medical Officer (DMO) for SEND role (filled or vacant), employed at CCG level. This is shown in Table 4. Government code of practice states that all CCGs should employ a DMO for SEND or be able to explain why this role has not been advertised/appointed in their area (section 5.4.1). The absence of a DMO for SEND role in 36.2% of Trusts indicates a concerning gap in service provision for children and young people with SEND.

This gap is compounded by the DMO for SEND role being unfilled for 6.4% of Trusts that report having the role, which is provided at CCG level. Table 4 shows that, where the role was filled,

ix Response rate for Designated Medical Officer for Special Educational Needs and Disability / Additional Learning Needs: England 141/169; Scotland 11/11; Wales 6/7.

this is largely by paediatric consultants (77.8%), followed by SAS doctors (15.6%) and nurses (2.2%). The remainder of filled positions were occupied by 'other' medical professionals (4.4%) such as doctors of other specialties.

6.4.2 Wales

A small minority (16.7%) of Health Boards in Wales reported that they have a DMO for ALN role (filled or vacant), shown in Table 4. Government code of practice stipulating the appointment of a DECLO comes into effect in 2020-2023, so the presence of a DMO for ALN role in some Health Boards suggests that they have already chosen to develop a lead role for SEND to meet population need.

Table 4 shows that, where the DMO for ALN role exists, its fill rate is 100% and it is filled by paediatric consultant(s).

6.4.3 Scotland

Almost thirty percent (27.3%) of Health Boards in Scotland reported that they have a DMO for SEND role (filled or vacant), shown in Table 4. Similar to Wales, in the absence of national code of practice stipulating the existence of SEND lead roles, this suggests that some Health Boards have chosen to develop the DMO role to meet local need.

Table 4 shows that where the roll exists in Health Boards, it was filled by paediatric consultants in 66.7% of cases and by SAS doctors in 33.3% of cases.

Table 4. Data on DMO for SEND/ALN in England, Wales and Scotland where the role exists

Lead Role	Role exists (%)	Fill rate (%)	Grade of person in role (%)			
			Consultant	SAS	Nurse	Other
England						
Designated Medical Officer for Special Educational Needs and Disability	63.8	93.9	77.8	15.6	2.2	4.4
Wales						
Designated medical officer for Additional Learning Needs	16.7	100.0	100.0	0.0	0.0	0.0
Scotland						
Designated Medical Officer for Special Educational Needs and Disability	27.3	100.0	66.7	33.3	0.0	0.0

7. Methodology and response rate

The RCPCH paediatric medical workforce census 2017 asked the clinical leads or directors at all 191 Trusts and Health Boards providing paediatric services in the UK to respond on behalf of their service. Across the UK, 80.6% (156/191) of core hospital and staffing information was completed or validated by the clinical lead/director. Response rates for individual questions are given in the footnotes alongside reporting of the analysis.

The census included the questions relating to lead roles and safeguarding reported here. The respondent was asked "Do the following roles exist within your organisation?" with the answer options 'a) Yes, provided by our organisation', 'b) Yes, but provided by another organisation', or 'c) No, role does not exist'. We also asked for the grade of staff occupying the role and gave the following answer options: 'Paediatric associate specialist', 'Paediatric specialty doctor', 'Paediatric staff grade', 'Consultant paediatrician', 'General practitioner', 'Nurse', or 'Other (please specify)'.[33]

During validation of the data, there were concerns that the response 'No, role does not exist' was given by respondents where the role was provided at the CCG/national employer level. This ambiguity is being addressed in the design of questions for the next census.

Respondents were largely paediatric clinical leads. They were asked to delegate questions to appropriate colleagues if they are unsure of the correct answer, but this may not have happened in all cases. Therefore, although the workforce team made every effort to follow up unclear responses, misreporting may have occurred.

8. Appendix

The below table sets out the lead roles that may be filled by paediatricians described by legislation or guidance according to each country in relation to four areas: safeguarding; child death service; looked after children (LAC) and special educational needs and disability (SEND). Some countries do not have a specific role for certain areas. The holders of safeguarding/child protection lead roles or other community paediatricians may therefore fulfil responsibilities relating to these areas, or employers may choose to develop roles in lieu of national guidance.

	Safeguarding/child protection		Consultant	LAC			SEND
England	Designated doctor for safeguarding	Named doctor for safeguarding	Designated doctor for unexpected deaths in childhood	Designated doctor for LAC	Named doctor for LAC	Medical Adviser for Adoption/ Fostering	Designated Medical Officer for SEND
Scotland	Lead paediatrician for child protection	Paediatrician with a special interest in child protection	Sudden Unexpected Death in Infancy (SUDI) paediatrician	-	-	Medical Adviser for Adoption/ Fostering	-
Wales	Designated doctor for safeguarding [encompasses LAC]	Named doctor for safeguarding	-	-	Named Doctor/ Medical Adviser for Looked After Children and Fostering	Named Doctor/ Medical Adviser for Adoption	- (DECLO requirement to be implemented 2020 - 2023)
Northern Ireland	Designated doctor for safeguarding	Named doctor for safeguarding	-	-	-	Medical Adviser for Adoption/ Fostering	-

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Focus on: Vulnerable children and families workforce

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