Executive Summary

The Munro Review and the Health and Social Care Bill both have significant implications on how the safeguarding of children will be managed by healthcare professionals. Updated statutory guidance on safeguarding, Working Together to Safeguard Children, is also due to be published in 2012. The purpose of this guidance is to set out how individuals and organisations need to work together to safeguard and promote the welfare of children and young people.

All Primary Care Trusts are required to have a ‘designated’ doctor and nurse whose role is to take a professional and strategic lead on all aspects of safeguarding across their designated health economy. All NHS Trusts have leads called ‘named’ doctors and nurses and these provide advice and expertise for fellow professionals on safeguarding children and promote good practice within their organisation. In addition, some Primary Care Trusts have named GPs.

In February 2012, the Royal College of Paediatrics and Child Health (RCPCH) conducted an event and survey of designated and named doctors. This was to establish how those responsible for safeguarding feel national changes will affect them in their role of protecting the country’s most vulnerable children.

Fifty nine professionals completed the survey; twenty nine of which were named doctors, twenty six were designated doctors and four held both roles. This represents around a sixth of the named and designated workforce in England. Each geographical region was represented.

RCPCH found serious concerns amongst doctors about the future of safeguarding, their role, and their ability to fulfil their duties:

- **Current guidance is not comprehensive.** Over a half of respondents did not believe, or were unsure, whether the current guidance in Working Together (2010) on the roles of designated and named professionals is sufficient for the effective delivery of their functions.
- **Clinical expertise is spread too thinly.** Over 75% of named and designated doctors feel that their contracted time to the role was insufficient to fulfil their duties effectively.
- **Safeguarding roles are not protected.** Just one respondent felt that the role of named and designated professionals will be protected and enhanced in the new NHS.
- **Safeguarding is an afterthought in the NHS reforms.** Just 12% believe that the health reforms will stimulate innovation and improvement in safeguarding and
only 13% of designated doctors are actively engaged with emerging health and Wellbeing Boards.

It is clear that doctors do not feel adequately trained or resourced to effectively safeguard children, potentially putting children’s lives at risk.

Therefore RCPCH is making a series of recommendations to Government and healthcare professionals:

1. The Department for Education should ensure the new statutory guidance on safeguarding details all the responsibilities and all the accountabilities of all agencies and professionals involved in the system

2. The Department of Health should ensure that the future of safeguarding arrangements in the new NHS are strengthened, clear and communicated quickly

3. NICE should develop a quality standard for safeguarding to drive service improvement.

4. Department of Health and Local Safeguarding and Children Boards should improve and promote existing training and develop new training opportunities for named and designated doctors.

5. Professionals and health organisations should create effective networks to share information and best practice with fellow experts. Local flexibility is vital; a network could be an informal or formal arrangement.

6. Emerging clinical commissioning groups, shadow health and wellbeing boards and named and designated professionals should engage with each other, develop new relationships, work across organisational boundaries and use each others’ expertise.

7. Health organisations should follow all the requirements in the intercollegiate safeguarding competences, e.g. to ensure named and designated doctors have the time they need to do their job properly, that effective supervision is taking place and to ensure that the named and designated roles are kept separate.
Introduction

In February 2012 the Royal College of Paediatrics and Child Health (RCPCH) held an event for designated and named doctors for safeguarding in England. Over 60 professionals attended and this document reports the quantitative and qualitative data collected at the event, analyses the information and makes recommendations for both practitioners and policy-makers.

Designated doctors take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across a Primary Care Trust. Named doctors support all activities necessary to ensure that a provider organisation meets its responsibilities to safeguard and protect children and young people.

The event comprised of entry and exit surveys, presentations from the Department of Health and the Department for Education, group discussions on the Health and Social Care Bill and its implications for safeguarding and the implementation of the recommendations made in the Munro Review, particularly focusing on the revision of Working Together to Safeguard Children.

59 professionals completed the entrance survey. 29 were named doctors, 26 were designated doctors and 4 held both roles. 56 were consultant-grade paediatricians and 3 were Associate Specialists. Each geographical region was represented, with particularly strong representation from London, the South West, the North West and Yorkshire & the Humber.

The full survey results can be found in Appendix 1.

General characteristics

Named and designated doctors are, for the most part, both experienced and long-serving. 95% are consultant-grade and 66% have been in post for over 3 years. However, with 20% having been in post less than one year, it is important that these professionals feel valued to continue the overall average significant length of service.

Designated Doctors

PAs and child populations

Understandably, the number of contracted Programmed Activities (PAs) allocated to the role varied significantly, ranging from 0 to over 5. 40% were allocated 2 PAs and 20% had 3 PAs for the role.

Only 17% felt that their contracted PAs were sufficient for fulfilling the role of designated doctor efficiently, with 62% saying their PAs were insufficient. Of the 5 respondents who believed their PAs were sufficient, 3 had 4 PAs or above.

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1 [http://www.rcpch.ac.uk/events/enhancing-clinical-expertise-safeguarding](http://www.rcpch.ac.uk/events/enhancing-clinical-expertise-safeguarding)
2 [http://www.rcpch.ac.uk/sites/default/files/Safeguarding%20Children%20and%20Young%20people%20202010%20final_v2.pdf](http://www.rcpch.ac.uk/sites/default/files/Safeguarding%20Children%20and%20Young%20people%20202010%20final_v2.pdf)
3 [http://services.parliament.uk/bills/2010-11/healthandsocialcare.html](http://services.parliament.uk/bills/2010-11/healthandsocialcare.html)
5 [https://www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN.pdf](https://www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN.pdf)
Respondents were asked to estimate the child population in the area that they covered. Populations ranged from 30,000 children to 300,000. When child populations were plotted against the number of PAs allocated to the role, the results identified a number of anomalies. For example, the respondent who was not assigned any PAs to the designated function was expected to cover a child population of circa 200,000. One respondent was allocated 4 PAs for a population of 80,000 whilst another only had 2 PAs to cover the same number of children.

One respondent had 5 PAs for a population of 110,000 yet another only had 3 PAs allocated. One clinician covers a population of 170,000 on 2 PAs yet others are given the same PA allocation for less than one third of the population.

The free text comments underlined the importance of the designated nurse role and the need for sufficient administrative support.

**Message for...PCTs**
The vast majority of designated doctors do not believe they have the time necessary to fulfil their functions effectively: this should be considered in job planning.

**Message for...PCTs and provider organisations**
Professionals should not hold both named and designated roles simultaneously.

**Change**

Reassuringly, 62.5% felt that the clustering of Primary Care Trusts had had no effect on their role. In fact, 8% stated it had led to increased influence and service improvements. However, 33% believed the clustering had increased their workload; with 8% and 16% stating a reduction in the number of designated doctors and an increase in child populations within their role respectively. Free text comments highlighted losses in the designated nurse set up and the fact that several felt that they could not yet be sure whether the clustering would have positive or negative implications.

When asked about their engagement with emerging Clinical Commissioning Groups (CCGs) in their area, designated doctors responded that 47% were actively engaged. However, when asked the same question about emerging Health and Wellbeing Boards, only 13% said they were actively engaged.

**Message for...Designated professionals**
All designated professionals should take steps to engage with emerging bodies such as CCGs and Health and Wellbeing Boards.

**Message for...Health and Wellbeing Boards**
Health and Wellbeing Board Chairs and members such as Directors of Children’s Services should both approach designated professionals and champion the role they can play in advising the Board.
Named Doctors

PAs

Named Doctors reported a range in PAs from 0.5 to 4. 40% have 1 PA and 27% have 2 allocated. Similar to their designated counterparts, only 21% stated that their contracted PAs were sufficient in discharging their duties effectively.

Two respondents reported that they had been asked to cover additional roles, without extra PAs, due to failures to recruit.

Message for...Provider organisations
The vast majority of named doctors do not believe they have the time necessary to fulfil their functions effectively.

Message for...Provider organisations
If named doctors are asked to cover additional roles, they must have additional PAs allocated to support them.

Change

When asked how the transfer of community services had affected them, 48.5% stated that it had had no effect, with 9% saying it had led to service improvements. 24% believed their workload had increased as a result and 21% reported that it has meant they have had to become a named doctor for multiple types of services. 12% reported a reduction in the number of named doctors and the same percentage stated an increase in the child population that they covered.

Message for...Provider organisations
Named doctors need to be given time to increase knowledge and understanding of new sets of services for which they will be responsible. In some circumstances there may be an inappropriate match and an additional paediatric named doctor should be appointed.

Named and Designated Doctors

Supervision

77% of designated doctors responded that they provided supervision for the named doctors in their area. Correspondingly, 70% of named doctors stated that they receive supervision from their designated doctor.

Message for...named and designated professionals
It is a requirement of the intercollegiate safeguarding competences that all designated professionals should provide supervision for all named professionals.
Training

“When I had just started I had no real grasp of my role and what I was expected to do and no specific training. I learned whilst in post”

When asked if they had attended the National Leadership for Influence: Safeguarding Children Practice Programme, only 25.5% responded affirmatively. Of that percentage, 40% reported that the programme satisfied their training needs and 53% said the programme had partly met their needs.

Additional comments included that there was very little training for designated doctors in strategic safeguarding leadership in practice and that, when speaking to fellow designated colleagues, respondent found that all posts are very different.

Message for...the Department of Health and NHS Commissioning Board
There is a need to publicise the programme and design a strategy to ensure more named and designated professionals have completed the course. Separately, a review should be considered as to how it can better meet the training needs of this cohort.

Statutory guidance, the new NHS and leverage

There was a markedly mixed response when respondents were asked whether the current guidance on named and designated professional in Working Together to Safeguard Children (2010) was sufficient for the effectively delivery of functions. 41% believed it was sufficient, 30% felt it was not and 29% were not sure. Free text comments included that the guidance should be more specific regarding the time needed to discharge duties and that covering tertiary centres provided a significant layer of complexity to the role.

Message for...the Department for Education
The revised Working Together to Safeguard Children must include, as a minimum, the current level of statutory guidance on named and designated professionals; and ideally be expanded to clarify some of the additional issues raised in this document.

Just one respondent felt that the roles of named and designated professionals will be both protected and enhanced in the new NHS. 62% believed the roles would be neither protected nor enhanced. 36% believed the roles would not be enhanced but they would be protected.

“I am not confident that the named and designated role will remain”

Message for...the Department of Health
The majority of respondents still have concerns about safeguarding arrangements in the new NHS- the implementation of the Health and Social Care Bill must not lead to weaker arrangements.
Named and designated professionals are extremely pessimistic about their role in the future: clear guidance on the detailed future arrangements should be communicated as soon as possible.

When asked if the health reforms provided an opportunity to stimulate innovation and improvement in safeguarding, just 12% answered that they could. 59% said they could not.

Examples of how the reforms are currently and can in the future improve services locally would give named and designated professionals a blueprint for how to stimulate innovation.

Only 26% of professionals felt that they had sufficient leverage and access to senior management structures to influence safeguarding policies and practices in their area. 34.5% said they did not, and 39.5% said they sometimes did.

“Senior managers are changing quickly and they do not have sufficient understanding of their, or our, responsibilities”

The intercollegiate safeguarding competences are clear that both designated and named professionals are accountable to the Chief Executive.

“Safeguarding seems an afterthought at best in central reforms”

“We feel as if we have no voice and no choice”

Professionals were concerned that a lack of clarity about the nature and structure of the health reforms may allow vulnerable services and patients to slip through gaps and that the provision of continuity of care is vital. There is “extreme doubt as to who is responsible for what” and the health reforms are “yet another challenge in an already busy job”, but there was a commitment to continuing to practice and ensure high quality services in times of organisational change.

A framework setting out future structures and accountabilities for safeguarding should be published as soon as possible to inform professionals and allay concerns.

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6 The summary reflects group discussions on the topic
GPs

It was felt that there was increasing fragmentation without strategic control and one respondent felt that putting control of the NHS into the hands of the professional group that is “least engaged with safeguarding” (GPs) will not improve or facilitate safeguarding. Delegates did not feel confident that GPs are interested or engaged in safeguarding agenda - and some have been told by GPs that safeguarding is low on their priorities.

Message for Clinical Commissioning Groups and designated professionals
It is crucial that there are amicable and effective relationships between CCGs and designated professionals based on sharing learning and expertise.

Innovation

Some felt there was, in theory, potential to innovate and improve during the health reforms but that it needed to be realised. New networks and links will need to be forged, often with people not versed in safeguarding issues- but the new structures “may offer frameworks for networks”. However, it is important that existing networks continue to be funded by emerging CCGs and the NHS Commissioning Board.

Message for practitioners
The principles of Protecting Children, Supporting Clinicians\(^7\) can aid practitioners in developing child protection networks locally.

Commissioning

Professionals felt that improving clinical leadership in commissioning should provide benefits, but that there is a great deal of uncertainty at present. Professionals felt that there was an expectation for them to be involved in commissioning but that they felt untrained and “out of the loop”.

Any Qualified Provider

Respondents were clear that all emerging provider organisations need named professional expertise and that if providers provide both acute and community services there must named professional representation for each.

Inspection

There is a need for accountability structures for monitoring and auditing to be clarified. The demands on time that inspections demand should be factored in by employing organisations, and it is vital for inspectors to come with “a blank sheet of paper” given the inevitable differences in local approaches that will arise as a result

\(^7\)http://www.rcpch.ac.uk/sites/default/files/asset_library/Health%20Services/Child%20protection%20clinical%20networks%20-%20FINAL.pdf
of the reforms. However, as systems renew focus there are opportunities for useful inspections.

**Financial considerations**

It was felt that at the moment the focus in organisations is entirely on saving money. There was an aspiration for ringfenced funding for safeguarding in localities.

**Key elements of a safe transition**

“We must maintain the capacity of named and designated; not many want to do the role and those in existence do not feel cherished”

Clarity and sense of purpose is required about structures, responsibilities and timescales. Strengths that are already present should be identified and supported and existing expertise should be maintained, avoiding unnecessary change. Partnership working should be protected and good communication links and dialogue should be built with local authorities, commissioners and providers.

Safety, quality assurance, monitoring and accountability are key elements of transition. Job security, leadership and training will enable cohesive team approaches and understanding of roles and responsibilities.

The professionals involved in designing the new systems need to understand the unique challenges in safeguarding. Safeguarding needs to be high on the agenda of future commissioning bodies and clinical involvement on CCGs is a necessity. Protected time for named and designated professionals, along with recognition and understanding of their role and skills will aid continuity of service.

A reliance on key individuals should be avoided. Organisational resilience and boosted morale requires clear direction for experienced clinicians, clear dissemination of information and inclusivity; using professionals to build governance and other arrangements.

Audits of current practice can ensure stability and detailed risk assessments, with directed work to mitigate risk which is adequately resourced ensure a safe transition.

Finally, training for professionals in *how* to influence local developments, model commissioning contracts and good networks to build accountability and shared risk can ensure a stability of services.

**Message for...health agencies**

Avoid unnecessary change and identify and support existing practice that is working well.
Remaining gaps and issues

“Increased choice serves only the most able and risks increased inequalities – we must not disadvantage the most disadvantaged”

Delegates reported that CCGs are not placing children, let alone safeguarding children, as a high priority and in some areas not a priority at all. There is a feeling that everyone believes safeguarding will be / is being handled by someone else. There is a risk that CCGs and fragmented and that existing expertise, such as PCT Executive Leads, is being lost.

There are concerns that a coalescence of organisations across large areas will potentially diminish and dilute both resources and experienced practitioners. Multiagency working and services across and beyond boundaries remains a concern, risking a lack of universal coverage and sharing examples of best practice will be made even more difficult.

Practical issues that remain include the accountabilities and responsibilities of non-NHS provider organisations and how to ensure competitive market providers are interested in safeguarding.

There is a risk of misunderstandings, of “eyes being taken off the ball” and a lack of checks and balances in the new system. There are concerns around loss of organisational memory, professional isolation and magnified inequalities. Informal working arrangements are being disrupted and problems may arise in both attracting and retaining safeguarding professionals.

Respondents felt that Health and Wellbeing Boards will not access input and expertise from designated professionals given that there are not mandatory members and there will be a dependence on one voice on the Boards in the form of the Director of Children’s Services. It is crucial that Health and Wellbeing Boards ensure that expertise in safeguarding matches not just the size of the population but the needs of the population.

Finally, professional safeguarding supervision for named GPs was regarded as a necessity, there is a risk that both health visitors and school nurses will be separated from health professionals if they are ever located in local authorities and that overall capacity of practitioners to attend case conferences and Children in Need meetings is stretched.

“We need to develop organisational resilience- and that needs consistency, continuity and clarity”

Message for...practitioners
It will be especially important in the new system to share best practice and work across organisational and geographical boundaries.
Opportunities

“The localism agenda could be a good thing- it allows you to look at your own priorities”

If safe transition can be ensured and remaining gaps addressed, there are opportunities for streamlined services across all agencies. It was felt that continuity of service following “seismic reorganisation” will be an achievement and professionals may be able to respond to local priorities and needs.

Greater joint working between children’s and adult’s services may be achieved, particularly in areas such as mental health and there is potential for good relations with public health colleagues, allowing communication and follow up with families and children to be achieved.

There are opportunities to develop local forums and provide a framework for safeguarding networks, which in turn could provider greater mutual support, emotional support and consistency of training. There can be recognition of clear outcomes relevant to local areas, and a real chance to recognise and confront the emotional and social impact of deprivation on children.

If the capacity of designated and named professionals can be reflected by child populations and weighted to levels of deprivation and need (as well as weighting against the number of LSCBs and the size of the PCT cluster) then there would be better team working and the potential for more flexibility, time to define roles and increased influence.

There are hopes that inspections can be improved and a new culture will develop systems reviews across agencies.

Message for…practitioners
Seize the opportunities that the reforms will present – develop relationships and work with new professional groups and form supportive networks locally.

The Munro Review and Working Together to Safeguard Children

The essential components of Working Together to Safeguard Children

“There must be no wriggle room in statutory guidance – if it isn’t mandated in Working Together it simply will not be done”

Respondents were clear that statutory guidance must detail the responsibilities and accountabilities of all agencies and professionals involved in the child protection system. Every agency that feeds into the wellbeing of a child should be included, including adult services.

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8 The summary reflects group discussions on the topic
Working Together should clearly describe structures, especially considering the changes which will arise from the health reforms and the guidance must be a tool for coordinating and improving interagency working. It needs to inform decisions when commissioning services and assessing outcomes.

The document could and should be shorter, for example reducing the training chapter and being less prescriptive on timescales. Non-statutory aspects should be shared as additional guidance and language could be more direct.

However, there was a clear feeling that the document should incorporate research, be evidenced-based and illustrate good practice that influence outcomes for children which can be locally adapted.

The document should provide clear guidance on responding to safeguarding concerns, outline the roles and responsibilities of named and designated professionals, include the various methodologies and learning processes for Serious Case Reviews, principles for effective and timely two-way communication to ensure consistent thresholds, provide a common training framework for all professionals and ultimately outline and prescribe what the requirements of the Children Act mean in practice; applying it to the different agencies involved in safeguarding.

Working Together should set out core principles and standards and include clear outcomes and minimum standards. It should interpret legislation to outline legal duties, and act as a tool for practitioners to evidence what should happen, i.e. when service standards fall locally it should be a mechanism to drive improvements.

The guidance is right to be child and family focused, it should have an executive summary version and it should be a compact framework of what is essential and what is recommended practice. It is vital that the document is e-friendly and is clear and concise with a glossary of terms, clarifying expectations for organisations and individuals in a simple, straightforward and sensible way. It should be holistic, informative, integrated and inter-related.

The fundamental principle in the guidance should be to inform a professional about what everyone else in the system does and should do, focused towards the one common goal of safeguarding children. There should be recognition that health services are universal and that recognition of abuse and supporting intervention and rehabilitation are key inclusions.

Respondents did believe one of the roles of statutory guidance was to be an aid to building non-blaming relationships, increasing personal chemistry and professional trust and clarifying how agencies cope with issues such as excess demand.

Message for...the Secretary of State for Education and the Parliamentary Under-Secretary of State for Children and Families
Revised statutory guidance must detail the responsibilities and accountabilities of all agencies and professionals involved in the child protection system.
Professionals want and need detailed guidance to both inform practice and to use as a lever for change locally.

“It is too dangerous to rely on professional judgement alone...Working Together must prescribe an overarching framework”

“There is very little you can throw out of Working Together without danger”

The risks and opportunities post Munro

Early help

“If commissioners have a choice about early help they may choose not to commission”

Respondents felt that a duty of early help should be prescribed in statutory guidance, that a focus on prevention was correct but that it must be supported by funding to ensure it is readily available.

It was felt that the provision of early help will not be effective without statutory support. There was also a view that early help should be targeted to effective results rather than needs and degrees of deprivation. Finally, there was agreement that current provisions such as Multi-Agency Allocation Groups are not working well and that early help is very difficult to get.

Miscellaneously, respondents felt that the Common Assessment Framework was a valuable tool when used appropriately for identifying Children In Need and that having a key worker for complex cases would be very beneficial.

Message for...the Department for Education

Professionals do not feel that the decision to not develop a statutory duty to provide early help will improve the delivery of such services.

Timescales

Respondents felt there should be less rigidity in timescales for assessment but that they should not be dispensed with entirely. It was felt that, without any prescription, cases may remain unallocated or it may lead to decisions based on a lack of information. There should be flexibility depending on the individual case circumstances and other quality measures should be put in place. Overall, timescales appropriate to the child, with exception reporting if those timescales have been exceeded would provide some flexibility but enough prescription to be robust.

It was recognised that reduced prescription relies on prioritising assessments effectively and managing risk. There was also thought to be a need to improve the quality of assessments.
Finally, there is an opportunity to revise case conference procedures, not only locations and timing but altering the process to ensure a pre-conference exchange of professional opinions, including compulsory input from GPs.

**Message for...the Department for Education**
Timescales for assessment should not be dispensed with entirely

**Evidence, performance and training**

Delegates were very clear that Key Performance Indicators (KPIs) should be agency specific as very few can cross-agency, but that standardised KPIs should be used for each agency, especially in light of the health reforms and the multiplicity of provider organisations.

The evidence bases for different agencies should be brought together. It was accepted that each agency has a good evidence base but this does not translate into cross-agency messages. There is real scope for NICE to develop work in this area, particularly a quality standard on safeguarding based on *When to suspect child maltreatment*.

Thresholds across boundaries should be consistent, and one suggestion to improve this was to introduce a common training framework across agencies. Two other ways to improve understanding of thresholds are joint initiatives in service provision and instigating a standard principle of feeding back to referrers to help learning.

**Message for...the National Institute for Health and Clinical Excellence (NICE)**
A quality standard for safeguarding should be developed to drive service improvement in safeguarding.

**SCRs and CDOPs**

There are opportunities to make Serious Case Reviews (SCRs) more efficient and effective. Respondents felt they should be completed in shorter timescales to be useful, that at present the reviewing process is too bureaucratic and that the learning from SCRs must be disseminated nationally.

Delegates felt that the numbers of SCRs are decreasing; firstly because they are arduous and secondly that there is now a requirement to publish them in full. It was felt that the lessons to be learned can be identified quickly, mostly from chronologies, and that much of the process was to satisfy Ofsted requirements.

Recommendations from SCRs need to be smarter and the SCIE model may improve learning, although it was felt that some weaknesses in that model exist; one delegate asserted that “when a child has died, conversations with staff just are not strong enough”.

14
It was recognised that Child Death Overview Panel (CDOP) processes were variable across the country. It was felt that most CDOPs were too small and struggled to pull out useful data trends and that guidance on population footprints or pooling data across regions would be beneficial. The benefits of the CDOP being chaired by a public health professional were advocated, particularly that they are experts on epidemiology.

**Message for...LSCBs**
SCR recommendations and lessons must be shared nationally

**LSCBs**

Local Safeguarding Children Boards (LSCBs) should focus on child protection rather than safeguarding. LSCBs can only be more effective in driving local agendas if they are accountable; LSCBs need to demonstrate how they impact on outcomes- at present the only clear impact is in relation to child deaths.

Large LSCBs struggle to maintain effective engagements and rely on good chairing and management. One delegate remarked that “the effectiveness of any committee is inversely proportional to its size”, although there are risks in smaller executives of cliques and disengagement of peripheral members. It was felt that the health input should be rationalised to increase effectiveness and the role of designated professionals should be strengthened.

**Message for...LSCBs**
Focus on child protection and tangibly improving outcomes for children

**Inspection**

Three comments were made; that unannounced inspections will be useful, that inspections should consistently be by the same people and that the inspection framework will be more robust if it explores the experiences of children and young people through all the facets of all the agencies involved.

**Summary**

“[Safeguarding] will not be protected or enhanced if we do not try and influence decision makers”

There is clearly still much to do. After the event, 66% believed they were more knowledgeable about the reforms but only 34% felt more empowered to influence developments in their local area. 74% of professionals urged the RCPCH to hold further events and seek to devise a structured training programme for named and designated doctors.

**Message for...all**
Effective and comprehensive training will enhance even further the ability of clinical experts to deliver safeguarding improvements.
Appendix 1

Are you a named or a designated doctor?

- Both: 4
- Designated: 26
- Named: 29

How long have you been in post?

- 0 to 1: 12
- 1 to 3: 8
- 3 to 5: 11
- Over 5: 28

Are you a consultant-grade paediatrician?

- No (Associate Specialist): 3
- Yes: 56
Which geographical area are you based in?

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<th>Region</th>
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<td>South West</td>
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FOR DESIGNATED DOCTORS ONLY

How many contracted PAs are allocated to your role?

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<thead>
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<th>Number of PAs</th>
<th>Number of Designated Doctors</th>
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Are you contracted PAs sufficient for fulfilling your duties effectively?

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<td>No</td>
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<td>Not sure</td>
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Designated PAs and child populations

How has the clustering of Primary Care Trusts affected your role?

- Increased my influence
- Increased my workload
- Increased the childhood population that I cover
- Led to service improvements
- Not affected me
- Reduced the number of designated doctors

Do you supervise the named doctors in your area?

- No
- Yes
Are you actively engaged with emerging Clinical Commissioning Groups in your area?

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Are you actively engaged with emerging Health and Wellbeing Boards in your area?

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<tr>
<td>26</td>
<td>4</td>
</tr>
</tbody>
</table>

FOR NAMED DOCTORS ONLY

How many contracted PAs are allocated to your role?

<table>
<thead>
<tr>
<th>0.5 PA</th>
<th>1 PA</th>
<th>1.5 PA</th>
<th>2 PA</th>
<th>3 PA</th>
<th>4 PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>13</td>
<td>2</td>
<td>9</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>
Are you contracted PAs sufficient for fulfilling your duties effectively?

- Yes: 7
- No: 18
- Not sure: 8

How has the transfer of community services affected you?

- Increased my workload: 8
- Increased the childhood population that I cover: 4
- Led to service improvements: 2
- Meant that I have become a named doctor for multiple types of services: 7
- Not affected me: 16
- Reduced the number of named doctors: 4

Do you receive supervision from the designated doctor(s) in your area?

- Yes: 19
- No: 10
- Not applicable: 4
Have you attended the National Leadership for Influence: Safeguarding Children Practice Programme?

- Yes: 15
- No: 44

Do you feel that the programme satisfied your training needs?

- Yes: 6
- Partly: 8
- No: 1

Do you believe the current guidance in Working Together (2010) on the roles of designated and named professionals is sufficient for the effective delivery of your functions?

- Yes: 24
- No: 18
- Not sure: 17
Are you confident that the roles of named and designated professionals will be protected and/or enhanced in the new NHS?

Do you feel that you currently have sufficient leverage and access to senior management structures to influence safeguarding policies and practices?

Do you believe the health reforms can stimulate innovation and improvement in safeguarding?