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Intercollegiate document on Safeguarding and Protecting Children and Young People: roles and competences for health care staff

1. I write with regard to the Intercollegiate document on Safeguarding and Protecting Children and Young People: roles and competences for health care staff.

2. The College welcomes the opportunity to respond to this document. On the whole we welcome the document as addressing a very important need: to document the specific training needs and competences of health care staff in relation to child protection and safeguarding. We appreciate the hard work and attention to detail that has gone into drafting the document. However there are a number of comments that we would wish to make on points of detail.

3. The RCGP is unhappy with the model of providing six levels of responsibilities and training. From our members’ perspective, it makes this unnecessarily complicated: we would suggest that three levels would be adequate.

4. The descriptor for Level 3 is particularly unhelpful in the case of GPs, who may not work ‘predominantly’ with children or young people, but who certainly have regular contact with children of all ages and with members of their families, and are all in a position to detect the signs of child neglect or abuse. Nonetheless it needs to be made absolutely clear that GPs belong at Level 3 on the scale – though there may be some at ‘core’ Level 3 and others, especially the CP lead in a practice, at the ‘specialist’ Level 3, depending on their experience.
5. Also under the Level 3 specialist competences, the distinction should be made clear between the Level 3 GP advising on specific child protection cases, and the Level 4 Named GP advising on child protection cases across a PCO.

6. Educational issues: while it is important to have core training, as well as updates on new developments and legislation, GPs deal with children and families every day, and it is unlikely that scheduled, repetitious refresher training will be beneficial or cost effective, especially when there are many other training priorities, even within child health. The role of ongoing practice quality improvement systems where staff at all levels could be encouraged to develop their knowledge year-on-year should be emphasized, as this will be more beneficial in the long run.

7. Specifically:
   i. 30 minutes training for level 1 competences may appear to imply a lower responsibility towards child protection from non-clinical practice staff at level 1. Very little of use can be taken in from such a brief session. Initial training of half a day, or even two half days, has been suggested as being more appropriate.
   
   ii. We note also that the training requirements for staff at Level 2 are not quantified, in terms of number of days or sessions required, unlike those for Levels 1 and 3. This seems inconsistent.
   
   iii. On the other hand, the list of structured training requirements for those at Level 3 appears excessive, and seems to assume that little learning occurs between training sessions. We welcome the implication that the learning is also effective when delivered through case discussion and internal audit, as well as e-learning and outside courses, because the evidence is that clinical staff learn best from ‘own patient’ triggers. Flexibility of educational methods is always to be appreciated, and this aligns with the need to incorporate child protection training within annual appraisal. This is one way of requiring GPs to reflect on the development of their child protection knowledge.

8. Some respondents felt, with regard to the Level 4 competencies, that flexibility needs to be left, without the strict requirement for additional training, for experienced GPs to demonstrate that they have developed the relevant knowledge and skills for the role of a Named GP. This is equivalent to accreditation of prior experiential learning (APEL), as many GPs will have led on child protection for some years. We would
advocate the following revised guidance under the person specification for the named GP:

i. Be an experienced GP of good professional standing with considerable experience in the care of children and young people.

ii. Be a member of the RCGP.

iii. Be able to demonstrate excellent communication skills.

iv. Be developing, or already be acknowledged to have, safeguarding/child protection expertise.

v. Have an additional paediatric qualification (for example, a Diploma in Child Health (DCH)) or work-based equivalent experience (for example, an attachment to community paediatrics, or have held a substantive lead role for child health).

vi. Have a qualification related to the nature of the post, for example: a GP trainer accreditation or similar level qualification for a post with mostly educational activities; or membership of the Faculty of Forensic and Legal Medicine (FFLM) for posts involving forensic work.

9. On a very specific point, we note the omission of audiologists from the lists of staff who come into contact with children. Failing to seek help for a child with hearing difficulties may well be an indicator in itself of child neglect, and audiologists ought to be expected to be trained for and aware of this.

10. We would also query the use of ‘signs’ in the description of level 1 competences. It is very important to be precise in terminology here, since the ‘signs’ that reception staff may be expected to pick up on are different to those expected of GPs and specialists. Preferred terminology would be ‘signals’ or ‘what to look out for’.

11. The use of the phrase ‘health education programme participants’, as on page 5 and page 9 of the document, is unclear. From the context this refers to professionals undergoing training, and the need for the trainer to understand the various curriculums – this could be phrased more precisely.

12. More broadly, the document would benefit from the addition of a glossary of terms – for example clarifying the role of a ‘Named GP’ as opposed to that of the ‘lead GP’ for a practice.
13. We gratefully acknowledge the contributions of members of the RCGP’s Council Executive Committee including our Child Health and Safeguarding Leads, and our Patient Partnership Group Chair, in formulating this response.

Yours sincerely

Professor Amanda Howe

Honorary Secretary of Council