1. What is getting in the way of this child or young person's wellbeing?
2. Do I have all the information I need to help this child or young person?
3. What can I do now to help this child or young person?
4. What can my agency do to help this child or young person?
5. What additional help, if any, may be needed from others?

To answer all of these questions comprehensively, there may be a need to collate information and/or share information with the child's Named Person and other appropriate practitioners. This is particularly important where the answer to any of these questions is no; or you do not know; or you are unsure of the answer to any one of the above questions.

There is disquiet about sharing information where there are wellbeing concerns, a threshold lower than where there are concerns about risk of harm ie. child protection. Advice was sought from the Information Commissioners Office (28th March 2013) and the response was reassuring: *'While it is acknowledged that practitioners need to be sure that their actions comply with all legal and professional obligations, fear that sharing genuine concerns about a child or young person's wellbeing will breach the Act (Data Protection Act 1998) is misplaced. Rather, the Act promotes lawful and proportionate information sharing, whilst also protecting the right of the individual to have their personal information fairly processed.'*

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FROM THE GEORGE STILL FORUM

The George Still Forum is a Special Interest Group of BACCH and of the RCPCH which has been successively contributing, enhancing and sharing knowledge about Attention Deficit Hyperactivity Disorder in Children. In the eight years of its existence it has made a significant contribution in increasing the awareness of ADHD, developing care pathways and influencing service development. By holding two days annual scientific meeting in the autumn each year the forum fulfils the above objectives.

The ASM offers opportunity to update ones knowledge base – a necessity in the age of rapidly advancing technology and refinement in the intervention. Paediatricians and related professionals engaged in the care of children are encouraged to take an active part in the ASM. A special aspect of the Conference is the poster presentation of findings of research, audit and special experiences.

The First day of the ASM is called, Masterclass **in ADHD**. Various aspects of the condition are covered through brand new, completely overhauled presentations on the topics, as would be in a newer edition of an authoritative textbook. We are confident that like previous years the day will not only meet the requirements of relatively junior paediatricians but will liked by all delegates.

The second day is called **National ADHD Studyday**. Specialists with concentrated experience of managing ADHD sufferers will be lecturing on related Topics.

Hence , dear readers all paediatricians and all health care workers, consider being part of this two day event on the **22nd and 23rd September in London when there would be the opportunity to find newer depth and breadth of this ever-growing field of science related to saving vulnerable children from harm.**

For registration and further details contact *gsfcoordinator@hotmail.co.uk*
And *www.georgestillforum.co.uk*

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SAS

STAFF, ASSOCIATE SPECIALIST AND SPECIALTY DOCTORS (SAS) BACCH SURVEY 2015

Introduction:

A survey was carried out to obtain an overview of the working life of the Staff, Associate Specialist and Specialty Doctors (SAS) thereby identifying the challenges and pressures. This would provide an opportunity to have discussions with relevant bodies to tackle the challenges present and offer solutions.

There were 78 respondents to the online survey, which represents 32% of SAS members of BACCH.

- 69% Associate Specialist(AS)
- 28% Speciality Doctors (SD)
- 88% female
- 21% Scottish Colleagues
- 4% Welsh
- 6% Northern Ireland
- 24% The Thames region collectively (South East 11%)
- 9% West Midlands
- 9% Wessex
- No representation from Oxford or Trent regions

There was no representation from the now disappearing grades -Staff Grades, SCMO or Clinical Assistant. There were two Trust Grade Doctors - an associate specialist equivalent and a Staff Grade/ Speciality Doctor equivalent. One of the respondents reported that his title remains CMO amongst allied professionals.

The questions were quite varied, looking at challenges, difficulties and satisfaction elements in the present employment. There was direct questioning on what the SAS Rep could do to offer support. Details of the job plan breakdown and sessions worked were also sought. The variety of practical assessments undertaken was noted. The Study leave/CPD issues and attendance at the Annual Scientific meeting of BACCH were also explored.

The survey looked specifically at Safeguarding as it was felt this was integral to our work and over the years has remained a national concern. It was surprising however, to note that involvement of SAS doctors did not reflect this. Safeguarding, as all legislation claims, is everybody's business and considered at every consultation. The variety of Special/Personal interests was also explored in the survey.

Ranking of answer choices was employed in many of the questions in the survey with the lower the value (closer to 1) being more significant.

Results:

Most Significant Challenges in current employment (number of respondents)

- Work Load (68)
- Limited resources and support (61)
- Limited collaboration with CAMHS (51)
- Lack of Sense of Fulfilment-29

Continues overleaf

- IT Changes-28
- Demands of Commissioning Groups /Unclear Progression Pathway -26 each
- Loss of Associate Specialist Grade-22

Most Significant Challenges in current employment –Top Five (Ranking Average 1-5)
- Work Load -1.88
- Limited resources and support-2.67
- Limited collaboration with CAMHS-2.9
- Loss of Discretionary point-3.07
- Loss of Associate Specialist Grade(AS) -3.09

Other parameters considered were the revalidation process, difficulty in carving out a niche to excel, feeling of being inferior to trainees, unclear progression pathway, removal of ability to obtain Discretionary/Optional points and speed of change regarding information technology.

It was clearly evident work-load was a significant concern as well as limited resources and support. Collaboration with Child and Adolescent Mental Health Service (CAMHS) was also felt to be a concern with the explosion of numbers of Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactive Disorder (ADHD) cases.

In the comments, self-value seemed to be key and perhaps lack of this was a reason for despondency in a number of SAS doctors. The loss of the AS grade was felt to make the Speciality Doctor (SD) a dead end post and advice was noted for many to return to core training. The AS also feels trapped with the closure of the grade, as movement to another equivalent post elsewhere is not possible. The Certificate for Eligibility for Specialist Registration (CESR) process was also felt to be very difficult for British trainees. There appeared to be a hierarchal illusion with highly experienced SAS doctors feeling left out regarding management issues in their Trust and not a part of the senior staff meetings which take place. Isolation was also felt by many in rural areas. It was also felt that consultant work-load left no time to support SAS doctors.

Factors to make a positive Difference -Time

The overriding theme here was time. A need to recognise all the hidden activities not easily quantifiable were seen as significant, as well as a need to make processes leaner.

In the comments, the now accepted theme of not replacing retired staff was mentioned as well as the increasing workload and demand to see more patients with less than appropriate secretarial/administrative support. It appeared the key was a good Job Plan. A further comment stated that it was now and difficult to offer a holistic approach.

Weighted (Rating) Averages-Ranking 1-5
- Increased recognition of hidden activities - 2.32
- Time for Direct Clinical Activity (DCA) - 2.33
- Time for Supporting Professional Activity (SPA) - 2.73
- Time to attend multidisc/agency meetings - 3.0
- Referral forms to be more concise - 3.12

Factors to make a positive Difference (Total Frequency-no of respondents)
- Increased recognition of hidden activities - 72
- Time to attend multidisc/agency meetings - 49
- Time for SPA - 48
- Time for DCA - 39
- Protected allocated time for diagnostic assessments - 29

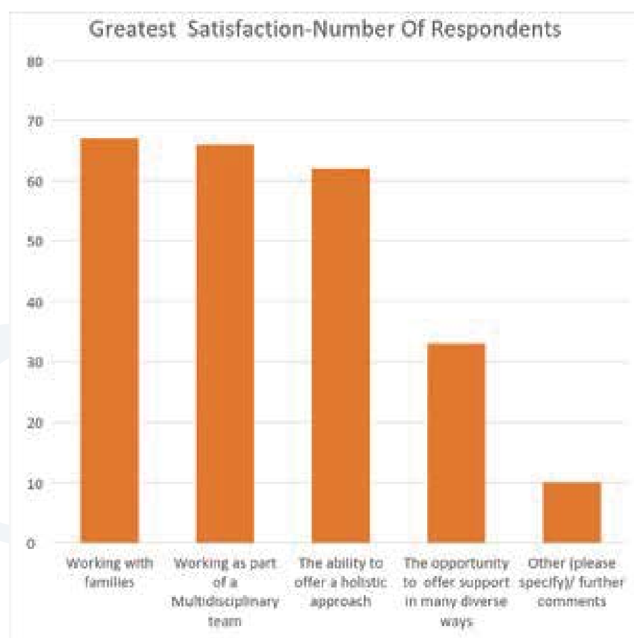
(Ranking questions calculate the ranking average for each answer choice so you can determine which answer choice was the highest ranked overall.)

Factors giving the greatest satisfaction - The top 3

Huge passion remains in the SAS Doctor. Working with families is said to be a source of job satisfaction. The holistic way of working remains a gold standard desire. The disappearing multidisciplinary team is a concern in some areas. On the other hand, some remain satisfied with the work environment and indeed having a lead role keeps interest alive.

Raw Numbers
- Working with families - 67
- Working as part of a Multidisciplinary team - 66
- The ability to offer a holistic approach - 62

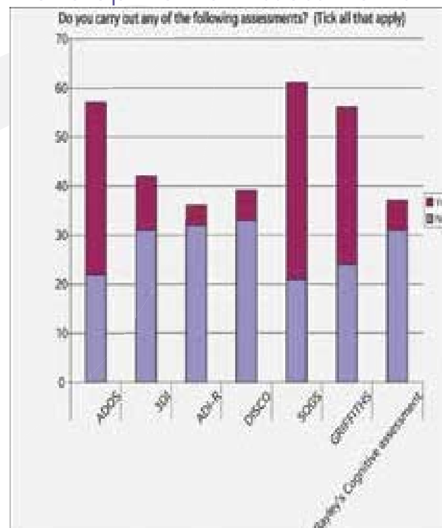
Weighted (rating) Averages
- Working with families - 1.64
- Working as part of a Multidisciplinary team - 2.08
- The ability to offer a holistic approach - 2.11



The Working week

The number of community clinics undertaken as well as total numbers of sessions of programmed activities (PAs) in a working week was also explored. It appeared about 50% of doctors surveyed had 4-6 community clinics; 40% had 1-3 clinics probably reflecting part-time working. Regarding programmed activities, 4-10 sessions were worked mainly with about one third working each 4-6, 7-9 or 10 or more sessions. Work in Audiology was noted in the comments.

Developmental Assessments



Regarding developmental assessments, there is variation in opportunity, training and use of these. Schedule of Growing Skills (SOGS), Autism Diagnostic Observation Schedule (ADOS) and Griffiths Developmental Assessment tool are most often carried out. Time constraints meant some were trained to carry out these assessments but were unable to do so. The transfer of specific Autistic Spectrum Disorder (ASD) assessment to a social enterprise was also noted in the comments. Other reasons noted for not carrying out assessments was an absence of a service for school-age children. A further comment noted the increasing expectation to assess cognition in children due to the reducing input by educational psychologists and hence a wish for time to do Griffiths assessments. Some SAS doctors are also carrying out Bayley's cognitive assessments.

Conferences, Study leave and Continuous Professional Development (CPD) opportunities

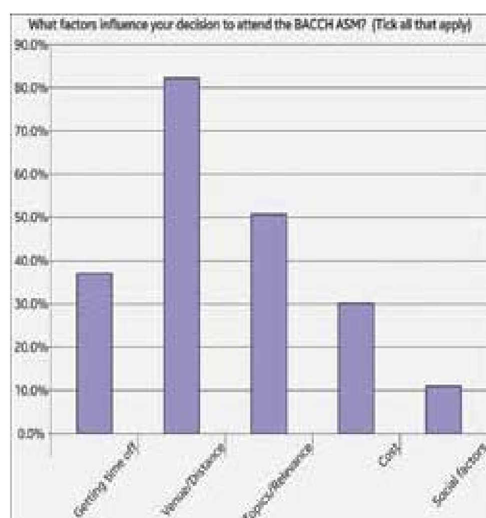
About 40% of respondents felt it was a fairly easy process to gain study leave. Difficulty with funding, reluctance to cancel clinics and absence of cross cover were also highlighted. Other factors included the pressure of work, logistics of travel, personal circumstances and local policy. The study leave approval process was also felt to take too long in some instances and places lost on courses as a result of this.

Other avenues are being employed to satisfy CPD requirement including e-learning, reading journals, case reflections, postgraduate courses and research.

The lack of rise with inflation regarding the allocated study leave budget was also highlighted. It was also noted that it was a struggle on the SAS salary to pay for courses. It appears an avenue to raise an invoice should be considered and be a more available option. Revalidation is also putting extra pressure on the SAS doctor and one comment noted achieving CPD requirement by attendance on non-working days.

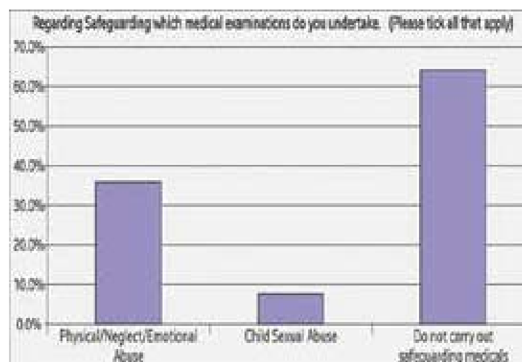
BACCH Annual Scientific Meeting-SAS Attendance

It appears attendance by SAS doctors has been dwindling over the last three years. 32% of delegates attending in 2012 were SAS doctors; this was down to 18% in 2015. The factors influencing attendance included the distance and cost. The relevance to practice was also highlighted in the comments by our Scottish Colleagues.



Safeguarding –Physical/Neglect/Emotional and Sexual (CSA)

64% of respondents did not carry out Safeguarding Medicals. Regarding Child Sexual Abuse, 7% are involved and 36% are involved in Physical/Neglect/Emotional Abuse. (The data as collected did not permit identification of those involved in both). On specific questioning surrounding Safeguarding examination for Physical/Neglect/Emotional Abuse, it appeared 69% do not carry this out and regarding Child Sexual Abuse, 94% do not carry this out. It therefore appeared that only about a third of SAS doctors were involved in safeguarding for Physical/Neglect/ Emotional abuse and less than 10% were involved in Child Sexual Abuse examinations.



The examination of siblings in safeguarding (physical/neglect/emotional) cases was also explored. This was carried out in 4% of cases at the same time as the index case, at the request of Children Services in 64%, in 17% of cases this was done at another appointment and in 13% examination of siblings was not offered. It appears from the comments this was flexible and the best time was advocated depending on discussions with children services. There was no obvious local policy in place.

The independence and autonomy afforded to the SAS doctor in safeguarding was also explored. Seeking advice was discretionary in 63% of respondents and a requirement by local policy in 37%. Experience varies across the country and some SAS doctors are given a chance to lead this discipline and offer advice to consultants in some areas.

The involvement of the SAS Doctor in CSA examinations remains minimal. Respondents (4) who carried this out related an autonomous practice (3) and a joint examination with forensic (1). In the comments made, joint examination is also practised routinely for CSA cases in some areas and not necessarily by a Consultant i.e. could be Associate Specialists or Speciality Doctors. In other areas only the consultant is permitted to carry out CSA examinations. This was noted to result in a loss of skill in a previously trained SAS doctor.

Regarding Safeguarding reports, the autonomy of SAS doctors was also explored. 24% of the respondents reported complete autonomy; 36% sought a consultant opinion if needed; while, 40% reported that a consultant review was essential before reports were sent out.

Special Interest Areas

The significant special interest of ADHD and ASD seemed to be in keeping with the explosion of frequency of these cases seen in recent times. Respondents were asked to choose all Special Interests that applied. It was interesting to note special interest in rheumatology and teenage health. General Neurodisability, developmental issues, educational welfare learning disability and Down's syndrome were also noted as special interests in the comments. Foetal alcohol syndrome was also noted as a special interest.

Personal/Special Interest Areas

- ASD-57%
- ADHD-43%
- Adoption/Fostering-28.5%
- Looked After Children-28%
- Hearing/Audiology-26%
- Other physical and Congenital anomalies-22%
- EBD-22%
- Mental Health-10%

 Continues overleaf

Other comments

Respondents were also given an opportunity to express freely other thoughts and concerns. It was most pleasing to note a reflection from one of our Scottish colleagues who stated that there were some things that were going well in their service - the managed clinical networks for complex needs and visual impairment. There is also a new legislation in Scotland to integrate health and social care and it is hoped that this will allow closer working with social services.

The increased stress and reduced job satisfaction by virtue of increased workload and reduced time was also noted. The pressure of work was felt to be a hindrance to carving out a niche. The lack of progression was also commented upon.

Good Community Child Health support and recognition was also noted. A further comment suggested encouraging retired Consultants to take up SAS posts in rural areas.

The SAS Representative Role

One of the survey questions sought to enquire on ways the SAS representative could offer support. Increasing CPD opportunities (1.69); developing advice on job planning (1.72) and offering targeted support in attaining Certificate of Eligibility for Specialist Registration (CESR) (2.11) were ranked as the top three. Other comments also suggested advertising CPD Courses appropriately as many were not members of the Royal College of Paediatrics and Child health (RCPCH). There was also a wish to promote reopening of the Associate Specialist Grade and increase recognition of the SAS grade. A suggestion to encourage further on-line CPDs was also proposed. There was also a request to support affordable realistic Supporting Professional Activity (SPA) probably by allocating adequate Direct Clinical Activity (DCA) time. Organisation of a SAS conference was also advocated in one of the comments.

Conclusions

It is evident that work load remains a huge concern. Time, pressure of work, increasing work expectations, as well as diminishing resources and available support are becoming increasingly significant. Multidisciplinary working is also disappearing and it is becoming increasingly difficult to carve out a niche and establish a special interest. Collaborative work with CAMHS remains difficult.

A significant number of SAS doctors do not participate in Safeguarding medicals and fewer still are involved in Child Sexual Abuse examinations. This may reflect the establishment of Sexual Assault Referral Centres (SARC) reducing the opportunity for SAS doctors to take part in CSA examinations. There is no established policy regarding examination of siblings in Safeguarding cases but local policies seem to be working well with discussions with Children's services. Safeguarding reports seem to be checked appropriately prior to sending out to other agencies. Peer review in safeguarding seems to be increasingly practiced with 1:1 and group peer reviews well established.

A number of SAS doctors have lead roles in their departments. There is a broad spectrum of work intensity across the country with some SAS doctors isolated and working in rural areas while many others report ever increasing pressure and time constraints. There is reduced Consultant support in some areas probably also stemming from time constraints.

There is a need to promote self-value and self-belief in the SAS doctor. Discretionary points were also removed in the new contract. It appears that an appropriate Job Plan may be the key.
The process regarding Certificate of Eligibility for Specialist Training (CESR) is said to be a laborious one, especially for British trainees. Study leave and attendance at conferences for CPD is hindered by distance, funds, application process and time pressure. Revalidation is increasing the pressure regarding obtaining CPDs.

The increasing special interest in Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactive Disorder (ADHD) seems to reflect the increasing numbers of cases seen at this time.
The significant input by our Scottish colleagues was most pleasing but different working models and legislation in England and Scotland was evident. They reported that there were things going well regarding complex needs, visual pathway and very well established internal CPDs. There is also a new legislation to integrate health and social care to facilitate closer working.

The way forward

The results of the survey afford a way to open a dialogue between colleagues, commissioning groups, clinical leads, appraisers, the Royal College of Paediatrics and Child Health (RCPCH), the British Medical association (BMA) and the government.
There is probably a need for increased awareness regarding the details of the present contract for SAS doctors, appraisers, supervisors and Clinical Directors/Leads.

Regarding advice on job planning and a sense of fulfilment, discussion with supervisors, appraisers and Clinical Directors/Leads may be a first step. The Royal College SAS section has recently incorporated advice on Job plans as well as mentoring support. There is also a 38-page document specifically for SAS doctors produced by RCPCH detailing training opportunities.

Regarding re-entering specialist training the GMC's opening lines regarding this relate that '*Applications for a CESR or CEGPR can be complicated and time consuming*'. There then follows a 167-page document on training in Community Child Health. The process also requires a significant financial commitment. It is however pleasing to note that many have embarked on and completed this process successfully.

Regarding increasing CPD opportunities, development of a targeted website of all CPD opportunities may be considered and registration of all conferences with a recognised body who in turn publish the courses.

Unfortunately, the fate of the previously specifically allocated government SAS fund is unknown and the study leave budget without this is yet to rise with inflation. I believe experience remains varied across the country as study leave allowance and opportunities remain dependent on local policy.

The British Medical Association (BMA) has also completed a SAS survey recently (2015) and the key findings related work pressures and giving up SPA time to fulfill clinical duties. Regarding questioning on the future of the grade 27% related a wish to re-enter the training programme and become consultants; 27% intended to retire in five years and 45% said they would not recommend the SAS grade career to colleagues.

The RCPCH and BACCH are also undertaking a workforce survey and I believe a systematic review of all the results would offer solutions and a way forward for our noble profession and for the SAS grade doctor in particular. Increasing recognition for SAS doctors remains the joint duty of the SAS doctor, colleagues, professional bodies and the government of the day. The SAS doctor is often the cornerstone of the department and performs a crucial role.

Acknowledgments:

I wish to express my sincere thanks to all my colleagues who took time to complete the survey.

I also wish to acknowledge the priceless support of Cliona Ni Bhrolchain; Gabrielle Laing and Isabelle Robinson.

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