BACCHNEWS

BACCH
British Association for Community Child Health

Mar 26

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The British Association for Community Child Health (BACCH) is an organisation representing professionals working in paediatrics and child health in the community. It is a specialty group of the Royal College of Paediatrics and Child Health.

BACCH welcomes new members!

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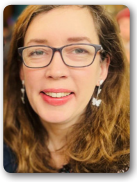

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From the Trainee Editors

Dr Ashra Omr

Hello all,

We are well and truly into 2026, and it feels like the rain and viruses just won't ease up. With spring just around the corner, we hope this edition brings a welcome touch of brightness to your day!

Recently, while watching Bluey with my daughters, a line stood out: 'Work on the heads later, for now, just hearts.' My eldest asked me what it meant, and it got me thinking.

To me, this phrase highlights the importance of nurturing both the intellect and the emotional wellbeing of children. While academic growth is valuable, teaching kindness, empathy, and emotional resilience is essential. Above all, children should be allowed the freedom to simply be children.

This belief is at the heart of community child health, and it's especially relevant in this issue. We're featuring several articles about CYPSAR: Children and Young Persons Seeking Asylum and Refuge. Every child deserves the chance to be a child, no matter their background, age, gender, ethnicity, or where they come from.

In this issue, you'll find inspiring articles on topics such as Project AEGIS, find out about initial health assessments for CYPSAR and a great summary of the intercollegiate document (2025) for safeguarding, among several other great articles.

Across the country, there's a fantastic number of projects happening and we're delighted to showcase some of the amazing work led by our colleagues.

We hope you enjoy this new issue! Please let us know your thoughts and we welcome your contributions for future editions.

Dr Ashra Omr
BACCH News Trainee Editor

From the Chair

As I sit at my computer and look out of my window, I see the first signs of the season changing. Birds are beginning to nest in our birdboxes, preparing for the new life and fresh beginnings that spring always brings.

It's a wonderful reminder that every year offers us the opportunity for renewal. And this sense of renewal is something we often seek in the work we do within the NHS as well. Year after year, we look for clearer, more effective guidance, hoping for positive change. But, as with the coming of spring, these expectations are often met with disappointment. However, this does not diminish our collective drive to improve and better serve the communities that depend on us.

This brings me to the role of BACCH, which exists to support you, our members, in advocating for the needs of children and young people, as well as to lobby governments to ensure that the wellbeing of children is always at the forefront of their minds. We all have a shared responsibility to ensure that the voices of children are heard, and that their health and development are prioritised.

As I mentioned in my last column, I'm pleased to report that we are making great strides towards integrating SACCH (the Scottish Association for Community Child Health) into BACCH. This is a significant and positive step forward, and it's exciting to see the collaborative potential it opens up for us all. Additionally, I'm pleased that this year's Annual Scientific Meeting (ASM) will be held in Wales, and I'm looking forward to seeing many of you there. It promises to be an inspiring event, full of opportunities for learning, networking, and sharing ideas.

However, I must also acknowledge that there are areas of the UK where BACCH has less of a visible presence. Northern Ireland, in particular, is one such region where our involvement is limited. If you are a member in Northern Ireland, and would like to become more involved, please do reach out. We are a national organisation, and our aim is to support members in all corners of the UK. We want to ensure that we are learning from the specific local issues that each region faces and reflecting this in our work and advocacy.

Turning my focus back to England, I'd like to update you on the current developments within NHS England. The organisation is working towards developing a core specification for community paediatrics, and I am actively involved in these discussions. Several key issues have already been raised, particularly around the balance between neurodiversity, safeguarding, and neurodisability. These are complex and nuanced topics, and I welcome your thoughts on them. If you have insights or concerns, please don't hesitate to email me. Personally, I feel strongly that we should not allow ourselves to be confined to a narrow 'neurodiversity' framework. While neurodiversity is an important area of focus, we must continue to be available to support children with a wide range of conditions that fall outside the 'acute' model. There is a lot more to paediatrics than just treating immediate or urgent cases, and it is crucial that we remain a resource for ongoing, holistic support.

Looking ahead, we are all excited for the upcoming Annual Meeting in Cardiff on 16-17 September. I truly hope you will be able to join us for this fantastic event. It will be a valuable opportunity to connect with colleagues, learn from experts in the field, and be inspired by the work being done across the country. Booking will open shortly via the BACCH website, and I encourage you to secure your place early.

In addition to the ASM, your Regional Representatives and the BACCH Executive will be meeting over the summer to discuss and evaluate BACCH's strategic plans for the next few years. We are keen to hear from you about what BACCH should focus on in the future, so please don't hesitate to share your views. Our organisation exists to serve you, our members, and through you, the children, young people, and families that we are all dedicated to supporting. Your input is vital to shaping the future of BACCH, and we want to ensure that our efforts are aligned with your priorities and the needs of the communities we serve.

As always, thank you for your continued commitment to the work of BACCH. I look forward to hearing from you and seeing many of you at the ASM. Together, we can continue to make a real difference in the lives of children across the UK.

Dr David Vickers
BACCH Chair

Children and Young People Seeking Asylum and Refugees (CYPSAR)

Cultural Curiosity in Healthcare: Learning from Work with Migrant Communities

Setting the scene – children and families forced to move

The topic of immigration remains prominent in the national discourse. Highly polarised narratives drive divisive media headlines and public debate on the risks and benefits of welcoming people into the UK. For those of us working with people seeking asylum and refugees (PSAR), anti-immigration narratives can be hard to relate to the lived experiences of those we meet who have fled conflict and violence.

By the end of 2024, UNICEF estimated that there were 48.8 million children displaced globally by conflict and violence[1]. In the Middle East and North Africa, 12 million children will have been displaced as of July 2025[2]. Here, the UK Home Office reports that 111,084 people (adults and children) had claimed asylum in the UK from June 2024 to June 2025[3], while the Department of Education reports that upwards of 7,000 unaccompanied asylum-seeking children are in care[4]. It is worth bearing in mind therefore – contrary to media declarations of excess – that the total number of those seeking asylum in the UK is a tiny fraction of the global refugee population.

As various global humanitarian crises develop and deepen, we can expect that these numbers will continue to grow. As health professionals, we must adapt to working in systems that care for people with vastly different cultural norms and expectations around healthcare. Many of us already work in teams committed to improving the health and wellbeing of PSAR through services attuned to their traumatic experiences. Here we aim to describe how our personal experiences of working overseas and in the UK have prompted us to further improve services through embedding cultural curiosity into clinical practice.

Culture – competence, curiosity and humility

Dr Rhys Elliott-Williams is a UK-based paediatric trainee who volunteered at Al-Germaniyya Hospital in Aswan, Egypt. Rebekah Hayes is a UK-based specialist infection and inclusion nurse who has worked in various contexts in the Middle East, including Yemen and Jordan. Reflecting on our work abroad, as well as in the UK, has made us increasingly aware of the impact that culture has on people's interactions with healthcare services and the importance of considering cultural context in healthcare encounters.

Culture, as described by anthropologist Ralph Linton, is 'the way of life of its members; the collection of ideas and habits which they learn, share and transmit from generation to generation.'[5] The Care Quality Commission defines cultural competence as 'being alert and responsive to beliefs or conventions that might be determined by cultural heritage'[6]. This may relate to how people describe their symptoms, understand their health or make decisions about treatment options. For example, in Somali populations there is significant vaccine hesitancy due to complex cultural views around autism and the MMR vaccination[7].

An awareness of cultural variability in health beliefs and behaviours is essential so that professionals can work with families collaboratively. Cultural curiosity, 'a commitment to understand and find ways to acknowledge the experience of a child and their family'[8], is critical to this process and should underpin the way we approach all conversations in health. We must all be aware that our own experiences of healthcare are rooted in our own culture and have the humility to ask questions about what other people expect and need from us.

We may assume that a person's experience of health services will automatically be better in relatively resource-rich places where facilities appear modern and better equipped. But our work abroad and in the UK has taught us that health and healthcare are more than just buildings and equipment. Health experience is often embedded in community and family settings, without long waiting lists or journeys to specialist centres. It is underpinned by knowing that there are people around you who will care for you with an understanding of your own cultural traditions.

Integration of lived experience into practice

So how can we practice cultural humility when working with children and families seeking sanctuary in the UK, and help children and families navigate a new system and cultural landscape?

It starts with considering our own cultural perspectives and being honest about how these may differ in a myriad of ways from the people we work with. It might look like taking time to ask questions about previous experiences of healthcare. We believe this offers an opportunity to confer dignity and value to people who have frequently been offered the opposite. It gives space for the voices of those who are the centre of our work to guide our practice, through open questions and a humble admission that there is much about their health experiences that we do not understand.

When designing and delivering health services in the UK, we must work closely with those whose own lived experiences differ vastly from ours. The opportunity to work alongside local people from within the communities themselves – for example local healthcare workers from marginalised Yemeni groups or doctors in hospitals in Egypt – has been invaluable in helping us navigate the cultural nuances we would otherwise have missed. By incorporating the expertise of those with first-hand experience of fleeing their homes and communities into the services delivered to them, we will be creating a health experience that puts the individuals at the very centre of their care.

What does cultural curiosity look like in practice?

- Being aware of your own cultural experiences, and how they may impact on the way you think, act and work with other people.
- Getting comfortable with asking questions that help explore another person's cultural attitudes to health, for example 'Are there any traditional practices or remedies that are important to you when it comes to staying healthy?'
- Actively seeking to include the perspective of people with lived experience in service design and delivery.
- Accepting you will never know all there is to know about every global culture – focus on learning, not knowing!

Conclusion

In our work across the Middle East and North Africa, we quickly recognised our lack of knowledge regarding the often-mystifying tapestries of the cultures around us. Both of us have felt the dramatic culture shock that accompanies leaving what is familiar, even with the close personal support of friends and co-workers. How much more daunting then is it to be newly arrived, often alone, in a country where it can seem hostility is the default public response to your presence? Cultural curiosity cannot erase the scars of being forced to leave your home, but it can help people feel seen and valued as fellow humans as they navigate a new and disorientating culture. Even a basic level of cultural competence can be transformative to people's experiences of healthcare.

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Safe Havens in Health: New Standards of Care for Children and Young People Seeking Asylum and Refugees

The Gateshead Experience

The child refugee and asylum service in Gateshead started in 2018, when a consultant paediatrician with humanitarian work experience noted a concerning pattern of late presentation of refugee children, including a child in epileptic status who ran out of medicines and was not registered with a GP. I started a pilot clinic, once every other week, offering comprehensive, one-stop health assessments that were based on existing literature, guidelines, and my own humanitarian experience. All referrals came though the TB nurse who also functioned as a specialist health visitor for migrants. Assessments included a comprehensive, trauma-informed history, a mental health screening (wellbeing questions, SDQ questionnaire), a thorough physical examination with WHO anthropometrics, and laboratory tests (infection screens, nutritional screen, haemoglobinopathy screen). Any identified health issues were directly addressed, or appropriate referrals to specialist or allied health professionals were made. A detailed letter with holistic recommendations covering the physical, mental, and social health of the child and their family would be provided to the family and their GP. There was no routine follow-up, but if secondary care health needs were identified, then follow-up was arranged.

A service data analysis of the initial cohort showed that refugee and asylum-seeking children had a high level of health needs, including chronic malnutrition, multiple micronutrient deficiencies, lack of vaccination, poor dental health, and unidentified or poorly managed chronic conditions. About one third had significant mental health and wellbeing issues (including depression, anxiety, and PTSD). Underpinned by these data, the local ICB commissioned a formal migrant health service based in a GP practice. The GP practice would receive referrals from housing providers, the voluntary sector, and other health services including local GP practices. Comprehensive health assessments were provided in the GP surgery, and a local hotel was used as asylum accommodation. The service would regularly run family assessment clinics jointly with a GP and a paediatrician in primary care – a first step to a genuinely integrated service. Whilst the primary care service continues, the hospital clinic closed in 2024 because hospital managers resisted its 'not formally commissioned' status, and the ICB would not commission it.

Why do we need guidelines and service delivery standards?

Refugees and asylum seekers face a high level of structural exclusion from the NHS due to multiple access barriers, which creates health inequalities. Patients often do not speak English, do not understand the functioning of the NHS, and have fears of being charged for services or being reported to authorities. On the side of the health system there is a lack of expertise in migrant health among many health professionals including GPs refusing registration (or if registered would not proactively offer a comprehensive assessment), a lack of interpreters, and GPs not having the time or resources to offer extended appointment times. Some services use 'opt-in' mechanisms requiring the patient to do a phone call or write an email (in English) to receive the service. These barriers create inequities for a population that is very vulnerable and has higher health needs than most of the resident population.

Among others, the Gateshead experience has informed the revision of the RCPCH guidelines in 2022, and the service delivery standards in 2025. The previous guidelines were very safeguarding- and unaccompanied children- focused, excluding the much larger number of accompanied children. Existing guidelines and national and international literature were combined with data and expertise from multiple sites in the UK. RCPCH recommends that children and young people seeking asylum and refugees (CYPSAR, previously known as Unaccompanied Asylum-Seeking Children or UASC) should be assessed early and comprehensively, and include a history, full examination and blood tests.

The guidelines have certainly enhanced the skills of paediatricians in the UK and have led to new initiatives. The observation of practice in the UK showed though that most health contacts of refugee and asylum-seeking children are not with paediatricians but with primary care (GPs, walk-in centres, health visitors, school nurses) or Emergency Departments, who would not routinely refer these children to paediatrics. Primary care professionals have different assessment formats which are not aligned with the RCPCH guidelines. In particular, WHO anthropometrics and blood tests for nutritional and infection screens are often not included. In many areas there is no latent tuberculosis screening for lack of TB service resources, whilst the UK has seen a concerning rise in TB cases which are to a degree associated with migration.

The new standards provide local services with guidance as to what provisions are essential, desirable and aspirational, rooted in the reality of limited resources but from the perspective of achieving health equality as intended by the RCPCH guidelines. More details are outlined below.

Continues overleaf

CYPSAR: Safe Havens in Health

Maria Marcolin on behalf of the ICHG Advocacy Joint Working Group

The International Child Health Group (ICHG) has recently launched the RCPCH-endorsed *Standards of Care for Children and Young People Seeking Asylum and Refugees (CYPSAR)* – a national framework to guide equitable, high-quality healthcare delivery across all paediatric settings.

This publication fufills a critical need by providing consensus-based recommendations for service delivery for CYPSAR, grounded in a rights-based framework aligned with the UN Convention on the Rights of the Child. Developed by clinicians and experts across paediatrics, public health, and child protection, these standards translate international obligations into practical guidance for everyday clinical care.

Why the standards matter

Children and young people seeking asylum or refugees are a diverse population often facing fragmented healthcare, trauma and structural barriers to access. Until now, there has been no consistent UK guidance on how services should respond to their complex needs. These new standards aim to close that gap, creating a benchmark for quality and consistency across different providers and acting as a lever to advocate for funding and commissioning of dedicated services.

Structure of the standards

The standards include bespoke frameworks for inpatient, outpatient, and emergency settings, recognising the unique needs, challenges, and opportunities in each setting.

Each framework is organised into three progressive levels:

- **Essential standards** – the minimum requirements that every service must meet to provide safe and equitable care.
  Desirable standards – best practice steps achievable through local planning and investment.
- **Aspirational standards** – innovative models for specialist or tertiary settings that demonstrate excellence and integration.

Each section aligns with six key domains of good practice:

1. **Access and environment** – inclusive registration, accessible appointments, professional interpreters, and recording of language preferences.
2. **Clinical care** – holistic assessment of physical, mental and developmental health needs, with culturally appropriate screening tools.
3. **Safeguarding** – staff trained to recognise trafficking, exploitation and migration-related vulnerabilities.
4. **Workforce training and wellbeing** – mandatory education on entitlements, trauma-informed care and cultural competence, supported by reflective supervision.
5. **Coordination and continuity** – clear referral pathways and information sharing between primary, secondary and voluntary sectors.
6. **Service leadership** – each service designating an *inclusion health champion* to oversee implementation and drive improvement.

Moving forward

The standards provide a practical audit tool for clinicians, commissioners and policymakers to understand current practice, support resource allocation, and prioritise policy for CYPSAR. This process must center on CYPSAR themselves, to ensure equitable access, experience and outcomes for CYPSAR.

Read the standards: *internationalchildhealthgroup.org/cypsar-standards-of-care*

Get in touch: *maria.marcolin@nhs.net*

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Reference

Moore Y et al. *Safe Havens in Health.* Arch Dis Child 2025; 110: 768–772.

Project AEGIS

Redefining Care for Children and Young People Seeking Asylum and Refugees (CYPSAR)

Project AEGIS

AEGIS team, 2025

Migration is part of our shared human story – people have always moved in search of safety, opportunity, and hope. But in recent years, that movement has grown dramatically due to armed conflicts, climate change, and economic hardship. In the UK, the number of people seeking asylum is now at a record high. In the year ending June 2025, 19,466 children and young people claimed asylum[1] – similar to the number of children admitted with asthma in England and Wales in a year.[2] Of these, 3,553 were unaccompanied (CYPSAR-U) – comparable to the number of children living with cystic fibrosis in the UK.[3]

CYPSAR face overlapping challenges that affect their wellbeing. They have unmet health, social, educational and safeguarding needs, with consistently high rates of mental and physical health problems.[4]

However, significant disparities exist in the availability, quality, and accessibility of NHS services for them.[5] Additionally, there is scarce research that asks CYPSAR directly about their experiences or priorities. We know too little about what 'good care' looks like to them.

Project AEGIS is working to change that.

Putting CYPSAR at the centre

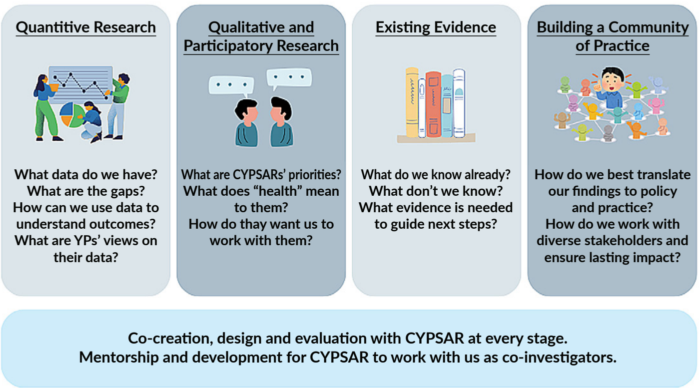
AEGIS (Advancing Equity for Children and Young People seeking asylum and refugees – a blueprint for Generalisable InterventionS) is a research project hosted at University College London Hospitals in collaboration with the Royal College of Paediatrics and Child Health and academic, clinical, policy and advocacy partners across the country*, currently funded by an NIHR Programme Development Grant. We convene expertise across health, education, social care, law, economics, and policy, alongside the voices of CYPSAR themselves, to better understand and deliver healthcare for CYPSAR – and ultimately learn how to reduce inequity for children and young people more broadly.

What makes AEGIS stand out is its starting point. Rather than assuming what CYPSAR need, we take a step back and ask them directly: What are your priorities? What does health mean to you? What does good care look like? How would you like us to work with you?

We are acutely aware of the barriers faced by CYPSAR in healthcare and research participation: language differences, digital exclusion, geographical isolation, and mistrust of institutions. The project actively works to reduce these barriers. We offer interpreters and provide online and in-person options for engagement. Beyond that, we're developing methodologies based on their preferences, exploring how they would like findings to be shared, meeting them in their own spaces, and supporting them to become peer facilitators. The process is fundamentally about relationship-building with CYPSAR – and we've learnt a lot along the way.

Our mixed-methods approach

AEGIS is structured around four main themes, each offering a different lens on social and health issues affecting CYPSAR.



Quantitive Research
What data do we have?
What are the gaps?
How can we use data to understand outcomes?
What are YPs' views on their data?

Qualitative and Participatory Research
What are CYPSARs' priorities?
What does "health" mean to them?
How do thay want us to work with them?

Existing Evidence
What do we know already?
What don't we know?
What evidence is needed to guide next steps?

Building a Community of Practice
How do we best translate our findings to policy and practice?
How do we work with diverse stakeholders and ensure lasting impact?

Co-creation, design and evaluation with CYPSAR at every stage.
Mentorship and development for CYPSAR to work with us as co-investigators.

AEGIS workplan

1. Quantitative research: looking at the bigger picture

At a local level, we're looking at short-term outcomes from CYPSARs' initial health assessments. We're exploring what data is available, what is not, and why. We also want to explore how CYPSAR feel about the data. Nationally, we are exploring how CYPSAR are (or are not) represented within datasets covering health, education, and social care outcomes across England.

The goal is to inform future research by identifying patterns (for example, in vaccination coverage) and to reflect on the data itself.

2. Qualitative and participatory research: listening and learning from CYPSAR

We've engaged with CYPSAR through interviews and focus groups to hear from them what's helped, what hasn't, and what health means – in their own words. Furthermore, we're involving them in the analysis of these findings using interactive 'data clinics', asking what they think the data really means. Their insights make us think beyond our assumptions and shape our next steps.

A big part of this process is co-design. We're asking CYPSAR how they want to work with us. What methods feel comfortable? What kind of space facilitates open conversations? In response, we're developing creative engagement methods – from visual tools to storytelling and art-based activities – that make participation more accessible and meaningful.

Looking ahead, we're co-producing a co-investigator role with CYPSAR, supporting the development of the competencies to be recognised as leaders in research.

3. The evidence: learning from what's already known

We're working with collaborators to review existing evidence on specific health outcomes and models of care. This includes examining areas such as vaccination coverage, sexual health, nutrition, and mental health, as well as best practices for service delivery.

Mapping what's already known (and what isn't) helps situate our primary research within a broader context. It also informs practical recommendations for service providers and policymakers.

4. Building a community of practice: from research to action

Perhaps the most crucial element of AEGIS lies in its stakeholder engagement and policy translation work. The project has convened a multisectoral community of practice across disciplines to share experiences and co-develop solutions. This network extends beyond health to include practitioners from education, social work, youth advocacy, the legal sector, the third sector, and policy.

Early insights and next steps

Common themes are emerging across work packages, including the need for continuity of care, trusting relationships with professionals, and greater cultural sensitivity in health services.

Data also points to the importance of education and community engagement as protective factors for wellbeing. CYPSAR want to learn, be autonomous and have a prosperous future. Schools, youth centers, and community organisations are key for health promotion, support and integration into society.

We've also identified evident gaps – where services fall short, where data is missing, and where research has yet to reach. These insights help point the way for policymakers and researchers to focus resources where they're most needed.

Hearing from you!

We're gathering information through an open survey to map initiatives working with CYPSAR across the UK and across sectors. We want to identify areas of good practice, potential gaps, and opportunities for collaboration.

You're also welcome to register your contact details to join our growing community of practice.
QR codes overleaf.

Continues overleaf

Survey
Mapping existing interventions for CYPSAR:
Do you work with CYPSAR in health or another way?

Join our stakeholder list:
Share your contact details, skills and interests

Long version

Short version

Survey and contact QR codes

Learn more: ***https://www.rcpch.ac.uk/resources/project-aegis***
Contact us: ***uclh.aegisproject@nhs.net***

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A Conversation on Youth Displacement, Identity, and Mental Health: Perspectives From Those With Lived Experience

Introduction

The experience of displacement and its impact on the mental health of children and young people who are seeking asylum or refugees (CYPSAR) is often explored clinically through pre-determined frameworks and constrained by limited time and resources. Young people are frequently the subject of conversation in policy and clinical spaces, but are rarely active participants in dialogue-building. Their voice is often lacking from the discourse that shapes decision-making.

We are two young people with lived experience of childhood displacement and resettlement, now working and studying in the human rights and migrant health sectors. Our dialogue is grounded in our experiences as 'insiders' with lived experience and also as 'outsiders' working professionally in this area. We explore our own experiences of displacement and its relationship with identity and mental health in our conversation. This conversation is our own; it cannot represent the countless nuanced and complex experiences of youth displacement. We offer our own personal reflections to help practitioners better understand the factors that may influence trust and engagement in mental health services for those children and young people who have been displaced.[1]

Key Points:

- **Identity:** Children and young people experiencing displacement often navigate dual identities and may act as cultural translators for their communities, often giving them a distinct experience in society, which may come with challenges as well as opportunities.
- **Trust:** Familiarity and cultural sensitivity enable practitioners to build a safe clinical 'world' where young people who have experienced displacement can speak openly about their concerns.
- **Mental Health Engagement:** Those who have experienced displacement from other cultures may experience mental health and its discussion differently from others. Stigma, limited understanding of legal rights, and lack of mental health vocabulary can hinder access to care. Culturally sensitive and gradual approaches are needed.
- **Capacity building:** Direct engagement with migrant communities builds trust, while cross-sector collaboration is critical to address complex needs.

The following conversation has been edited for clarity and brevity.

Maryam: When you think back to your early years of resettlement, what psychological, emotional, or mental health adjustments did you experience?

Motaz: I think most people would agree that when you go into a new environment, you start from 'below zero' in terms of connections. It takes time to find the right spot where you can fit in and to understand that this is where home is now. Most people, in the first few months, face homesickness. They say, 'Back in my country, we had this and that, so I am not used to this system.' When you compare the same people, after a year or two, you start to find the ice melting. You start seeing integration and contribution. You start to see people trying what they really enjoy. It's the same when you move from school to uni. You try to figure out: What should I do? Who am I?

Maryam: Absolutely, especially as a young person. It's already a time when you're asking yourself those questions. For me, the biggest psychological adjustment was realizing that the adults in my life were also navigating this new system. I came to the States when I was five. I started school in America. My gut reaction to the homesickness was to turn to my family. I thought, 'Certainly, they'll know the answer?' But we were all figuring it out. So as a child, you have this strange experience where you become a translator for the adults around you. You do not just translate the language, but the culture you pick up.

Motaz: It's funny you mention that, because I think in that state you start feeling like you are the bridge between your own country and the new country. You are a translator not only for your parents but for yourself as well. You are at this stage where you are very flexible. Anything can shape you. You did not grow up in your home country or your new home, so you do not have established roots in either place. Which is good and bad. Sometimes, you don't fit in. It feels like you have two personalities. This constant back-and-forth can affect your wellbeing and mental health, shaping how you experience and react to stress and uncertainty. I drink tea in the afternoon, but I have coffee with dates in the morning, that is also me. It's special to mix both cultures. It takes a while to understand that I am both faces of the same coin. I can be Arab-British, have both my Britishness and Arabness.

Maryam: Absolutely. When you are a kid, you have an instinct to fit in. But it's not until you get older that you realize, 'Wait, I think I actually got the best of both worlds.' You really do have the ability to bridge and analyze both cultures. And with political tensions so high, we need more of those bridges. But it can feel like an uphill battle. At just 8 years old, I found myself fighting the harmful stereotypes present in the media. It was exhausting. When you are in a new country, you feel the psychological weight of your identity daily. This fundamentally affects your mental health, how you trust authority, process emotions, and how you speak about your needs.

Motaz: Of course, if you grow up feeling judged, you carry that into every space, including the clinic. A child should not be expected to explain that they are not a bad person because of the picture drawn by the media. I think that is one of the big issues – in America and in the UK, particularly now – society expects migrants to explain themselves. Because there is already a very well-established picture of what you should look like and who you are. You can be a great person, but whether you like it or not, you are assigned to a negatively perceived group. So you need to put in extra work to prove yourself. There was an article I read that said third culture kids often need to work more than their peers to prove themselves.

Maryam: I appreciate you saying that. As migrant kids, we are often placed in a position where our new community, peers, teachers, etc., are both the judge and the jury. We have to prove ourselves every day. As a child, I remember my teachers in school speaking to me as if I did not understand what was happening. I did not know the word racism, but I knew what it felt like. Even when I knew the answer, I did not feel comfortable raising my hand. There's this idea that children do not know what is going on around them, but it is the opposite; they are uniquely attuned to their environments, they just do not have the vocabulary to explain. **I'm curious, do you think the adults around you, teachers, practitioners, social workers, understood the weight you were carrying?**

Motaz: As you mentioned, most kids would know what it is like to be discriminated against; they just can't name it. It does not mean it does not exist; they feel it deeply. It impacts their mental health, especially their self-esteem and emotional resilience. There are so many stories of kids going to school, and because one teacher said they were not good at a subject, they start to believe it. They think that because they were born overseas, they cannot learn English in the way others can. In the early stages, their personality is still developing, and they are still figuring out what they are good at. And these ill-informed people do not understand how harmful their assumptions are.

Maryam: Yes, they internalize it.

Motaz: That is why, for example, we are trying to do workshops for teachers and practitioners in clinics, teaching them those blind spots and how they impact children's mental health and emotional development. It can happen intentionally, but most of the time it is unintentional. Your teacher may not be evil and racist; they are probably just unaware. How do we educate those adults (teachers, practitioners)? Also, how can we equip kids with the right tools to spot and call out this stuff? To understand that they are more than what people think of them. As a third culture kid, you will have so many assumptions made of you, and if you are hit by every single one, you will probably break down.

Maryam: Absolutely. And navigating identity, stereotypes, and the need to prove yourself impacts how you internalize and cope with stress. So these early experiences fundamentally influence how young people later engage with mental health services. If you grow up in a constant state of defensiveness, it changes your willingness to open up to professionals. So teaching practitioners how to speak to children is incredibly important. I really appreciated that in the clinics I visited at UCLH, staff spoke directly to children, not their parents. Knowing that the doctors are there to talk to you, not around you, is powerful. It recentres the child. This really highlights why trust building in the clinic is so important. People may be hesitant to share health concerns, particularly mental health concerns, out of fear of the Home Office. Without safe spaces to discuss emotional needs, young people may struggle to access mental health services. This means that doctors need to become world builders, showing patients that the rules that govern their interactions are fundamentally different from those that define government offices. Here, there is no surveillance and judgment. There is safety in the clinic, allowing for productive conversations that lead to an individualized treatment plan. But they cannot do that in one sitting. That takes time, often a limited resource for both practitioners and CYPSAR.

Motaz: I agree, trust is the most important thing. And familiarity is the key to trust. Familiarity not only with the doctor but also with the translator. The more I see your face and hear your voice, the more I trust you to speak with me about sensitive topics like mental health. You cannot get the clinical information you need from the Home Office. That is a government space. As you mentioned, people are coming from that scary world. So when they come to a practitioner, they need to be in a new world. I love the word you used, world-builders. They need to make you feel safe, in another world. Both sides win, doctors do a great job, and patients get the right care.

Maryam: Absolutely. And that becomes especially important when considering mental health concerns. Because so many migrants are skeptical of mental health services. There's a hesitation there. Mental health is considered very taboo in some cultures. There is little understanding of preventative mental health services. So when a doctor suggests seeing a therapist, you feel the need to insist you aren't crazy.

Motaz: Yes. What you hear is, 'Hey, do you want to go to the asylum?'

Maryam: Right. And in some cases, slowly breaching the topic is better than directly asking. Maybe give the patient a handout to read later. This gives the patient time to process their feelings and decide for themselves how to continue. In your experience, what mental health considerations have you noticed among CYPSAR?

Motaz: With physical health, you can do examinations. But with mental health, it is solely information coming from the patient that would give information. There are symptoms, yes, but they may not be clear until they are explained. So mental health should be mentioned carefully. There are three main concerns for many people who are seeking asylum regarding mental health. First, will this impact their asylum case? They might think that if they are suffering from mental health conditions, it will impact their asylum claim. Secondly, the people who have children may feel scared that their children may be taken away by social services. Which, again, if you understand the law, is unlikely. But people get scared. Thirdly, and most importantly, people do not have the vocabulary to talk about mental health. They are asked, 'do you feel sad?' but they may not know what that means or how to explain.

Maryam: Right, there might be a 'why even test it?' mentality. **Given those concerns, how can we better approach mental health among CYPSAR?**

Continues overleaf

Motaz: First, you need to build trust before directly addressing mental health. Once you have their trust, patients will answer questions without fear that the information will somehow affect their asylum claim. Secondly, practitioners should explain that seeking support for a mental health condition is acceptable, reasonable and will not in itself jeopardise safety, security, or family, and that there are processes to ensure this. Lastly, patients should be educated and equipped with the necessary vocabulary to talk about their mental health. Without this mental health vocabulary, young people may struggle to express their needs. Therapy cannot be a question/answer; it needs to be a conversation. The best therapists ask the same question in many ways to get the full context of the patient's experiences. Therapists empower patients to express how they feel by putting their feelings into words.

Maryam: Beautifully said. Laying a foundation of trust, knowing your legal rights, and building a strong emotional vocabulary are all great starting points. People need to know it's okay to not be okay. Importantly, practitioners must also be culturally sensitive because 'healing' looks different across the world. Physicians should give people the agency to talk about their mental health however they see fit.

Motaz: Absolutely.

Maryam: I would love to know, how has your own experience of resettlement shaped how you look at your work?

Motaz: I have been privileged to work with others seeking asylum. My background helps me understand their experiences. There are two ways to know something. First to experience it. Second, to talk to someone who experienced it. There are incredible people with lived experience who want to contribute to the sector.

Maryam: I have had a similar experience. As I entered the migrant healthcare sphere, I noticed that sharing a cultural background with patients is a great asset. It can speed up the process of trust building. For example, a conversation that might have otherwise taken me several months might take a few weeks simply because I speak someone's language or dialect, share someone's religion, or simply look like them. There are cultural references that I can make to help someone feel at ease. That has been my favorite part of the transition from the classroom to the clinic. You really do become the bridge. Having lived experience allows you to communicate not only across language but, more importantly, across cultures, helping patients feel safe in sharing their physical and mental health concerns. I was that kid in the clinic in a new country, so if I can make someone else feel more comfortable, that means the world to me.

Motaz: Yes, it is those cultural microreactions that allow you to make a difference.

Maryam: With that in mind, how can practitioners build trust and meet the mental health needs of young people experiencing displacement?

Motaz: The best thing practitioners can do is learn from the experiences of patients. For example, volunteer with local charities to build community. Set up a table with biscuits, bring people together, and let them have a conversation. And if you do not have the privilege of that time, the next best thing you can do is read. Reading books about third culture children and migrants. Books give you a deep understanding of the struggles someone faced moving. These changes help practitioners understand both the cultural context and the mental health challenges their young patients face.

I still remember one of the nicest nurses I ever met. He told me he lived in an area with a lot of migrants and knew about the Friday prayer. I told him about Arab culture and being Muslim in the UK. It was such a lovely conversation, I even forgot about the appointment. He built that trust in just one appointment. So, as you mentioned, sometimes just being familiar with the culture will let you do in one visit what might otherwise take months. You can build that relationship more easily if you engage with the community.

Maryam: I agree, participating in the community is the best way to build that trust. But once you have that, I think the next step is connecting with other networks of support. For example, at UCLH there are monthly meetings across sectors to discuss difficult cases, bringing together doctors, social workers, teachers, and mental health experts. These monthly meetings address not only physical and educational needs, but also the overall psychological wellbeing of the child. Individual care won't change the system, but having teams of professionals collaborating across disciplines does.

Doctors are in a unique position to facilitate this cross-sector relationship building. With the patient's consent, these interdisciplinary discussions can directly combat the dangerous fragmentation of the UK healthcare system. Although it seems this is currently reserved for the most difficult cases, this approach should be the gold standard. I know doctors are overworked globally. But if every professional can do their part, with the support of experts across sectors, we might just see the development of a more dignified healthcare system.

Motaz: Absolutely. I am a big advocate of connecting people and sharing best practices. That is the ideal solution. For example, if doctors had one day to go out and connect with the community and other professionals, that would change the healthcare system. Because you will not only be more informed about the community's physical and mental health concerns, but also have the knowledge, skills, and support to solve them. Health professionals engaging with the community and across-sectors is not a luxury; it is a necessity.

Conclusion

What emerges from our conversation is simple: trust is the foundation of care, and we must build a system that cultivates it. The lived experiences and complex identities of CYPSAR fundamentally reshape how they understand and approach mental health services. Practitioners must therefore build trust through consistency, familiarity, and community engagement, creating spaces free from fear and mistrust. Cross-sector collaboration combats an otherwise siloed system, strengthening the delivery of care and providing much-needed holistic support. Key questions remain: How can we empower young people to articulate their mental health needs and participate actively in their care? How can practitioners build trust quickly yet meaningfully? How can professionals collaborate across disciplines to address complex needs? These questions can feel overwhelming, but deliberate choices – inside and outside the clinic – can transform our strained systems of care into ones that uphold dignity and compassion. In this pivotal moment, we are all called to reconsider how we show up for those we serve. How will you respond?

About the Authors

Maryam Badr is a recent graduate from Wesleyan University, now completing a year-long independent research project through the Thomas J. Watson Fellowship. Her project, titled 'Health in Transit: Navigating Care in Displaced Communities,' bridges her Pre-Medical academic background with her lived experience as an Iraqi-American. Her work examines how healthcare and immigration systems intersect to shape relationships between social actors – healthcare workers, legal experts, and displaced communities – as they navigate complex networks of care and policy. Maryam has been working with the AEGIS Project and the UCLH Respond service as part of her Fellowship. *Email: mbadr@wesleyan.edu*

Motaz Amer is a university student at the University of Glasgow and has lived experience of seeking asylum. Alongside his studies, he works in the refugee and migration sector and serves as a New Scots Advisor to the Scottish Government and as a Young Advisor to the UK Home Office. His work focuses on human and social rights, with a specific focus on youth participation, refugees and migrants, and the structural factors shaping mental and physical health outcomes for young people seeking asylum. *Email: motaz.am@outlook.com*

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1. The authors acknowledge that many CYPSAR, particularly those who are unaccompanied, may have experienced additional factors affecting their mental health beyond those discussed here, including family separation, torture, sexual violence, and poverty. These experiences may lead to severe and disabling mental health challenges. This dialogue focuses on identity, trust, and engagement in care while recognising these realities.

Animal Bites in Migrant Children: Are We Asking the Right Questions?

Introduction

A healed dog bite was identified during the initial health assessment of a young person seeking refuge and asylum (CYPSAR: Children and Young Persons Seeking Asylum and Refuge). The injury occurred during the child's migration journey to the UK. Subsequently, the child needed rabies vaccination for post-exposure prophylaxis.

This prompted a reflection on CYPSAR health assessments. While existing guidance (e.g. RCPCH) emphasises infectious diseases and safeguarding-specific enquiries, targeted questions about animal bites are not routinely included.

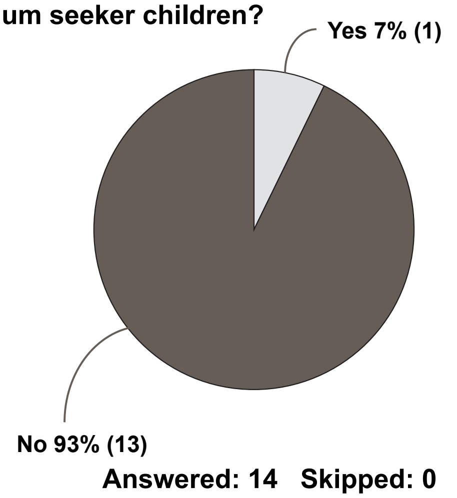
Why do we need to ask this?

Animal bites acquired abroad require a careful risk assessment for rabies and tetanus, following Public Health England (PHE) guidance[1]. Since 1946, the United Kingdom has recorded 26 rabies cases, all of which originated from outside the country.[5]

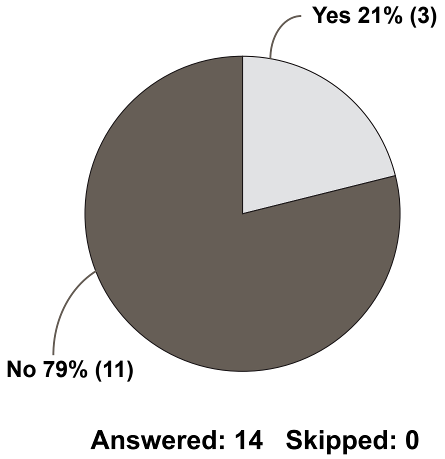
CYPSAR often undertake lengthy and perilous journeys. This might also involve travelling through jungles and being exposed to elements of nature, including wildlife. They are often exposed to torture and violence, including being pursued by border authorities and security personnel using dogs.[8,9]

A short survey undertaken in the BACCH (British Association for Community Child Health) community paediatric registrars' forum, consisting of 200 doctors, with responses received from fourteen doctors (7%), revealed that enquiries about animal bites are not done routinely as part of the CYPSARs' initial health assessment. None of the respondents encountered children who reported having been bitten by animals during their journey.

Do you routinely ask about animal bites during the initial health assessment for unattended asylum seeker children?



Are you aware of the pathway (RIgs)/UKHSA to get advice about potential rabies exposure?



Clinical Significance: Infection and Trauma

As rabies is nearly always fatal, it is important to treat even minor bites seriously when they occur in countries with a high risk of the disease.[3] The vast majority of human rabies cases, around 99%, are the result of deep bites from infected dogs. Nevertheless, contact with other animals such as cats, bats, foxes, raccoons, skunks, jackals, wolves, primates, and even rodents can also transmit the virus to humans.[6]

Any warm-blooded mammal or bat – even those that appear healthy – can potentially carry and transmit rabies. Exposure to vaccinated animals should still be assessed, as transmission remains a possibility. In general, carnivorous species of animals pose a higher risk of transmitting the virus to humans compared to herbivores, such as cattle, horses, or deer.[6]

Rabies symptoms typically appear within three to twelve weeks, but they can also present after a few days or not for several months or years. Symptoms include numbness or tingling at the bite or scratch site, hallucinations, feeling very anxious or energetic, difficulty in swallowing or breathing, and paralysis.[7]

When administered properly and without delay after exposure, post-exposure treatment (PET) with the rabies vaccine – either alone or in combination with rabies immunoglobulin (HRIG) – is highly effective in preventing the onset of the disease.[6]

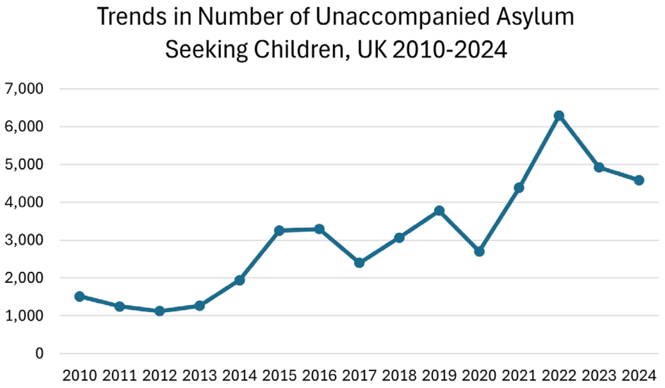
Continues overleaf

Since rabies can have a lengthy incubation period, there is no definitive time limit for initiating post-exposure treatment (PET). All suspected exposures should be evaluated based on risk, considering factors such as the animal involved and the rabies status of the country where the incident occurred. Even if more than a year has passed since the exposure, the vaccine can still be given, although rabies immunoglobulin (HRIG) is typically not recommended. In such cases, expert guidance from the Rabies Immunoglobulin Service (RIgS) should be sought.[6]

In addition to managing the immediate risk of infection, paediatricians should also consider the psychological effects these injuries may have on children.[1,2]

A dog attack, especially amid forced displacement, can exacerbate trauma and mental health challenges. Psychological effects are frequently experienced but remain understudied and are often neglected.[1,2]

Studies reveal a variety of disturbances, including post-traumatic stress disorder (PTSD) [2], dog phobia, nightmares, anxiety, and avoidance behaviours[2], which can persist for months[1,2]. This impact extends to carers[1,2]. Psychological treatment is insufficiently recorded or offered[2].


Trends in Number of Unaccompanied Asylum Seeking Children, UK 2010-2024

Why This Matters Now

Asylum applications in the UK reached a record high in 2024, with over 100k claims – more than double the typical annual figures from 2004 to 2020. The number of unaccompanied children has also increased significantly over this period (see plot). As a result, clinicians are increasingly likely to care for children and young people seeking asylum[10].

Recommendations

- Incorporating specific questions about animal bites into standard CYPSAR assessment templates to gather thorough history, reveal injury patterns, and highlight safeguarding concerns[1,4].
- Liaising with local Health Protection Teams or UKHSA for post-exposure protocols[1,3].
- Considering both physical and psychological sequelae when planning care and referrals[1,2]
- Raising awareness of this issue could help ensure more holistic, multidisciplinary care for this vulnerable population.

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Clinical

Dystonia – an overview of assessment and management

Introduction

Dystonia has been defined as ‘a movement disorder characterised by sustained or intermittent muscle contractions causing abnormal, often repetitive, movements, postures, or both. Dystonic movements are typically patterned, twisting, and may be tremulous.’ [1] Exacerbation with voluntary action is a hallmark feature and symptoms are often affected by factors such as emotions and effort.

Dystonia is frequently seen in paediatric neurodisability but is likely under-recognised.[2] It can have a significant impact on quality of life (see figure 1).

This article does not cover status dystonicus, which is a medical emergency.

Classification

A 2013 international consensus described classification by clinical features (age at onset, body distribution, temporal pattern, coexistence of other movement disorders, and other neurological manifestations) and by aetiology.[1]

Aetiology is described as:

1. **Inherited** – proven genetic condition (relatively rare[2])
2. **Acquired** – known specific cause such as brain injury, infection, haemorrhage, metabolic or autoimmune disease or drugs/toxins.
3. **Idiopathic** – unknown cause[1]

Diagnosis

Presentation varies widely, and recognising dystonia is further complicated by the broad range of underlying causes and overlap with other movement disorders. It is a clinical diagnosis and recognising key features in the history and examination is important, whilst eliminating other conditions, including functional presentations.

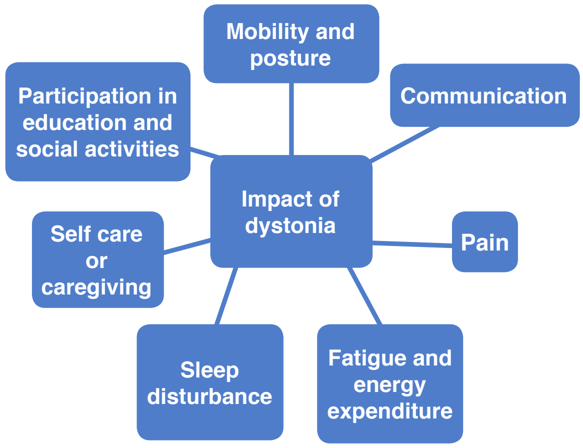

Figure 1: Impact of dystonia

Key points in History

- Abnormal postures and involuntary movements
- Movements are usually repetitive and predictable
- Movements typically stop during sleep, although sleep is still commonly impaired, for example due to insomnia or painful posturing
- **Focal dystonia** affects one muscle group e.g. hand cramps, twisting movements of the neck or body, blepharospasm, dysphagia or dysphonia[1]
- **Segmental dystonia** affects two or more contiguous muscle groups e.g. blepharospasm with lower facial involvement[1]
- **Generalised dystonia** affects the trunk and at least two other muscle groups[1] resulting in motor impairment
- Factors which induce or exaggerate symptoms such as emotions, voluntary actions, illness

Examination

- Spasticity can be difficult to distinguish from dystonia and the two co-exist in a third of cases[2]
- Dystonia is a *non-velocity dependent* increase in tone i.e. there is resistance to passive stretching even at low speeds; spasticity is velocity dependent
- Fluctuating tone may be seen with repeated stretches
- Tactile stimulus or voluntary movements may trigger the movements or posturing

Investigations

- MRI brain is usually indicated and can aid with understanding aetiology. It is worth noting that a small number of children with cerebral palsy have a normal MRI but some of these will likely have genetic causes.[3,4]
- If there is no clear cause in the history, genetic and metabolic investigations are indicated. Some conditions may be treatable or modifiable with drugs or diet.[2]
-

Management

Management can be challenging, in part due to a lack of high-quality evidence to guide treatment options.[2]

Treatment should be aimed at reducing abnormal movements to improve functioning and quality of life.

General principles

- Therapists should be involved with goal setting as well as optimising factors such as positioning, seating and communication
- Identify and address triggers such as constipation, reflux and pain

Oral/Enteral medication

Benefits of enteral medication are often limited, and side effects can significantly affect quality of life. It is recommended that medications are trialled with a review of response and only continued if there is symptomatic benefit, taking into account the child and family's goals.[5] A combination of drugs may be necessary.[6]

Baclofen – GABA-B agonist, will affect all tone and some benefit has been seen for children with spasticity and dystonia.[5] Side effects include loss of axial tone, drooling and central nervous system side effects such sedation.

Trihexyphenidyl – Anti-cholinergic drug, may be more beneficial for children with isolated dystonia and sialorrhea.[5] This is often well tolerated but can have anti-cholinergic side effects.

Gabapentin – Calcium channel blocker, benefit has been shown in children with cerebral palsy and severe generalised dystonia[5] and improving mood and sleep.[6]

Benzodiazepines – GABA-A agonist, may be particularly helpful in specific situations such as short-acting diazepam used for dystonic spasms after surgery or long-acting clonazepam used for painful posturing affecting sleep.[5]

Clonidine – Alpha-2 adrenergic receptor agonist, has also been shown to have small benefits in children with cerebral palsy and dystonia. Side effects include hypotension and bradycardia. Particular care should be taken during weaning to avoid a withdrawal syndrome.[5] Clonidine can also be given transdermally.

Levodopa – Dopamine precursor, can be used in the assessment and treatment of suspected dopamine-dependent dystonia, a rare genetic disorder.[5]

Tetrabenazine – Dopamine depleting agent, used for rapid hyperkinetic movements and may worsen spasticity.[5]

Injections

Botulinum Toxin A - Inhibits acetylcholine release into the neuromuscular junction, used for focal or segmental dystonia. Side effects include transient weakness and flu-like symptoms.

Neurosurgical options

Intrathecal baclofen – Intrathecal administration allows higher doses to be used with fewer peripheral side effects, and it should be considered for children with severe dystonia who do not respond to other medication. There is a moderate risk of complications and compliance with follow-up is important for pump maintenance.[5]

Deep brain stimulation – Effective in selected cases. Benefit has been seen particularly in children with dystonia and choreoathetosis.[5]

Summary

Dystonia is a complex movement disorder with diverse causes and presentations. Early recognition, targeted investigations, and a multidisciplinary, goal-oriented approach are essential. While pharmacological and surgical options can improve symptoms, the importance of careful trialling, monitoring, and tailoring to individual needs remain key.

Dr Sasha Thambapillai,
ST8 Community Child Health Registrar,
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Continues overleaf

Useful resources

- Dystonia: A Guide to Best Practice for Health and Social Care Professionals, available from ***www.dystonia.org.uk***
- BPNA Dystonia Action Plan – guidance and template personalised plans can be accessed through ***www.bpna.org.uk*** or ***www.dystonia.org.uk***

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Theraplay as an Attachment-Focused Intervention for Children and Families

Published December 2025 in the American Journal of Medicine, *Healing through play: Theraplay as an integrative therapy for parents and caregivers* (Purrington *et al.*) presents the most comprehensive overview of Theraplay research to date. The paper outlines numerous paediatric DSM-5 presentations which are often referred for specialist assessment and subsequent medicinal management. The empirical evidence base for Theraplay in reducing these presentations as a therapeutic modality without medication is outlined. The following presents a synopsis of the paper.

Theraplay theoretical background and rationale

Theraplay was developed over 60 years ago and is grounded in attachment theory, developmental psychology, and neuroscience. Secure attachment is foundational to emotional regulation, resilience, and long-term mental health. Disruptions in attachment, arising from trauma, neurodevelopmental differences, parental mental ill-health, or chronic stress can manifest as emotional, behavioural, and relational difficulties across childhood and adolescence.

Unlike many conventional therapies, which rely primarily on verbal processing and individual work, Theraplay is experiential, activity-based, and relational. It operates at a pre-verbal, procedural level, engaging neurobiological systems involved in regulation and relational safety. Strategically orchestrated and clinician-directed, Theraplay uses structured, playful interactions to strengthen attunement, co-regulation, trust, and emotional connection between child and caregiver.

Clinical implementation

Initial intake includes a structured attachment assessment (the Marschak Interaction Method) allowing the clinician to observe and diagnose a child's particular needs. Following this, Theraplay sessions are organised around four core dimensions: Structure, Engagement, Nurture, and Challenge. These dimensions guide the selection of specific therapeutic activities.

Early sessions are led by the clinicians, and over time, supported and coached by the clinician, the caregiver increasingly assumes a lead role. Throughout treatment, the clinician attends to the emotional needs of caregivers as well as those of the child. Many caregivers present feeling distressed, ineffective, or blamed due to ongoing difficulties. Theraplay explicitly addresses maladaptive interaction patterns that may have developed under such stress, offering education, emotional validation, and corrective relational experiences. This dual focus supports the establishment of secure attachment relationships and reduces relational strain within families. By the end of therapy, caregivers have gained the understanding, confidence, and skills needed to continue therapeutic interactions independently, extending benefits beyond the clinical setting.

Flexibility and scope of use

Theraplay principles have been applied effectively with children prenatally through to older adolescents, including those with complex developmental profiles. Treatment duration varies, ranging from brief interventions to longer-term adjunctive use alongside other therapeutic modalities. The mean treatment length of only approximately 15 sessions reflects the strategic, intense, and embodied nature of the intervention and the sustained impact of caregiver-led interactions beyond therapy.

Theraplay has been safely used with vulnerable populations, including neurodivergent children, children with physical disabilities, and those with histories of abuse, neglect, or trauma. It has been delivered in individual, dyadic, family, and group formats across diverse settings, including clinics, schools, residential care, and humanitarian contexts.

Evidence of efficacy across presentations

The reviewed literature comprises 41 studies using a wide range of psychometric outcome measures, reflecting both the adaptability of the model and the diversity of clinical presentations.

- ***Neurodivergence:*** Studies involving children with autism, ADHD, intellectual disability, and FASD demonstrate improvements in attachment behaviours, child-caregiver relationship quality, emotional regulation, social communication, behavioural functioning, and reductions in parental stress.
- ***Trauma and attachment disruption:*** Strong evidence supports Theraplay's effectiveness in reducing trauma-related symptoms, improving regulation, enhancing relational safety, and improving quality of life for children and caregivers following experiences of abuse, neglect, or developmental trauma. Caregiver involvement is particularly important given the central role of attachment figures in trauma recovery.
- ***Social, emotional, and behavioural difficulties:*** Theraplay has been associated with reductions in internalising and externalising symptoms, aggression, and relational conflict, alongside improvements in peer competence, emotional expression, and adaptation to social settings.
- ***Physical disabilities and health-related challenges:*** Evidence also supports the use of Theraplay with children with physical differences and chronic health conditions, demonstrating benefits including improved tolerance of touch, reduced anxiety around personal care, enhanced sleep, and increased social engagement.

Relevance to common paediatric diagnoses

Theraplay addresses the relational mechanisms underlying many DSM-5 diagnoses commonly encountered in paediatric practice, including PTSD, anxiety disorders, depression, oppositional defiant disorder, conduct disorder, reactive attachment disorder, and disruptive mood dysregulation disorder. Rather than focusing solely on symptom reduction, Theraplay aims to modify internal working models of relationships through lived experiences of safety, predictability, attunement, and co-regulation. By strengthening caregiver sensitivity and consistency, Theraplay supports the development of emotional regulation, executive functioning, trust, and behavioural flexibility, each core developmental capacities that underpin mental health across diagnostic categories.

Applying Theraplay as a paediatrician

While Theraplay is usually delivered as a structured psychotherapeutic intervention, its principles and activities integrate into routine paediatric practice. The judicious use of Theraplay-informed interactions such as playful eye contact, rhythmic turn-taking, shared humour, and brief nurturing or regulating activities can build rapport, reduce stress, and establish a sense of relational safety for both child and caregiver. Theraplay principles may help reduce anxiety for children and caregivers around medical interventions by promoting co-regulation, predictability, and trust. For paediatricians, adopting an attachment-informed, Theraplay-consistent stance characterised by appropriate use of warmth, structure, attunement, and playfulness can support engagement, enhance adherence to treatment plans, and strengthen caregiver confidence. In this way, Theraplay offers paediatricians a brief, practical, evidence-informed framework to support emotional regulation, relational safety, and therapeutic alliance alongside medical care. Paediatricians interested in Theraplay can attend a Theraplay Level 1 Training course. Following this, at the heart of safe Theraplay practice is a simple but essential question: 'Whose need is being met by what I am about to do?'.

Implications for paediatric practice

Theraplay offers a clinically relevant, family-centred intervention that aligns with current priorities around early intervention, trauma-informed care, and integrated working across physical health, mental health, and social care. Theraplay reframes treatment from an individual pathology model to a relational health model, positioning the caregiver–child relationship as the primary mechanism of change. In an overstretched system, interventions that strengthen family capacity and promote sustained relational health offer significant long-term value.

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Improving Sleep Outcomes: Service Evaluation of a Community Paediatric Sleep Service in a Secondary Care Setting

The East Sussex Healthcare NHS Trust (ESHT) Community Paediatric Sleep Service has undergone a period of recovery and transformation, resulting in significant improvements in service access, efficiency and patient care for children and young people with neurodevelopmental conditions and physical disabilities. The sleep team consists of two community paediatricians, a specialist nurse and five Neurodevelopmental Associate Practitioners (NAP).

The Community Paediatric Sleep Service evaluation analyses the journey of the sleep service since 2023, highlighting both achievements and the challenges. The team has demonstrated phenomenal progress over time, with helpful learning points that would set the benchmark for future quality improvement. Following a period of closure to new referrals in July 2023, with reinstatement to accept referrals in late 2024, the service had reduced operational capacity until late 2025. Collaborative teamwork, consistent clinical leadership, along with focused pathway development, enabled the service to return to safe and effective delivery.

Service Background

The Community Paediatric Sleep Service is a Tier 2 pathway providing specialist sleep assessment and management for children and young people with neurodevelopmental conditions and physical disabilities. The service accepts referrals following successful completion of Tier 1 sleep support for a period of 6 months from health visiting (for preschool-age children) and school health services (for school-age children). The referral criteria for the services are laid out as below:

- Neurodivergent (diagnosed with autism/ADHD/intellectual disability/Smith Magennis Syndrome), 2-11 years of age, and under the care of the ESHT Child Development Service
- Under the care of the neurodisability team due to profound intellectual disability/ physical disability
- Children before their 16th birthday with a neurodevelopmental condition assessed and identified by community paediatricians (and are not under the CAMHS developmental pathway) will be considered

Those commenced on Melatonin, once stabilised, are discharged and transferred back to primary care who support with ongoing Melatonin prescriptions.

Rationale for Evaluation

The evaluation was prompted by identified service risks, including limited staffing capacity, prolonged referral backlogs, delays in triage and assessment, variable referral quality, and challenges with Melatonin prescribing and transfer of care. We also wanted to review whether our provisions adhere to the Sussex ICB Area Prescribing Committee guidance (introduced in early 2024).

Methods

A combined retrospective and prospective review was undertaken using data from our electronic records (SystmOne). The evaluation commenced on 15th August 2025, with an expectation to complete by 15th January 2026, and this was successfully achieved.

Results

Referrals from May 2023 to December 2025 were analysed and a total of 151 referrals were received. Around 119 referrals were accepted, with 19 referrals being rejected, and the remainder moved to nurse follow-up or the prescribing paediatrician, as they were already on Melatonin. Most referrals originated from Tier 1 services (106 referrals).

The outstanding sleep referrals received following the service pausing were triaged between April 2025 to end of August 2025. Thereafter referrals received could be triaged in a timely manner. We commenced the paediatrician-led sleep initial clinics in July 2025. Between July and December 2025, 11 sleep clinics were delivered and 50 children were assessed. Due to limited capacity, the children initiated on Melatonin, following the sleep initial assessment, were followed up by our NAPs. The specialist sleep nurse supported with conducting sleep reviews for children and young people historically on Melatonin, with the aim of transferring them to primary care at the earliest.

Marked improvements in timeliness were observed over the evaluation period:

- Mean referral-to-triage time reduced from 607 days in 2023 to 7 days between July and December 2025. This refers to calendar days as data also includes retrospective data
- During July–December 2025, 82% of referrals were triaged within five working days, meeting KPI standards (refers to working days – prospective data)
- Eight children referred in 2025 were seen within the 18-week referral-to-assessment KPI, as they met the prioritisation criteria

Continues overleaf

Key Interventions

Service improvements implemented:

- Introduction of a Standard Operating Procedure (SOP) for sleep referral triage
- Revision and piloting of a structured sleep referral form
- Development of standardised letters for referral acknowledgement, appointment and rejection letters
- Sleep diary request through the SNappD app - information for parents shared in the appointment letters
- Implementation of a sleep review template within our electronic records (SystmOne)
- Waiting list validation and a structured transfer-of-care process

Outcomes Achieved

- KPIs for triage and referral-to-assessment
- Improved clarity and consistency in referrals
- More efficient use of limited staff capacity – buddy system between paediatricians within the sleep team and neurodevelopmental associate practitioners
- Smooth patient care with clearer plans for review and transfer of care

Service gap/commissioning and further discussion with ICB

- Lack of sleep service for young people aged 16-18 years
- Children attending independent schools do not have access to Tier 1 sleep support
- Reluctance from some primary care services to take over Melatonin prescriptions

Next Steps

- Revise ESHT Community Paediatric sleep guidelines (last updated 2017)
- Provide clearer guidance to Primary Care on Melatonin titration
- Melatonin questionnaire to optimise repeat prescription request
- Undertake a Quality Improvement Project on the sleep pathway, as a baseline service evaluation is now completed.

Acknowledgements

We sincerely acknowledge the dedication and contribution from the multidisciplinary team, including medical, nursing and administrative colleagues.

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East Sussex Healthcare NHS Trust (ESHT)
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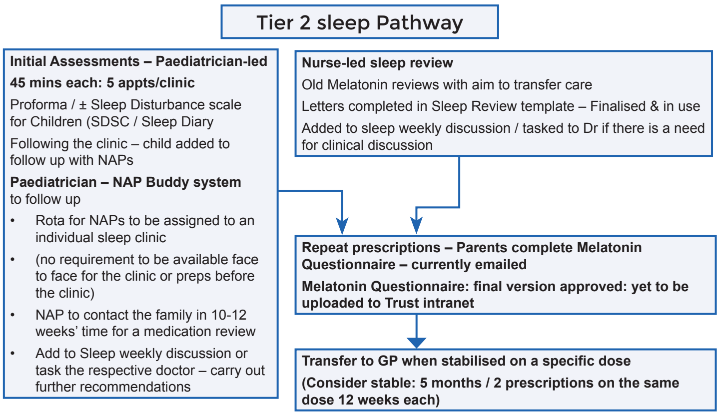

Tier 2 sleep Pathway

Initial Assessments – Paediatrician-led

45 mins each: 5 appts/clinic

Proforma / ± Sleep Disturbance scale for Children (SDSC / Sleep Diary

Following the clinic – child added to follow up with NAPs

Paediatrician – NAP Buddy system to follow up

- Rota for NAPs to be assigned to an individual sleep clinic
- (no requirement to be available face to face for the clinic or preps before the clinic)
- NAP to contact the family in 10-12 weeks' time for a medication review
- Add to Sleep weekly discussion or task the respective doctor – carry out further recommendations

Nurse-led sleep review

Old Melatonin reviews with aim to transfer care

Letters completed in Sleep Review template – Finalised & in use

Added to sleep weekly discussion / tasked to Dr if there is a need for clinical discussion

Repeat prescriptions – Parents complete Melatonin Questionnaire – currently emailed

Melatonin Questionnaire: final version approved: yet to be uploaded to Trust intranet

Transfer to GP when stabilised on a specific dose

(Consider stable: 5 months / 2 prescriptions on the same dose 12 weeks each)

The Genetics Revolution in Community Paediatrics

One of the highlights of our October National CCH Trainee Study Morning was an engaging talk from Dr Neeta Lakhani, exploring the past, present, and future of genetics in community paediatrics.

Clinical genetics has undergone a transformation so rapid that, for many of us, it feels less like the steady evolution we once expected and more like a revolution unfolding in real time. What was once a discrete subspecialty has moved firmly into the mainstream of paediatric practice, where genomics is now woven through the curriculum, the clinic, and conversations with families.

It is an exciting shift. But to participate fully and confidently, we need to understand why the change has come, what it means for children in our care, and how we as community paediatricians can navigate this new landscape with purpose.

From Evolution to a National Revolution

The roots of this new era stretch back decades. Many remember the excitement of the Human Genome Project which was completed in 2003 and the bold claim that the book of life had been read. Yet what we gained then was only a list of letters; understanding those letters would take years.

Progress, at first, was incremental. We learned to count chromosomes using karyotypes and to answer urgent but highly specific questions using FISH. Microarrays arrived, and suddenly submicroscopic copy-number changes could be identified, a significant step, though still limited in scope.

The real turning point came when powerful sequencing technology met well-curated clinical information. The sequencing of the 100,000th genome in the 100,000 Genomes Project in 2018 demonstrated that pairing whole genome sequencing with robust phenotyping could deliver real answers, with around one in four children in the study with previously undiagnosed rare conditions receiving an actionable diagnosis. Importantly, this success did not remain confined to research. The NHS recognised that every child, wherever they live, should have equitable access to genomic testing and its benefits. In response, the NHS Genomic Medicine Service was created that same year, built around seven Genomic Laboratory Hubs and a single National Genomic Test Directory, laying the groundwork for genomic medicine to become part of routine paediatric care.

Genomics Goes Mainstream

Shortly after this breakthrough, genomics entered the mainstream of public consciousness. During the pandemic, words like *PCR* and *variant* suddenly belonged to everyone. Families increasingly arrived in clinic aware of genomic testing, sometimes already having searched their eligibility in the publicly available National Genomic Test Directory.

This has altered the clinical dynamic. We are expected not only to order the correct tests but also to explain their value and their limitations. For many paediatricians who trained before this shift, that expectation can feel uncomfortable. Yet it represents a profound opportunity: when families understand the science behind their child's care, they become active partners rather than passive recipients. Empowered families engage more fully, adhere better to management plans, and make decisions with greater confidence and emotional resilience. In this way, genomics is not simply changing what we can diagnose; it is supporting the very heart of paediatrics: enabling children and their carers to take ownership of their health and move forward with clarity, confidence and hope.

Test ***Year developed***	**Best used for**	**What it won't show**	**Key practice notes**
Karyotype ***1955***	Extra/missing whole chromosomes (e.g. trisomy 21) and very large rearrangements	Small deletions or single-gene variants	'Are the books on the shelf in the right number and order?' Takes 10 days to process because cells must be in metaphase — a phase that only occurs in ~3% of the natural cell cycle. Still essential to confirm some aneuploidies e.g. Trisomy 21 The only test that requires a lithium heparin (green) bottle; all others require EDTA
FISH ***1980s***	Rapid yes/no answer to a very specific chromosomal question (e.g. suspected trisomy in a newborn)	Everything else in the genome	Like word search: checks only one location. Works in interphase so it's faster but cannot show whole-chromosome structure. Useful for preliminary guidance in Trisomy 18 but still always need a karyotype for diagnosis.
Microarray (aCGH/ SNP) ***1992-2006***	First-line for developmental delay, learning disability, congenital anomalies	Single nucleotide changes; deep intronic variants	Checks whether pages or paragraphs are missing or duplicated in the genetic 'book' A 'normal' result does not rule out a genetic diagnosis as it does not read the words.
Single-gene sequencing	Classic, recognisable phenotype pointing strongly to one genetic cause (e.g. typical NF1)	Any differential outside that gene	Reads a single word in the genetic text. High diagnostic value only if the phenotype is textbook.
Gene panel sequencing	When several genes could explain the clinical picture	Conditions outside the selected gene set	Reads all relevant words for one problem. Reliant on the quality of phenotypic data provided on the form.
Whole Exome Sequencing (WES)	Complex cases with many possible genes	Some regulatory/non-coding changes	Reads the important words (exons = <2% of DNA, but >85% of known disease-causing variants). Best as a trio (parents + child) for interpretation.
Whole Genome Sequencing (WGS)	When other tests are negative or strong suspicion of a genetic disorder remains	Some very deep intronic/ epigenetic mechanisms	Reads everything but still analysed via selected panels unless broader review is justified. Turnaround time is approximately 10 -18 months, depending on local timelines and driven by the complexity of interpretation.
Rapid WGS (R14 pathway)	Critically unwell children where genetic results will change acute management	Stable cases without urgent implications	Around 2-week turnaround. Needs national eligibility. Contact genetics early if you think a child may qualify.

Making Sense of Genetic Testing

To engage well with genomic medicine, we must remain clear about what different investigations can and cannot do. A normal microarray does not rule out single-nucleotide pathogenic variants. A FISH result suggesting three centromeres cannot diagnose a full trisomy without the structural picture offered by a karyotype. Even whole genome sequencing only tells us what we choose to analyse within it; the technology reads the entire genome, but analysis focuses on the selected clinical question.

All of these tests rely on phenotype. Without a clear clinical description – developmental profile, dysmorphism, medical complications, family history – the laboratory cannot meaningfully narrow the search from thousands of genetic variants to a single answer worth holding onto. Good genomics still starts at the bedside.

This is where community paediatricians excel. We observe children over time, understand their day-to-day functioning, and know how developmental pathways unfold. When we describe clearly what we see, genomic testing becomes significantly more powerful.

Testing with Purpose: The National Test Directory

The National Genomic Test Directory is now the foundation of NHS genetic testing. We do not simply request 'a whole genome sequence'; rather, we request sequencing aligned to a specific clinical question, expressed as an R code with the directory. For example, R27 (Paediatric disorders) covers a broad range of children with congenital anomalies, dysmorphic features and/or developmental disorders where comprehensive genomic investigation, including whole genome sequencing, is appropriate. The R code reflects the clinical question and ensures that testing is aligned with nationally agreed eligibility criteria and commissioning arrangements.

Using this shared language ensures equal access and avoids fragmented approaches that once varied from region to region. Trio analysis (including both parents) is encouraged wherever possible, as it dramatically improves interpretation by filtering out benign inherited variation.

Turnaround times remain measured in months, depending on complexity and laboratory workload, though nationally commissioned rapid pathways exist for children where a pressing clinical decision depends on diagnosis. Open discussion with families about timing and possible outcomes remains essential.

Answers that Change Lives

Even at this early stage, clinical benefits are striking. In conditions such as spinal muscular atrophy, early genomic diagnosis can fundamentally alter prognosis through the availability of disease-modifying treatment. In many neurodisability presentations, a molecular diagnosis offers far more than a name: it provides tailored surveillance strategies, accurate recurrence counselling and an end to the long and often distressing search for answers, marked by years of uncertainty for families.

Importantly, access to testing is now a matter of equity. Whether a child lives near a major teaching hospital or in a rural community, they can and should receive the same opportunities for diagnosis and personalised care. Community paediatrics, often the first specialists to see children with developmental concerns, is central to ensuring that principle holds true.

The Future We Are Helping to Shape

There is, of course, much we still do not understand. A 'normal' genomic result today may yield answers in the future as knowledge expands. Variant interpretation remains challenging. But this uncertainty reflects progress: for the first time, we are looking directly at the code rather than guessing from the outside.

Continues overleaf

Genetics has moved from laboratory benches to our everyday practice. It has moved into public dialogue and family decision-making. And now, it moves with us into community clinics, school assessments and multidisciplinary care plans.

We are practising at a time when medicine is actively redefining itself. The challenge ahead is to embrace genomics not as an additional burden, but as a tool that allows us to offer more to the children and families we serve.

We are not simply adapting to a revolution. We are taking part in it, and the future of paediatrics will be more precise, more equitable and ultimately more hopeful because of it.

Dr Claire Stewart, BACCH National Trainee Rep
Dr Neeta Lakhani, Consultant in Clinical Genetics

Safeguarding

A summary of the intercollegiate document (2025) Safeguarding Children and Young People & Children and Young People in Care

The 2025 intercollegiate document (ICD) is a competency framework based on a review and update of two intercollegiate documents: *Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (2019)* and *Looked after Children: Roles and Competencies for Health Care Staff (2020)*. It is a web-based document found via the 'Key Topics' section of the RCPCH website under 'Child Protection and Safeguarding'.

The ICD emphasises the importance of ongoing professional development for all healthcare staff to keep children and young people safe. All staff groups are required to reflect on their own learning, with competencies being achieved through training, experience, appraisal and revalidation. It outlines when specific clinical expertise and skills are required including child protection medical assessments, child sexual abuse assessments and initial and review health assessments for children in care.

The previous documents split each level into competencies, knowledge, skills, attitudes, values and training requirements. The new document simplifies this to core and additional competencies and provides a helpful overview at the start of each section. It assumes cumulative knowledge at each level (i.e. those competent at level 5 have the competencies of levels 1-4). Levels 1 and 2 should be covered in annual mandatory training programmes. Levels 3-5 are service-dependent and should be individualised and reviewed at annual appraisals.

The expectations described apply to both NHS and NHS-commissioned independent providers, with organisations responsible for ensuring equal safeguarding standards for all children and young people in line with the UN Convention on the Rights of the Child.

The Competency Levels

Level 1: Recognition
Aimed at: Any healthcare professional who may come into contact with a child or young person. Examples include receptionists, domestic and laboratory staff.
Summary: This level is about staff being able to recognise the signs of child maltreatment and knowing whom to escalate to. They are expected to be able to identify different categories of physical abuse, emotional abuse, sexual abuse, neglect and criminal/sexual exploitation. An understanding of adverse childhood experiences (ACE), disability and confidentiality is also required.

Level 2: Response
Aimed at: Healthcare professionals who encounter children and young people, but who may not necessarily provide clinical care. Examples include pharmacists, opticians, volunteers and medical students.
Summary: This level introduces information-sharing principles, appropriate documentation and the ability to respond to concerns. It assumes an understanding of the implications of ACEs rather than just the identification. A wider knowledge of specific practices (such as female genital mutilation) is required. An awareness is required of the multi-agency approach and relevant services available to support families.

Level 3: Expertise and action
Aimed at: Healthcare professionals who deliver a clinical service to children and young people. Settings where the family may be affected are included, such as adult mental health and substance misuse rehabilitation services.
Summary: It suggests cyclical training updates are required and lists more advanced safeguarding themes. Professionals should not only have an awareness of these but be able to appropriately respond. This could be through directly offering advice, communicating with other agencies, providing a professional opinion or recommending structured interventions. It also outlines what is expected from those who carry out child protection medical assessments, initial review health assessment or review assessments for children in care.

Level 4: Leadership Role & Additional Responsibility
Aimed at: Professionals who work in a senior leadership role within organisations involved in safeguarding children and young people or children and young people in care. This includes senior/named doctor and nurses, the safeguarding lead or named GP for safeguarding.
Summary: It builds on level 3 competencies but includes providing expert advice and supervision to other professionals, leading safeguarding practice and the development of policy, training and quality assurance. Professionals at this level should be able to support colleagues who have been instructed by court or involved in legal processes. They should also collaborate with multi-agency colleagues to support young people leaving care or transitioning into adult services.

Level 5: Strategic Oversight
Aimed at: Senior health professionals who will be providing strategic oversight and leadership. Examples include designated or named safeguarding nurses/doctors and 'Head of' roles where level 4 staff are managed.
Summary: It suggests that different expertise is required to be level 5 competent in safeguarding children compared to safeguarding children in care, and it needs to be tailored to the setting the individual works in. Professionals should be able to give safeguarding expert advice for commissioning, governance and system response. They are expected to take on a leadership role and provide supervision and support to safeguarding teams. They should also be confident identifying and advocating for children placed in an inappropriate health setting and play a key role in striving to reduce health inequalities. This includes reviewing and presenting data and taking part in enquiries/national reviews.

Competencies for Senior Managers and Executives

The final section of the document reflects those working as executive and non-executive directors and senior managers providing NHS health care and senior leaders in other organisations providing services to children and young people. Their role is extensive but includes ensuring an effective relationship with subject matter experts for safeguarding children and young people.

Voice of the Child

This section has many quotes from care-experienced young people about what is important to them. In particular, children ask to be kept involved in decisions, be communicated to clearly and honestly and not be stereotyped. These are collated from reports written by Coram Voice, a branch of the Coram charities.

There is also an inspirational reflective piece written by a healthcare worker with experience of their own childhood trauma. It highlights how each positive encounter with professionals impacted on their mental wellbeing and future aspirations. They outline five safeguarding tips which are accessible to all professionals. Examples are remembering to ask for help and looking after your own wellbeing.

Conclusion

The document recognises the impact that healthcare staff have on children and young people and the importance of the right expertise to safeguard and prioritise their needs. It standardises the expectation of professionals and promotes safe practice through supervision and training. It is important to note the challenges that professionals may face including getting support from the organisation they work in, obtaining protected training time and appropriate supervision. An organisational and individual approach is required to facilitate this.

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The Introduction of a 'Safer Internet Week' in Community Paediatric Centres: A Quality Improvement Project

Introduction

Our use of the internet has changed significantly following the lockdowns imposed during the heights of the COVID-19 pandemic. This change has affected the way children and young people communicate, and the ways adults or their peers may exploit them online.

The internet itself has changed drastically during the half decade that has since passed. Algorithm-based platforms can expose children to harmful online content without their consent, and the introduction, and subsequent rapid rise, of Generative AI invites new potential harms.

The internet and the online space can be a wonderful resource for children and young people, but it can also expose them to harms including violent or sexually explicit content, extremist ideologies, hate speech, and material that encourages self-harm, eating disorders, or suicide.

More recently, these harms have been mitigated by online legislative reforms with the introduction of the Online Safety Act 2023, and by parental mediation and supervision of children's use of the internet.

Children with special educational needs and disabilities (SEND) have been shown to be at greater risk of experiencing harm online. In addition, their parents may struggle with online literacy, limiting their ability to effectively support and protect them online.

It is clear that parental support and positive relationships can promote healthy and rewarding internet use, and the UK Safer Internet Centre (UKSIC) has pioneered its Safer Internet Day, starting in 2017, to promote safer use of the internet in schools around the country. In its most recent edition, 1,726 schools participated in a day focusing on online scams and how to recognise them.

Given the benefit of positive relationships, and the impact of public-led initiatives on children's confidence online, this project team made the decision to promote online safety from local Community Paediatric Centres. This ran from two centres in the South London boroughs of Lambeth and Southwark, with the specific aim to deliver an interactive service, raising awareness of online safety, accessible to both children and parents/guardians, in the waiting rooms of local Community Paediatric Centres.

Methods

The community centres see high footfall of patients, with the Southwark centre seeing an average of 40 children and their families per day. The patient cohort is predominantly children with SEND, but appointments range from Child Protection cases to Autism and Related Diseases clinics.

The centre that this project focuses on contains a central waiting room that is adjacent to a 'family room,' which on an average day contains age-appropriate books/toys for children aged 0-17 years old. It is within this room that we held our intervention.

This project used the pre-existing UK Safer Internet Day date of 10th February 2026, and extended the intervention to cover the whole week, aiming to target a larger patient group. In discussion with UKSIC, the project team secured printed and online resources to share with parents and carers, and their young people.

Continues overleaf

The intervention consisted of three stalls designed for parents, older children, and younger children respectively. The parents' stall had informative posters and A4 sheets containing QR codes of 7 internet resources, focused on providing support with parental controls, and how to talk about online safety with their children. The older children's stall contained interactive exercises with an internet safety theme, and an A4 sheet containing QR codes of 4 resources containing advice re: identifying online harms and reporting them if they occur. Finally, the younger children's stall was interactive, featuring colouring activities and a poster competition centred around an online safety theme.

A feedback form was given to the patients' families upon arrival, for them to hand in when they left after their appointments.

Results

Over the week, 14 feedback forms were collected. Of these, 8 were fully completed, while a further 5, though incomplete, still addressed the main themes of confidence in accessing resources and having constructive conversations with their young people.

The questionnaires explored confidence using a 1-5 confidence scale. Prior to engaging with the stall's resources, participants' mean confidence rating was 3.9/5. Following the event, all responses showed an increase, with participants reporting a confidence mean score of 4.2/5 regarding accessing resources, and 4.1/5 regarding talking to children about internet safety.

Subjective qualitative feedback regarding the presentation of the stalls, and their clarity of information, was vastly positive. Parents remarked that the stalls were easily identifiable, the message they were conveying was clear, and the information was easily accessible.

Discussion

In summary, the week appears to have had a positive impact on those who engaged, with no negative responses and a global increase in confidence, if minor. However, limitations with the feedback forms themselves and the low completion rate of the forms reduces the reliability of the cycle's results.

The form's complexity and length made it difficult to navigate, resulting in unanswered questions, and participants appeared to find both completing and submitting it a challenging task. This has led to a small sample size that does not reflect the engagement that occurred on site.

For this project to be reproduced elsewhere, it is key that its impact can be reliably measured. In further cycles of this intervention, ideas to begin adapting include simplification of the feedback form (or its conversion to online format), addition of an age identifier question to understand demographics of participants using the stalls, and increasing focus on how this intervention can reach those most at risk, particularly children with SEND.

Overall, this project targets an emerging and contemporary risk to children's social and mental health, and has shown a tenuous, but overall positive, effect on those that have engaged with it. The project team is keen to adapt for further cycles and will discuss keenly the provision and frequency of future 'Safer Internet Weeks.'

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The authors wish to thank the following team members who were vital to the delivery of the project: Danielle Ashley (Transition CNS), Karen Suna (Family Support Worker), Matthew Turner (Family Support Worker), Nasrin Ahmed (MSC Reception Lead)

Public Health

Public Health in Pictures: Designing Short-Term Condition Pathways

Community child health is sometimes described as a long-term condition specialty, since our clinics are shaped by autism, ADHD, neurodisability, safeguarding complexities and enduring vulnerability. It would be easy to conclude that short-term condition pathways sit elsewhere in the health system, but just remember all long-term conditions start with an initial pathway, and sometimes only time will tell whether initial symptoms represent the beginnings of a long-term issue. Short-term conditions also co-occur alongside long-term morbidities, and supporting primary care so more care can be provided 'out of hospital' is part of the NHS 10-year plan.

What Do We Mean by a Short-Term Condition or Concern?

A short-term condition or concern can be thought of as a presentation of limited duration, typically less than six months, which does not initially imply ongoing specialist management.

In community child health, this might include:

- Acute behavioural dysregulation
- School refusal or attendance anxiety
- Hearing impairment
- Sleep disturbance
- Functional neurological symptoms
- Emotional distress following family disruption
- A concern about developmental progress e.g. language or toileting

For some children, these difficulties settle with time and appropriate support. For others, they represent the early expression of an underlying neurodevelopmental or psychosocial condition.

The purpose of pathway design is to ensure that all components of care are in place and functioning cohesively, delivering a positive experience and optimal outcomes for children and families.

However, pathways influence more than outcomes alone. They also shape the timing of recognition, the accumulation of secondary harms, levels of family stress, and – critically – the equity of access to appropriate support.

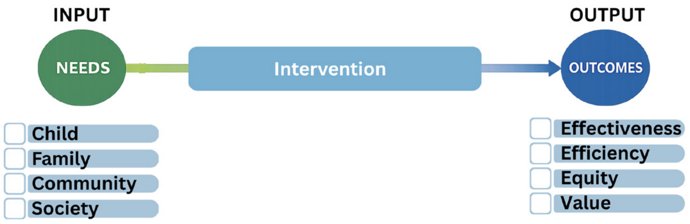
Short-Term Pathway Design

The simplest construct for a short-term pathway is an 'unwell' presentation, a straightforward intervention and a 'better' outcome. A cut finger presenting to ED results in closure and dressing, then complete recovery. Conceptually, this is a simple input – intervention–output sequence. It is important to note is that an output is always a changed input.

Secondly, public health defines a need as the ability to benefit from an intervention. The outcome is the result of that intervention. In the cut-finger example, the need is wound management; the outcome is healing. However, the concept of need becomes more complex when we widen the lens beyond the immediate clinical concern.

In safeguarding, while the child may have a need for treatment of an injury, if the injury was intentional, or occurred in the context of neglect, parental mental health difficulty, domestic violence or substance misuse, the family also has needs. The intervention extends beyond suturing to assessment of potential hazards and then support from the wider integrated care system.

Similarly, if an injury was sustained through bullying at school this introduces a community-level need. The intervention may lie within the school environment rather than solely within healthcare; hence the need for integrated care systems. Finally, there may be a need for still wider interventions such as poverty-proofing services, advocacy to improve safe play space, or potentially legislation to reduce traffic speeds or improve cycle lanes.



Outcomes, too, can be viewed from multiple perspectives. The child may be satisfied with injury healing, but a clinician considering productivity might question whether the most appropriate professional delivered the care. A commissioner might then ask whether the episode could have been managed in a community setting or prevented altogether. Prevention, productivity and value then all become part of the pathway conversation. This is where the simple linear model begins to expand.

Within a single consultation, we can already identify distinct components: recognition that there is an issue, assessment of the underlying cause, and the impact on the child and family and appropriate management options. If causation can be addressed, future prevention –promotion and protection – also enters the frame. For some conditions prevention, recognition, assessment and management may happen in different places with separate teams ideally working together in a network – think component parts of a glue ear pathway. The expanded pathway does not replace the simple model; it builds on it, making visible all the stages and system influences that were implicit all along.

The Four Stages of a Short-Term Pathway

When we step back and examine service design, most short-term pathways contain four components.

1. Prevention

Population-based prevention in community child health is often upstream and cross-sectoral. It includes:

- Immunisation programmes
- Perinatal mental health support
- Early years parenting programmes
- Trauma-informed school environments
- Reduction of poverty-related stressors

We may not directly deliver these interventions, but their absence is often visible in referral patterns. However, family-based prevention, 'making every contact count' might include advice on dental care, home injury prevention interventions or advice on local services, for example food banks.

2. Recognition

Recognition is rarely a single event. It may occur through:

- Concerns by family members
- Surveillance within early years settings
- School assessments
- Screening within the Healthy Child Programme

Recognition relies on awareness, training and clear referral thresholds. If recognition is inconsistent, children may present late, after difficulties have escalated or relationships have fractured. Early recognition can therefore significantly improve longer-term outcomes.

3. Assessment

Community paediatricians are central to this stage. Effective assessment integrates:

- Clinical formulation relating to the condition
- Functional impact on the child (learning, relationships, daily living)
- Implications for the family (stress, safeguarding, deprivation, adversity)
- Context community assessment (deprivation, racism, crime)

A diagnostic label alone is rarely sufficient. Nor is a purely social explanation. Balanced formulation prevents both over-medicalisation and minimisation. Arguably the care plan is only as good as the assessment!

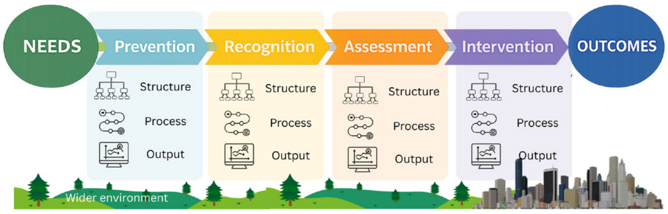
4. Intervention

Intervention may involve:

- Advice and reassurance
- Parenting strategies
- School support
- Early help referral
- Referral to specialist services
- Safeguarding action
- Therapy input

Where interventions are timely and proportionate, children may improve and families regain confidence. Where services are inaccessible, waiting times prolonged or thresholds high, short-term distress may compound into longer-term functional impairment.

Looking Beneath the Surface – standards and assurance



When first designing a service, it is essential to first translate evidence and competencies into expected standards by which the service can be assured. Then as patients pass through services, the assurance process focuses on the effect/outcomes of the service using measures relating to output, outcome and impact (more on this in the next BACCH Public Health in Pictures article!).

Each component of a pathway depends on:

- Evidence-based guidance
- Skilled and supported professionals
- Adequate clinic place, space and time
- Robust administrative and IT systems
- Effective network relationships

Continues overleaf

When demand rises and waiting lists lengthen, it is tempting to attribute pressures solely to increasing prevalence. While sometimes true, it may reflect weaknesses in prevention, recognition or early intervention elsewhere in the system.

Community paediatricians often experience these pressures in clinic where complexity converges: at the point where unmet need, family stress and system gaps converge. From a public health perspective, pathway quality assurance and improvement requires more than clinical expertise. It requires systematic examination of four domains at each of the four components:

- Structure

Structure refers to the tangible foundations of care: location, accessibility, clinic environment, staffing, training, adherence to guidance and access to investigations. It includes whether families must travel unreasonable distances, whether clinic space is fit for purpose, whether NICE guidance is embedded in protocols, and whether waiting times meet expected standards. Without adequate structure, even skilled clinicians cannot deliver high-quality care.

- Process

Process concerns the less tangible – what actually happens within the consultation: the quality of communication, degrees of participation, shared decision-making, formulation co-production and multi-agency collaboration. Two services may have identical structures but very different processes, and therefore different outcomes.

- Output

Outputs are the immediate changes resulting from contact with the pathway: reduction in distress, improved school attendance, stabilised behaviour, enhanced parental confidence. Outputs should also be examined through an equity lens. Who benefits? Who waits longer? Who drops out? A technically effective intervention that is inaccessible to disadvantaged families cannot be considered fair.

- Environment

Finally, environment reminds us that pathways sit within wider systems. Workforce shortages, commissioning decisions, poverty, housing instability and education pressures all influence outcomes. These factors may lie outside direct clinical control, but they are not outside public health and integrated care responsibilities. This relates back to our understanding of the wider determinants of health and disease and pathogenesis and salutogenesis which we discussed in the last Public Health in Pictures article.

Summary

Designing and assuring short-term pathways through this structure–process–output–environment lens for all four stages shifts the conversation from ‘demand management’ to system design and quality. It allows us to ask not only how many children are referred, but how well the system responds to their needs.

In community child health, one of the clinical roles is to ask, ‘Is the system working?’ ‘Are all the parts in place?’ ‘Is there a process to recognise and rectify the weakest links?’ When the answer is no, we can help be part of the solution – diagnosing system gaps, supporting redesign and fostering a culture of continuous learning.

Next time: long-term condition pathways and measures that matter.

***Claire Stewart**, BACCH National Trainee Rep*
***Simon Lenton**, Chair, BACAPH*

Link to B-BISS
https://www.bacch.org.uk/pages/b-biss-designing-pathways-networks

Training

Stronger Together: Advancing family support through a collaborative virtual community paediatrics study day for health visitors and school nurses in Lambeth and Southwark

In the diverse and vibrant London boroughs of Lambeth and Southwark, health visitors and school nurses are often the first point of contact for families navigating concerns about their child’s development, providing health education and promotion services and offering longitudinal care for children with complex needs. Recognising their pivotal role, the Community Paediatrics team set out to strengthen collaboration, build confidence, and enhance shared understanding through a Community Paediatrics Study Day.

Listening First: Identifying Learning Needs

Effective collaboration begins with listening. A pre-event survey circulated to health visitors and school nurses across both boroughs sought to understand where additional training and support would be most valuable. Four clear priorities emerged: identifying features of Attention Deficit Hyperactivity Disorder (ADHD), strategies to improve sleep, managing challenging behaviours, and strategies for selective feeding in children. Most respondents reported that they would prefer a virtual study day to a face-to-face event.

Designing a Collaborative Learning Experience

In response, a four-hour interactive virtual study day was designed and delivered by members of the multidisciplinary Community Paediatrics team including community paediatricians, a senior clinical psychologist and a senior occupational therapist. The study day was held on 21st November 2025. The session aimed not only to provide practical, evidence-informed strategies but also to clarify referral criteria and service pathways.

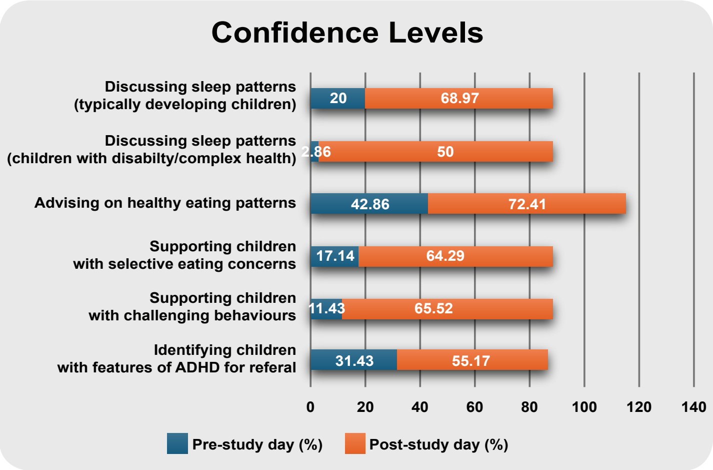
Beyond knowledge-sharing, the study day had a broader purpose: to strengthen working relationships across services. By creating a shared space for discussion, reflection, and learning, the event sought to promote clearer communication and more seamless collaboration in supporting families.

A Strong Turnout and Measurable Impact

Seventy-five professionals attended the virtual event, including SCPHN School Nurses, Community Staff Nurses, SCPHN Health Visitors, Early Intervention Health Visitors, Community and Child Development Workers, and student health visitors and nurses. Thirty-five participants completed a pre-study day survey, with 29 completing a post-study day survey on the day.

While many respondents had significant professional experience – nearly half with over 10 years in post – about two thirds reported they had never received formal training in these key areas. This gap presented both a challenge and an opportunity.

Feedback after the event was overwhelmingly positive. All respondents (100%) reported that they found the study day useful. Participants particularly valued the practical strategies shared and the interactive format, which allowed for discussion of real-life scenarios and peer learning. Most importantly, confidence levels increased significantly across priority areas (measured on a Likert scale of 1–5). In addition, health visitors and school nurses reported feeling more confident in recognising features suggestive of ADHD and making appropriate onward referrals.



These shifts represent more than statistics; they reflect strengthened professional capability and enhanced reassurance when supporting families facing complex challenges.

Building on Success: A Sustainable Model

The success of the study day has laid the foundation for a series of themed virtual sessions to be delivered in the future. Suggested topics from participants include understanding typical development, recognising developmental delay, autism support, and disability in children.

By continuing this programme of collaborative learning, the Community Paediatrics team aims to build sustained confidence and deepen partnership working across Lambeth and Southwark.

Conclusion: Investing in Confidence, Strengthening Communities

When professionals feel confident, families feel supported. This virtual Community Paediatrics Study Day demonstrated how responsive, targeted education rooted in partnership can meaningfully enhance frontline practice.

Through shared learning and strengthened relationships, health visitors, school nurses, and community paediatric teams are better equipped to work together in delivering timely, informed, and compassionate care. This model developed across Lambeth and Southwark offers a scalable and sustainable approach that could be adopted more widely, ensuring that families everywhere benefit from confident and collaborative community care.

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Trainee Update

The BACCH trainee community has been incredibly busy over the past few months! Trainees have been actively involved in multiple projects and working groups, while also engaging enthusiastically with national teaching initiatives.

We are delighted to report record numbers of trainees attending national teaching; on average we have 70 trainees attending our quarterly study mornings and 45 trainees joining our weekly Wednesday lunchtime (1-2pm) sessions. This is a fantastic achievement and reflects the appetite for high-quality, accessible national education in Community Child Health. We are extremely grateful to supervisors and departments for protecting trainees' time to attend, and we encourage continued support to ensure equitable access to these valuable opportunities for all.

In this update, we would like to highlight two new important developments for trainees:

1. Guide to Community Child Health Training

A trainee-led working group is currently developing a Guide to Community Child Health Training, in response to calls for clearer guidance on best practice in delivering training – particularly around the non-clinical aspects of CCH.

While many trainees benefit from the advice and informal mentoring of senior colleagues, we recognise that this support is not universally available. In areas without senior trainees, navigating the non-clinical elements of training can be more challenging. Our aim is to promote equity and accessibility in training experiences across the UK.

The guide will summarise best practice from trainees' experiences across the UK and will cover key areas including:

- Induction
- ePortfolio
- ARCP and CSAC
- Community work
- On-call commitment
- Study leave
- START assessment
- Acting up and Approaching CCT
- Wellbeing

Although the guide will not mandate local delivery models, it will provide practical, experience-informed recommendations to help ensure all trainees are supported to achieve the best possible training experience.

The document will shortly be submitted for approval by BACCH and the CCH CSAC, and we hope it will be available for both trainees and supervisors in the near future.

2. Expanding Our National Wednesday Teaching Programme

The success of our National Wednesday Lunchtime Teaching Programme has been hugely encouraging. Thank you again to supervisors for protecting time so trainees can attend these sessions between 1–2pm each week. In case you are unable to attend, we also ensure most sessions are recorded and stored in the members' area of the BACCH website.

Our monthly structure includes:

- First Wednesday – Community Case-Based Discussions
  Designed to support START assessment preparation from the outset of training, embedding skills longitudinally rather than as last-minute revision.
- Second Wednesday – Lightning Learning
  A responsive teaching programme rotating through curriculum learning outcomes, shaped by trainee choice. This model has been widely praised and ensures national experts' voices are accessible to all trainees.
- Third Wednesday – Population Health Problems
  Delivered in partnership with Public Health registrars and third-sector colleagues. These sessions explore a public health issue that may arise in clinical practice, widening the lens beyond the case discussion to consider the broader system, prevention and advocacy perspectives.

Continues overleaf

Training: Trainee Update

New Launch: ‘Research Ready’ (Fourth Wednesday)
We are excited to announce the launch of a new session on the fourth Wednesday of each month: ‘Research Ready’.

This will consist of two components:

1. Journal Club – Supporting trainees to critically appraise research papers.
2. Academic Skills Development – Focused on building research and academic skills specifically relevant to Community Child Health.

We recognise that the academic skillset required in community paediatrics differs from that of hospital-based colleagues, reflecting the unique environments and population-focused nature of our work. These sessions aim to equip trainees not only to critically review the literature, but also to contribute to it – ensuring that future consultants in CCH are confident in generating, shaping and leading research relevant to our field.

It has been inspiring to see such strong engagement from trainees across the country. We remain committed to ensuring high-quality, equitable training opportunities and look forward to continuing this work together.

As always, we welcome feedback and ideas from trainees and supervisors alike.

Claire Stewart and Kimberley Hallam
BACCH National Trainee Representatives

Wellbeing

Spotlight on… Lucy Doig (Executive Officer, BACCH and BACD)

1. Describe your job in three words.
Different every day!

2. Who has been your greatest inspiration and why?
A lot of people have inspired me over the years, but one of my greatest inspirations for applying for my current role with BACCH was my youngest sister, who has multiple complex disabilities. Having grown up alongside her and not only seen the struggles she faced, but the vital support both she and my parents received from healthcare professionals, made me jump at the chance to become part of an organisation like BACCH which supports doctors and others working with our most vulnerable children.

3. What has been your biggest challenge of your career and how did you overcome it?
The biggest ongoing challenge in my life has been my diagnosis with Crohn’s disease when I was a teenager. Although I’ve been lucky that it hasn’t prevented me from working, it’s a debilitating condition and has certainly made my life more difficult than it otherwise would have been. In a previous role I had to take a month off work for planned surgery, which would have been even more challenging had it not been for my fantastic colleagues who held the fort during my recovery. Almost any career challenge can be overcome if you have people around you whom you can rely on for support and guidance.

4. What is the highlight of your working day?
My role is very much ‘Jack of all trades’ and involves juggling multiple tasks. A typical day might involve a Teams call with NHS England, a planning meeting for the BACCH ASM, drafting our next monthly e-bulletin, and a catch-up chat with our Chair Dr David Vickers – all alongside the day-to-day admin that keens BACCH running! As I am still fairly new to this role, I love the fact that I am learning something new every day.

5. What is the best advice you have received so far?
‘Don’t let it live rent-free in your head’ (from a former colleague when I was ruminating over a negative comment someone had made). I’ve tried to live by it ever since!

6. What is the single, most encouraging thing that one of your colleagues can do to make your day?
It’s great to hear that my work is valued, so a thank-you from a colleague will always make my day!

7. After a hard day at work, what is your guilty pleasure?
I don’t really believe in guilty pleasures – if you enjoy something (and it’s harmless!), why feel guilty? As a full-time working mum with a school-age child, my relaxation time after work is quite limited! I love reading, choral singing, playing the piano and spending time with my husband and 10-year-old daughter, who is fantastic company. I also enjoy video games and am currently playing my way through Skyrim, which is brilliantly escapist.
A genuine guilty pleasure is BBQ flavour Pringles – they’re so addictive yet so bad for me!

8. If you had a superpower, what would it be and why?
I’m always torn on this question between flying and time travel, but I think it would have to be time travel just so I could go back and experience great events from history as they actually happened!

9. What advice would you give to inspire the next generation of community paediatric trainees?
This is a bit tricky to answer as I’m not a medic myself, but having worked alongside community paediatricians for almost a year now, my advice would be to take pride in the career you have chosen. With the numbers of children with disabilities or who are otherwise vulnerable increasing year on year, community paediatricians must feel they are constantly firefighting, but the role they play in the lives of these children and their families could not be more vital.

10. Finally, if you were stranded on a desert island, what three luxury items would you take with you?
If we’re avoiding cheat answers like ‘a phone to call for help’, then I’d have to say a kindle full of books (more convenient when stranded than carrying lots of paperbacks around), something to listen to podcasts on (my favourite is The Rest Is History), and probably some sunscreen so I don’t burn to a crisp!

Exploring Drama: Finding Resilience & Wellbeing Under the Stage Lights

‘The practice of medicine is quite theatrical. We have our own language. We have our own style of dealing with people. We wear a particular uniform or costume.’ – Dr. Michael Hayter, Canadian physician and radiation oncologist

When I first read this quote, I immediately resonated with its perceptivity and admission of what most of us have always known. Medicine *is* theatrical.

As alluded above, we wear ‘costumes’ (scrubs, stethoscopes around our necks, lanyards heavy enough to double as neck weights). We step onto brightly lit ‘stages’ (clinics, wards, multidisciplinary team meetings), and perform defined roles under time pressure and scrutiny, using a language that sounds Shakespearean to outsiders. As community paediatricians, we are particularly adept at role-switching. In one clinic, we might be an advocate, a detective, a counsellor, and an emotional anchor – sometimes all within the same consultation. We modulate the tone of our voices for anxious parents, playful children, frustrated teachers, and over-stretched colleagues. We improvise constantly. We manage our faces, even when our brains are screaming *‘this clinic is running an hour late!’*. Yet, for all its theatricality, medicine rarely allows us the joy of play.

This is where drama – unapologetic, glitter-and-greasepaint drama – has unexpectedly become one of the most grounding, resilience-building hobbies of my adult life.

The parallels between medicine and theatre are surprisingly rich once you start looking for them. Ward rounds have a clear performance element: residents presenting cases before an audience of peers and seniors, hoping to sound competent, coherent, and unflustered. Consultants (let’s be honest!) sometimes enjoy the spotlight… just a little. We all know the feeling of standing centre stage, hoping we won’t forget a crucial line or… lab result when discussing a case.

Like actors, we doctors memorise ‘scripts’ – diagnostic criteria, guidelines and developmental milestones, to name a few. We rehearse how to break bad news, how to phrase difficult conversations, how to sound calm even when internally panicking. We learn when to pause, when to emphasise, when to soften our voice.

Both theatre and medicine demand attentiveness to others. The audience attends to the performer; the doctor attends to the patient. Both require empathy, presence, and the ability to read a room. Medical education has long recognised this overlap – simulated patients, role-play, and improvisation exercises are now standard tools for teaching communication, empathy, and teamwork. Despite all this, many of us leave drama firmly in childhood, filed under ‘things I used to enjoy before I became sensible’. I nearly did too.

I have always loved drama. As a child, I was *that* seven-year-old, utterly captivated by Shakespeare long before fully understanding what on earth was going on. I devoured abridged versions of his plays, sighing over the tragic story of *Romeo and Juliet* with my friends, cackling gleefully like one of the witches in *Macbeth*. I vividly remember chanting, with maximum menace, *‘Double, double, toil and trouble; fire burn and cauldron bubble!’*

My mother, realising this was not a phase that would quietly pass for me, took me to Toys‘R’Us (at the time, the biggest toy shop in the town of Petaling Jaya, Malaysia, where I grew up, akin to Hamleys in London) and bought me my first witch costume – complete with broom. This, in hindsight, was either excellent parenting or a terrible mistake. I took to the stage every year in primary school, relishing the audience, the costumes, and the thrill of performing, with very little self-consciousness.

Then adolescence happened. Self-awareness crept in. Suddenly, being seen trying too hard felt mortifying. Drama didn’t disappear entirely for me, but it retreated into private performances for my closest friends. On occasion, I did participate in elocution contests in high school, which would be my substitute to drama.

By medical school, acting had largely fallen away, to be replaced by textbooks, written exams and OSCEs, and the slow shedding of hobbies that didn’t obviously serve career progression. Ironically, this was when I began to understand just how theatrical medicine itself could be.

Years later, life had moved on. I finished medical school, started paediatric training, and had a family. Then my eldest daughter caught the acting bug.

She joined our local amateur drama group, which met every Monday evening. Because she was under 18, a parent was required to attend. I dutifully brought her along, fully intending to sit quietly on the sidelines, doomscrolling on my phone and wondering how long before it was time to go home.

The group was planning their annual pantomime, *The Witches of Oz*, and auditions were underway. As I watched my daughter perform, someone casually lobbed a question in my direction: ‘Why don’t *you* audition too? We need more actors. It’s all a bit of fun.’

Continues overleaf

To my surprise (and mild alarm), my daughter was *keen* for her mother to join. Clearly, this phase of adolescent embarrassment had not yet fully matured. Without too much overthinking (a rare event in my life), I auditioned.

We were both cast as Munchkins.

If you have never been in a pantomime, I highly recommend it – preferably with a wig (that defies gravity, if you dare!) and a costume involving more sequins than one's dignity.

Pantomime is gloriously silly. It thrives on slapstick, exaggerated characters, and the deliberate breaking of the fourth wall. The audience is not a passive observer; they are an active participant. They shout warnings, boo villains, cheer heroes, and laugh loudly at jokes that are unrepentantly terrible.

Very quickly, I realised just how much fun it was to *act* again. Running lines, exaggerating my facial expressions, playing with timing, listening to the audience laughter and adjusting delivery in real time. It felt oddly freeing; here was a space where perfection was neither expected nor desired! Mistakes weren't disasters; in fact, they were often the funniest moments.

It also became something precious to me: a shared activity with my daughter. Every year since, we've acted together in pantomimes. We practise lines at home, cheer each other on, and laugh at ourselves in the process. Then one year, my son decided he wanted to see what all the fuss was about and opted to join in for the *Puss in Boots* pantomime with us both.

Yes, there are teenage groans about 'Mummy doing drama too'. But beneath that, there's a shared language, a shared experience, and a connection that feels increasingly rare as children grow older.

For me, drama has become a surprisingly effective stress reliever. While community paediatrics is deeply rewarding, it can carry a particular emotional weight. We work with vulnerable children and families. We hear stories of trauma, anxiety, and uncertainty. Our work requires sustained empathy.

Drama offers something beautifully different. When I'm rehearsing, I am not a paediatrician. I am someone else entirely – a villager, a villain, a suspicious dinner guest in a murder mystery. My brain is busy memorising lines, refining gestures, and thinking about delivery. There is little mental space left for clinic letter backlogs or unanswered emails.

There is also something profoundly liberating about being allowed, even encouraged(!) to be loud, expressive, and slightly ridiculous, just for a few hours. Qualities we often suppress in professional life are not only permitted but celebrated.

Then, there are the costumes. Let's not underestimate the joy of wearing something wildly impractical, slathering on stage makeup, and knowing that under bright lights, *more is* ***more***. No one bats an eyelid. It's acting, dah-ling!

After three years with my local amateur drama group, I've progressed from a naïve Munchkin in *Witches of Oz* to a shifty murder mystery suspect to being a conniving Mother Gothel in *Rapunzel*. Along the way, I've learned far more than I expected. I am part of a motley crew, part of a unique and eclectic team where we plan shows for our own and local enjoyment, socialise, learn and laugh together.

Drama has sharpened my awareness of voice projection and modulation. I'm more conscious of pace, tone, and emphasis – all of which translate directly to clinical consultations. I'm more attuned to non-verbal communication: posture, facial expression, gesture. In paediatrics, where engagement and trust are everything, these skills matter. Drama doesn't replace clinical knowledge, but it does enhance the human connection.

Acting may not be everyone's cup of tea, and that's absolutely fine. One of the great joys of amateur drama is the variety of ways to be involved.

Backstage work is its own quiet magic. Stage design and scenery construction, prop sourcing, costume design, makeup, lighting, sound, and stage management. These roles offer creativity, teamwork, and purpose, without the need to step into the spotlight.

During one production, while playing a smaller role, I spent much of the show backstage helping with props, costumes, and quick changes. It was deeply satisfying and reminded me of the unseen coordination that keeps clinics running smoothly. For anyone intrigued by drama but wary of performing, backstage involvement can be an ideal entry point.

We talk a lot about resilience in medicine, often as something to be built, trained, or measured. I suspect resilience grows best when we have spaces where we are allowed to be human, to be imperfect, playful, creative, and connected.

For me, drama provides this space. It offers community, laughter, creativity, and perspective. It reminds me that I am more than my job – my own personal reminder that feels increasingly important in modern medical practice.

Drama may not be your thing. Though I urge you to give it a shot! But *something* outside medicine should be.

For me, that something just happens to involve learning lines, wearing questionable costumes, using copious amounts of glitter/hair dye and discovering that practising confidence in one setting can quietly strengthen it in another. Apparently, my version of wellbeing involves pretending to be other people for a few hours a week and somehow returning to work as a better paediatrician for it.

Dr Thushara Latha Perumal
Consultant Paediatrician
Brent Community Paediatrics, London

RECIPE

Spicy Prawn Tacos

Ingredients

Prawns Marinade:
- 400g of peeled prawns
- 2 tbsp of olive oil
- 2 tbsp of paprika powder
- 1/4 tsp of garlic powder
- Salt and black pepper to taste

Coriander Slaw:
- 2 cups of shredded cabbage
- 1/4 cup of thinly sliced onions
- 1/4 cup of coriander
- 1 tbsp of olive oil
- 1 tbsp of honey
- 2 tbsp of lime juice

Sriracha Sauce:
- 1/4 cup of Greek yogurt
- 2 tbsp of Sriracha

To serve:

6-8 small soft tortillas
Diced avocados and tomatoes (optional)

Method:

1. In a bowl, combine the prawns with olive oil, paprika, garlic powder, salt and pepper until well coated.
2. Heat 1 tsp of olive oil in a pan over medium–high heat. Add the prawns and cook for 4–5 minutes, until pink and cooked through.
3. For the slaw: mix the cabbage, onions, coriander, olive oil, honey and lime juice until fully combined.
4. For the sauce: in a small bowl, mix the Sriracha and Greek yogurt until smooth.
5. Warm the tortillas for a few seconds on each side. Fill with prawns and slaw then drizzle the sauce. Top with diced avocadoes and tomatoes (optional).
6. Serve hot and enjoy!

Dr Ashra Omr
BACCH Trainee Newsletter Editor

Events Calendar

- If your organisation would like to list an event on the BACCH website (free of charge) please contact ***bacch@rcpch.ac.uk***
- If you are interested in placing a full advert in the Newsletter, please see prices and deadlines on page 2.
- The events section on the website is regularly updated: ***https://www.bacch.org.uk/pages/events***
- BACCH does not affiliate group or endorse external events – listings are for information only

BACCH Events

Date	Event	Location
10 Mar 2026	BACCH Cheshire & Merseyside Regional Meeting ***https://www.bacch.org.uk/events/bacch-cheshire-merseyside-regional-meeting-chester***	Chester
18 Mar 2026	Population Health Problems: Poverty ***https://www.bacch.org.uk/events/population-health-problems-poverty***	Online
23 Mar 2026	BACCH Trainees' National Study Morning: Child Sexual Abuse ***https://www.bacch.org.uk/events/trainees-national-study-morning-child-sexual-abuse-online***	Online
25 Mar 2026	Research Ready: Trainees' Journal Club & Skills Sessions ***https://www.bacch.org.uk/events/copy-of-research-ready-trainees-journal-club-skills-sessions***	Online
1 Apr 2026	CCH Trainees' Clinical Case Discussions ***https://www.bacch.org.uk/events/copy-of-cch-trainees-clinical-case-discussions-online-***	Online
8 Apr 2026	National Monthly Lightning Learning Session for Trainees ***https://www.bacch.org.uk/events/bacch-national-monthly-lightning-learning-session-for-cch-trainees-online-apr-26***	Online
15 Apr 2026	Population Health Problems: UASC Screening ***https://www.bacch.org.uk/events/population-health-problems-uasc-screening***	Online
22 Apr 2026	Research Ready: Trainees' Journal Club & Skills Sessions ***https://www.bacch.org.uk/events/research-ready-trainees-journal-club-skills-sessions-apr-26***	Online
24 Apr 2026	WCCHN (BACCH Wales) Conference ***https://www.bacch.org.uk/events/wcchn-conference-april-2026***	Wrexham
28 Apr 2026	How to be Brilliant: BACCH Trainee Day 2026 ***https://www.bacch.org.uk/events/how-to-be-brilliant-national-trainees-day-2026***	London/ online
15 May 2026	BACCH North West Conference 2026 ***https://www.bacch.org.uk/events/bacch-north-west-conference-2026***	Preston
16-17 Sep 2026	BACCH Annual Scientific Meeting 2026 ***https://www.bacch.org.uk/events/bacch-asm-2026***	Cardiff/ online

Affiliate group events

Date	Organisation	Event	Location
10-11 Mar 2026	BACD	Annual Scientific Meeting 2026 ***https://www.bacch.org.uk/events/bacd-annual-scientific-meeting-2026-sheffield-and-online***	Sheffield/ Online
12-13 Nov 2026	APPM	Conference 2026 ***https://www.appm.org.uk/events/appm-conference-2026/***	Birmingham

External events

Date	Organisation	Event	Location
23 Mar 2026	RCPCH	Child Protection: From Examination to Court (Level 3) ***https://www.bacch.org.uk/events/child-protection-from-examination-to-court-england-wales-level-3-blended***	London/ Online
21 Apr 2026	British Association for Neonatal Neurodevelopmental Follow-Up (BANNFU)	Study Day ***https://www.bacch.org.uk/events/bannfu***	London/ Online
23 Apr 2026	RCPCH	Masterclass: Safeguarding Children NHS Level 4 ***https://www.bacch.org.uk/events/masterclass-safeguarding-children-nhs-level-4***	Online
29 Apr 2026	RCPCH	Effective Educational Supervision ***https://www.bacch.org.uk/events/effective-educational-supervision-online-***	Online
29 Apr 2026	RCPCH	A General Paediatrician's Guide to Common Ano-genital Presentations – Level 3 ***https://www.bacch.org.uk/events/a-general-paediatricians-guide-to-common-ano-genital-presentations***	London
8 May 2026	RCPCH	Effective Educational Supervision ***https://www.bacch.org.uk/events/effective-educational-supervision-online-may-2026***	Online
11-13 May 2026	RCPCH	RCPCH Conference 2026 ***https://www.bacch.org.uk/events/rcpch-conference-2026***	Birmingham/ Online