Community Child Health Research Career Pathways Report

The health of our children is the power of our nation…

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The independent reviewer and report author takes responsibility for interpretation of the perspectives in this report, including any errors.

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ACF	Academic Clinical Fellowship
ACL	Academic Clinical Lectureship
AHP	Allied Health Professional
ARC	Applied Research Collaboration
ASD	Autism spectrum disorder
BACCH	British Association for Community Child Health
BACD	British Academy of Childhood Disability
CCT	Certificate of Completion of Training
DHSC	Department for Health and Social Care
ICB	Integrated Care Board
IPL	Inter-professional Learning
MD	Master of Medicine
MRC	Medical Research Council
MSc	Master of Sciences
NIHR	National Institute for Health Research
PA	Programmed activities
PhD	Doctor of Philosophy
MDT	Multi-disciplinary team
MRCPCH	Membership of the Royal College of Paediatrics and Child Health
NIHR	National Institute for Health and Care Research

QI	Quality Improvement
RCPCH	Royal College of Paediatrics and Child Health
SAPHNA	School and Public Health Nurses Association
SPA	Supporting professional activities
ST	Specialty training level (ST1-8)

Community Child Health Research
Career Pathways Report

1. Introduction

The health and wellbeing of children in the UK is extremely important because what happens in childhood sets an individual's life course; and it is important for the NHS, because treating ill children takes up a disproportionate amount of NHS resource, and childhood health/ill health can have a life course impact, with related repercussions for NHS services. It follows that research into child health is necessary and valuable. Yet there is surprisingly little clinician-led (or academic) research undertaken into acute and community child health in the UK, and for community child health the amount of research is dwindling.

1.1 Project aim

This project aimed to understand the facilitators and barriers to clinician-led research in community child health. The project was commissioned by the BACCH (British Association for Community Child Health) Research Strategy Working Group[1] with a view to informing the development of a roadmap to support community child health clinicians and practitioners to engage in impactful community child health research.

1.2 Project context

Recommendations supporting the project were made in the *BACCH Research Strategy Working Group Report to BACCH Executive (June 2022)*; in which identified areas of joint interest and focus for an interdisciplinary group was:

- Social Paediatrics (safeguarding, vulnerable children addressing health inequalities)
- Child development (growth, nutrition, neurodevelopment, mental health and wellbeing, health promotion)
- Child Population Health (including life course, health promotion, environmental health, health services research, integrated care).

The BACCH report highlighted the loss of critical mass of research-active community child health professionals over time. Contributors to this were thought to include a lack of dedicated research time for established professionals and limited early career opportunities/experiences to inspire newly qualified clinicians and practitioners to pursue research. The report recognised a need to increase research-awareness in the community child health workforce, as relevant research questions are often best identified via practice-led interest.

[1] The BACCH Research Strategy Working Group remit includes: refining the scope of community child health research; mapping existing successful UK community child health research activity; developing a methodology and process to prioritise community child health research areas; and developing a plan to promote practice-led research in community child health.

1.3 Project consultant

The project has been undertaken by Dr Christine Christie, of Chanon Consulting. The principal project output is this report, including recommendations for the roadmap to encourage and support paediatricians to pursue action research in community child health.

2. Methodology

The project methodology was a mixed methods qualitative approach to achieve collaboration between a select group of expert community child health clinician researchers, a wider community of community child health clinicians with a range of expertise-by-experience, and the researcher.

2.1 Project plan, participants & timeline

The project plan comprised three stages – interviews, a Delphi survey and consultation with stakeholders:

- Stage 1 involved in-depth interviews with seven established expert community child health clinician researchers.

- Stage 2 involved the Delphi survey with statements which were informed by the findings from Stage 1. The survey was circulated to 15 participants across England and including Scotland.

  To preserve anonymity the names and designations of the community child health clinician researchers who participated in the interviews have not been included in this report. Their current locations included London, the south east, the south west and the west midlands, though many had also worked in other areas previously.

  Respondent anonymity is a feature of Delphi surveys, however, the respondents' current locations included London, the south east, the east of England, the east midlands, the north east, the north west, Scotland; and two English national school nursing/health visiting organisations.

- Stage 3 involved consultation expert stakeholders and the BACCH Research Strategy Working Group, translation of the findings into recommendations and preparation of this project report.

The project time period was ten months, concluding with this report.

2.2 Project questions and presentation of findings

The questions which the project sought to answer were:

- How and why research areas have been chosen, and what the facilitators and barriers which can influence these decisions might be.

- What might be needed to develop a community child health research strategy.

- With whom and how awareness needs to be raised about the possibilities of practice-led research career pathways (and also, what these might look like).

- The potential for clinicians and practitioners to integrate the accessing of research to inform their day-to-day practice.

Additionally, it was hoped that the project's collaborative approach would promote interest in research amongst the community child health clinicians who participated in the Delphi study.

In relation to presentation of findings, to ensure participant confidentiality for the very small number of participants interviewed in stage 1 of the project, the numbering of quotes has been withheld. For quality assurance purposes they have been retained in a stored version of this report.

3. Findings

3.1 Findings context

As already mentioned, the BACCH Research Strategy Working Group identified a number of issues which appear to have contributed to a loss of critical mass of research active individuals in community child health research over time.

The Working Group's report to the BACCH Executive noted a number of factors which, if addressed, might reverse the reduction in community child health research. These included:

- Clarity in defining the scope of community child health

- A need for a community child health research strategy

- A need to promote dedicated community child health academic research departments

- An agreed mechanism for prioritising community child health research

- Encouragement to employers to invest in research time for community child health clinicians and practitioners

- Investment in funding opportunities for community child health research

- Promotion of 'research awareness' in the community child health workforce

- Creation of a BACCH infrastructure to support research.

All the factors noted by the BACCH report were echoed in the interviews and Delphi study for this project, as were a number of other issues. The project focus was on identifying and attempting to address the elements which it appears may have most impact on the development of a career pathway or roadmap for community child health clinicians and practitioners – to re-establish a critical mass of research active individuals to take forward community child health service innovation and improvement.

INTERVIEWS

Following from the BACCH observation that there has been a reduction in community child health research, the interviews sought to contextualise the participants' views on community child health research in 2024, by exploring with them what, in their experience, has changed over time.

Additionally, there was a focus on potentially rectifiable factors which might have contributed to reduced activity in community child health research. This focus in the interviews has resulted in a significant list of areas where there is scope for improvement, which risks creating an overly negative impression. However, readers are invited to view the list as offering scope for promoting community child health research – and with it, potentially contributing to a step-change in the health of all children. Areas of current strength are also set out below.

See appendices 2 and 3 for the interview information sheet and semi-structured interview guide.

The next subsections 3.2.1-3.2.13 present the findings; and are summarised in subsection 3.3 below.

3.2 Challenges for community child health research

Areas where there is scope for improvement in community child health research include:

3.2.1 Research included in training

All the participants thought that the route into community child health research is much more difficult than it used to be. To begin with, training to reach senior Registrar level used to include mandatory two-years of research but that mandatory research element was removed. There is now no time post-qualifying for those who would like to do research. The change has been largely driven by pressure to staff work rotas, which mitigates against absences to undertake research. However, the competencies programme itself has also shifted the focus away from learning about research. Participants said that the competencies are so rigidly structured and the individual 'moves through' them with such precision, that, *"There is no space/scope for curiosity and the generation of ideas to pursue avenues of research to find answers".* The result is that the new generation of juniors are less motivated to identify/create and use opportunities to generate (or implement) research.

A participant described being inspired whilst training, to pursue research as a result of noticing a difference between the experience of children in special schools compared to mainstream schools: *"The research was desk-based and just needed a study afternoon per week, yet when published it made an important contribution to the health children with special needs."*

Additionally, the steps to reach consultant level used to include an MD (Doctor of Medicine) or a PhD (Doctor of Philosophy). This both prompted interest in and a valuing of, research, as well as developing research skills, however it was dropped. A participant noted that the opportunity to explore research as an option was critical to their decision to become a community child health clinician researcher: *"I had to do a three month research project for my MSc (Master of Sciences), it was the gateway to my research career".*

The lack of requirement, or incentive, to do an MSc, MD or PhD has created a generation of consultants who do not have research skills. A participant commented that this is apparent in the audits and reviews consultants undertake. Following from this, consultants are much less likely to value and undertake research; and also less likely to inspire or have the confidence to manage, juniors doing research.

Over the same period of time the pathways through Medical Health Research into academia have been strengthened, so that individuals with a research interest do not take a clinical route hoping to include research in their portfolio of day-to-day activities. They just take the research route. Additionally, the clinical and academic career pathways have become rigid, with no cross-over points. There is a mismatch between the clinician's seniority and level of clinical expertise and the very junior entry point into academia. A participant explained that this means for example, that despite a long and successful career of undertaking research, there was no way of accessing the academic world without *"going back and completing a PhD to demonstrate an ability to do research"*. This situation is underpinned by a lack of recognition in academia of the fact that the an established senior clinician researcher is likely to cope very well with streamlined assimilation of research methodologies, process and practice.

A participant described a significant additional benefit which was consequent to having had to undertake a masters degree. The degree had enabled the participant to develop relationships within a university which both encouraged the participant's research (including completing a PhD) ; and longer term, had created the academic partnership clinician researchers need to win for funding bids (see also subsection 3.2.9 Funding models and decisions).

3.2.2 Choosing research

Community child health clinicians usually make the choice to specialise later in their careers than clinicians who choose other specialisms. An example of how this can happen was offered by a participant who said,

> *"I did my training in a hospital-based specialist respiratory team, I didn't know about community child health. So, I only switched later."* (see also subsection 3.2.9 Funding models and decisions).

A consequence of a late choice is that community child health clinicians identify a desire to engage in research later in their careers than do clinicians in other specialisms. Participants noted that this often happens when a community child health clinician begins looking for answers to the gaps in knowledge they encounter in their clinical practice. The relatively recent establishment of community child health as a specialism means that there are many such gaps in knowledge.

The late focus on research in a clinical career puts community child health clinicians at a disadvantage because the NIHR (National Institute for Health and Care Research) academic pathway is structured to suit junior doctors who know from the beginning that they want to pursue a career in research as well as clinical practice. The early selection of [the top 5% of high achieving] junior doctors as future medical researchers may suit e.g., genetics and other laboratory-based specialties; but it does not accommodate the requirements of community child health research. A participant described the context saying,

> *"Community child health needs the researcher to be a clinician first, with a starting point of: 'how do I tackle the problem in front of me?' because the issues are so much more context-dependent, than discrete diseases i.e., a ground-up approach not top-down."*

Another participant described this in a different way, saying that:

> *There is a view that research is the preserve of academics and is planned, led and reported on in universities not in clinical practice. There is little understanding that 'research is for all of us'."*

Where they do follow a research career, there is also a challenge arising from the fact that it is much easier and, crucially more rewarded, in terms of establishing a professional identity to focus on a narrow specialism e.g., paediatric renal research, rather than the more general/holistic, complex, and under-valued field of women and children's health – in the community. Reputations are more easily built on the funding generally awarded to specialist research rather than to complex, not well understood, multi-disciplinary community child health research. A participant noted that,

> *"R*ecently, a *'smart, young clinician' had specialised in an illness experienced by only 50 children a year in the entire country, rather than trying to raise the quality of health and wellbeing for all children."*

3.2.3 Community child health profile

A relatively prominent public profile for any specialism is helpful in attracting, engaging and sustaining career interest. The public profile of community child health, whilst never very high, has diminished to the point that it now has no public or NHS profile. Similarly there has been a demise in the profile of senior academic roles in child health. A participant noted that,

> *"Senior community child health clinician researchers used to be 'at the table' in government departments (e.g., the DHSC (Department for Health and Social Care). They were sought after both for their expertise in academic research and for their leadership within the NHS (innovative clinical practice and quality). They were 'movers & shakers' ".*

The participant added that there are now not many senior community child health clinician researchers and they are not linked into national or even regional policy and strategy; and they do not have the status which goes with that sort of networking and influence.

The lack of profile means that the discipline does not attract people; and juniors considering specialism have no role models (see also subsection 3.2.4 Role models, mentors and supervisors); career goal or status they might aim for. Child health, and community child health in particular, is regarded as less exciting than more high profile and more narrowly defined specialisms. In consequence it does not attract young clinicians.

The established community child health clinician researchers are not formally valued by the NHS and the body of evidence they are developing is not used to improve practice. Instead, community child health practitioners across the country find out about the community child health research in an ad hoc fashion. This 'post-code lottery' of learning from community child health research is exacerbated by the fact that lack of national recognition of expertise creates a circumstance in which local Trusts appear not to value their own clinician-researcher's work.

3.2.4 Role models, mentors and supervisors

As noted above, there used to be thriving centres of community child health research each comprising a partnership between the NHS Trusts and local university. These teams were led by clinician researchers with senior roles in both clinical and academic spheres, and in these roles they could inspire, demonstrate and support good community child health research. The majority of participants said that they had benefited significantly from having a role model/mentor at the beginning of their careers as community child health clinician researchers.

However, the universities no longer accommodate individuals who can only offer small time commitments. As a result, There are so few clinical and academic paediatricians that university departments do not have leads in the specialty. Centres of expertise in community child health are not being nurtured. Several participants described starting their careers as clinician researchers as a result of their engagement with a centre of expertise. The centres offered them excellent role models and mentors e.g., three or four paediatricians with a mix of community, general and ambulatory expertise. There were no divisions between community and hospital clinical practice and research interest (see also subsection 3.2.5 Integrated acute and community paediatrics).

The senior paediatricians were described as fostering an environment which encouraged ideas and enthusiasm, presented role models and demonstrated a career path which could be followed. There were also enough seniors to provide proper supervision to the juniors. A participant said that now, even in the more popular community child health specialism of neuro-disability, there are as few as only four or five established community child health clinician researchers across the country. Between them they do not have enough time to provide supervision to the next generation of neuro-disability community child health clinician researchers.

Finally, the lack of experienced and senior community child health academics means that established community child health clinician researchers who want to undertake research, cannot co-produce the research. This is important because the NIHR is reluctant to award funding to research which, without suitable academic input, would be considered to lack rigour (see also subsection 3.2.9 Funding models and decisions).

3.2.5 Increasing specialisation

Community child health clinicians' interests used to encompass all of child health. They had not been constrained to choose acute or community child health, or to specialise on one aspect of community child health rather than the whole child. This allowed individuals to experience both. However, now junior doctors have to choose either acute or community child health, and it is very difficult to change course during training. In the past, a junior doctor might start in a hospital but because the seniors were not split into hospital/community it was easy to move between the two.

Participants described a current situation in which trainees are given a list of competencies which they have to acquire – not areas they have to work in. This has led to trainees avoiding community child health by acquiring the competencies in hospital paediatrics. This choice is partly due to intensity of the competencies programme. So, even where a student has a six month placement in community child health, they will be on-call in the evenings for the hospital, and will take days off in lieu. This results in them not being consistently available for community child health clinics, and it keeps their focus in the hospital.

Junior doctors are not just having to make an early choice between acute and community paediatrics, with the focus shifting in favour of acute/hospital paediatrics. There has also been a move in child health away from the whole child, to narrowly defined specialisms. A participant described this as follows,

> *"Within community child health the focus has shifted to 'neuro-disability'. This is now what people think of as community child health, with safeguarding and looked after children as side-issues. Each of these specialisms are only one aspect of child health – and not the whole child."*

3.2.6 Practice placements

With the decrease in the profile and popularity of community child health, and the reduction in centres of research into community child health, there has been a parallel fall in available training posts for community child health clinician researchers. A participant noted that the numbers of applicants to university is higher than the number of places available, and that the restriction is driven by a lack of practice placements. Participants noted that the lack of training posts reflects an undervaluing of community child health by the RCPCH (Royal College of Paediatrics and Child Health) and NHS England.

As mentioned above, junior doctors are 'on-call' , and trainee paediatricians cover the acute and neo-natal paediatric rotas in their local Trust. Participants noted two challenges with this: firstly acute and neo-natal paediatrics do not form part of the skill set needed for community child health, so the time is 'wasted' in terms of acquiring knowledge and skills relevant to community child health. Secondly, junior doctors who are 'on-call' overnight lose time gaining experience in community child health clinics in the days before and after each night shift. This means that they cannot be part of routine practice and would struggle to lead a research project.

3.2.7 Funding for posts

Community child health clinician researchers used to be funded by flexible funding streams from both the NHS and the universities – enabling them to maintain a workload which was split between clinical and research work. Clinicians wanting to also pursue research used to be able to apply for posts which were funded fifty-fifty by the NHS and a university – recognising the benefit to the NHS in terms of improving clinical practice and the benefit to the university whose students were educated by practicing clinicians. Grant funding paid the salaries of the juniors who undertook the fieldwork/analysis and report writing. However, the NHS withdrew funding for research work and the universities started requiring the posts they fund to be 100% focused on academic work. The lack of value placed on research by the NHS is not unique to community child health. However, it is a relatively new field and does not have a strong academic base. (see also subsection 3.2.13 A national framework).

3.2.8 Funding models and decisions

All the participants described an increasing funding bias by central government, universities and grant-making trusts in favour of hospital-based research. Their experience has been that the NIHR favours hospital-based research in all areas of health. They attributed this to community child health being a relatively new field with a very low profile; one participants commenting that this was exacerbated by the fact that, *"community child health is too small for the NIHR to set up dedicated community child health funding approval group"*. However, the fact that community child health is a relatively new field should prompt policies and action to establish the evidence-base, rather than allowing a funding bias to continue.

The participants also said that clinician-led research is important in community child health because the research questions develop to solve clinical and systems gaps in operational knowledge and practice (see also subsection 3.2.2 Choosing to do research). In contrast, academic research is more likely to seek to answer questions with less immediate practical value. Additionally, academic research is very often based on small population samples. In contrast clinician researchers can much more easily access very large populations.

From this practice-generated research perspective, a participant described the difficulties which arise when a practitioner contacts the established community child health clinician

researchers for help to initiate some research. The challenge being that there are no resources available to support undertaking (let alone implementing) research. In terms of learning from research, a key aim of the NIHR ARC (Applied Research Collaboration) is to translate research into practice i.e., for research to 'make a difference'. However, with the split between clinician-led research and academic-led research, now almost all of the small amount of funding that is available for community child health research nationally, is channelled to the universities. Following from this, the focus remains on 'knowledge acquisition' not on translating knowledge into practice – implementation is minimal and inconsistent across the country.

Participants noted that community child health does not benefit from the commercial funding which supports a lot of health research for two reasons. One is that paediatric health research does not that there are such small numbers of children with each special condition and there is such a range of conditions (compared e.g., to diabetes). The second reason is that the focus for commercial parties is biomedical, mechanistic and pharmacological research.

There are three aspects to the funding that is available for community child health research:

- There is intense competition for funding to study/research fellowships, but funding decisions are biased towards the more traditional specialties where people knew that they wanted to undertake research from the beginning of their career journey and already have a track record of research and publication (because they started early).

- Project funding decisions are taken by people who do not understand community child health research methodology and approaches e.g., creative arts, use of community researchers and the need for translators. They are comfortable with quantitative and experimental methodologies (see also the subsections on profile, roles and mentors, ethics and strategy)

- Within the detail of funding envelopes:
    - there is no provision to cover the time researchers take away from their clinical work
    - there is no provision for paying the fieldwork participants i.e., recognition of the contribution of children and families.
    - the focus is on roles below doctors on the basis of the, now incorrect, understanding that doctors are facilitated to do research
    - competitively funded studies with proper ethics mean that the NHS Trust gets funding for all recruited patients (this is biased towards hospitals). There is a disincentive to participate in research not led by the Trust (e.g., by academics) because e.g., doubling the number of patients for the fieldwork only increases the funding by 5%, not 50%.

- Funding models for research projects have followed the high specialization/narrow focus of acute child health and small pockets of specialism (e.g., neuro-disability) in community child health. These funding models tend not to accommodate the multi-disciplinary, preventative and longer term profile of community child health research. In consequence, there is almost no research focused on multi-disciplinary service delivery (health, social care, education and the voluntary sector/community). Yet children are significantly impacted by, and cared for in, settings other than their homes e.g., therapy for ASD (autism spectrum disorder) is delivered in school.

3.2.9 NHS capacity

Participants noted two areas in which reductions in NHS capacity are contributing to a decrease in community child health research. The first is that consultants (and trainees) no longer have time to do research, there used to be PA (programmed activity) time for research but now it is used for mandatory training or clinics. A participant said that some employers expected consultants to use SPA (supporting professional activities) time for research, however SPAs are for routine service audit. The withdrawal of PAs for research is partly due to management not valuing research, but mainly due to the fact that there are not enough community child health consultants, so there is no-one to run their clinics in order for them to take the PA time in their week to do research. A participant described this,

> *"The problem is that even where grants are available for research, those of us who are established community child health clinician researchers have had to do our research in our own time. This has affected what gets researched and also what it is possible to research – given the time-constraints."*

Hospital-based child health clinician researchers have not faced the same challenges because traditionally they have had research SPA/PA time in their contracts.

The lack of community child health consultants who are clinician researchers (or who have the time to focus on research) means that where staff want to undertake research in an NHS Trust e.g., to address a gap in practice knowledge, there is no consultant in the Trusts to lead the project. Pertinent, well thought through projects with potential to enhance practice/service delivery are not happening because of this.

Referring to the withdrawal of joint-funded posts (see also subsection 3.2.7 Funding for posts), a participant said,

> *"Unlike in the USA, in the UK there is no recognised 'integrated position or post' which allows a clinician to be employed as both a clinician/clinician researcher and an academic researcher."*

The second reduction in NHS capacity are contributing to a decrease in community child health research followed from the transfer of public health to local authorities. This removed the public health workforce (e.g., health visitors) who traditionally contributed e.g., by undertaking the fieldwork for community child health projects. In this context, whilst there is some single-agency community child health research, much of it has become more complicated and time-consuming, because it is no longer a single agency enterprise. Instead it requires the negotiation of multi-agency relationships, governance, funding; and similarly requires multi-agency working to translate any learning into practice.

Participants described past research with joint-funded posts as being undertaken by a team comprising e.g., a professor, a senior lecturer, a lecturer and an administrator, however, now a professors have to do everything themselves. As noted above, there is also now much more paperwork, which is resource intensive. Established clinician researchers who are still joint-funded said that they do not have the time to think creatively (or analytically) because their workload is excessive from both clinical and academic employers; with both employers shifting the time-requirement to the other. One added that it is easier for busy operational professionals in the various agencies (or NHS sites) to refuse research, than to take on 'the extra burden' of facilitating research.

3.2.10 Access to research publications

Some participants noted that the withdrawal of joint-funding for clinician researcher posts has restricted access to the academic research databases. This contributes to the already concerning lack of evidence-based practice in community child health and resulting potentially sub-optimal quality of NHS services. A participant articulated this as follows:

- With the small numbers of community child health clinicians in the country, individual clinicians could greatly benefit from the thinking and ideas contained in international research publications

- Clinicians wanting to address specific service delivery problems cannot use the research findings (including by contacting the publication authors) to improve NHS practice locally

- Clinicians wanting to undertake research cannot scope that research (understanding exactly where the knowledge gaps are) and inform their research plan on the basis of what is already known/has already been tried

3.2.11 International collaboration

Several participants noted that there has been a set-back in research collaboration with European community child health research colleagues post-Brexit. This has reduced both funding opportunities, fieldwork opportunities and stimulation of ideas and perspectives. Government support for international collaboration has dwindled and is now much more restricted e.g., to colleagues in Australia, Canada, the USA and India amongst others.

3.2.12 Ethics

Participants agreed that ethics has improved enormously and is now it much more consistent, comprehensive and professional. However, they also said that it has become really complex and bureaucratic creating resource issues for completing ethics applications and delays, both of which mitigate against research being undertaken. A participant noted that the universities have an unfair advantage in that their ethics committees are less exacting than the NHS ethics committees.

Community child health is very context dependent and as a result community child health research can be 'social' rather than 'medical'. Following from this community child health research methodology, population samples and other issues can differ significantly from medical research. Participants said that NHS ethics committees do not have the understanding to cope well with this, suggesting that multi-sector ethics committees are needed. A participant described ethics committees as 'gatekeeping',

> *"Over-protecting fieldwork participants – without an understanding of the practice expertise that is routinely exercised in the professional-patient/family relationship – and which cannot be adequately described in the ethics application".*

The participant said that this routinely resulted in, *"pages of misguided questions and requests for detail which is difficult to articulate"*. This stifles research.

Another participant described community child health research as being "*messy and more complicated than research with adults*", often because:

- *"The client group are very vulnerable, many are looked after children and/or have had experiences requiring safeguarding intervention;*

- *Others are neurodiverse or disabled;*
- *It is often difficult to isolate a condition;*
- *Families are struggling and exhausted, they cannot cope with the requirements participation in research imposes; and*
- *The research can't be undertaken in one location because there are so few children with a specific condition in one area and because it requires parents/carers' support."*

3.2.13 A national framework

Community child health research does not sit within a national framework. Participants talked about the fact that there is no national research strategy/plan to ensure that research is focused on and able to address the most relevant issues, across the country in community child health. Such a framework would offer a way of understanding the supporting structures, systems and funding needed to sustain it, as well as promoting the profile and value of the research. One of the participants described, also, having been approached by at least half a dozen junior doctors requesting mentoring/supervision to pursue an interdisciplinary approach to child health. Their difficulty is that there is no framework which,

> *"Legitimises focusing on the whole child, sets out a career pathway, and provides recognition for specialists in the field. These junior doctors have 'no tribe'."*

These clinicians are not able to engage with local government public health colleagues, not only because the latter are not within the NHS, but also because local authority public health has a more general focus on 'life-course', inequalities, and the 'under-served' sections of the population.

The lack of research guidance means that NHS management focuses only on the short term goal of reducing waiting lists. This means that they prioritise more clinics over allowing time for research. In many cases the decision is made by relatively junior people with no understanding, investment or overarching guidance in or about research to improve services. Participants said that this was counter-productive because clinical vacancies are more likely to be filled if doctors' contracts were more attractive (with clinics and research time); and service quality and efficiency (e.g., reduced waiting lists) is more likely to be achieved with research and innovation.

Participants said that research needs to be part of standard community child health single and multi-agency service delivery. In their view whilst quality improvement is presented as important, it is not actually happening. A participant identified the cultural tensions which need to be overtly managed, between following protocols for consistent and safe service delivery and the requirement to 'think outside of the box' to stimulate and benefit from research. The participant said that top-down intervention was needed to support research because without it 'process trumps innovation'. Innovation is needed to keep pace with the changing nature of community child health. A participant said:

> *"Community child health used to be about screening, school entry medicals, speech & language and 'heart murmurs' but it has become more complex and challenging as children with neuro-disabilities live longer and continuous improvement is needed in responding to neurodiversity and safeguarding."*

3.3 Summary of interview findings

The findings from the interviews are summarised here in terms of the themes from the headings above.

Participants thought that becoming a clinician researcher is much more difficult than it used be. Research is no longer included in clinical training and clinical and academic research career pathways have become siloed and rigid – with no cross-over points or overlapping networks of peers to facilitate research. Participants also noted the difficulty that the NIHR academic pathway is structured to junior doctors who know from the beginning that they want to pursue a career in research as well as clinical practice but community child health clinicians usually make the choice to specialise later in their careers. Where they do follow a research career the breadth of focus in community child health mitigates against establishing a professional identity. Participants thought that a significant contributor to these issues or the fact that they have not been addressed, that the status of community child health has diminished to the point that it now has no public or NHS profile; with a related collapse in the status of roles. This is important because a prominent public profile for any specialism is helpful in attracting, engaging and sustaining career interest. Several participants described starting their careers as clinician researchers as a result of their engagement with a centre of expertise inf community child health research each comprising a partnership between the NHS Trusts and local university. These teams were led by clinician researchers with senior roles in both clinical and academic spheres, however this type of arrangement is no longer available; and there are no longer enough clinical or academic researchers supervisors to support co-produced research.

Participants noted that the pressure towards specialization included junior doctors having to choose either acute or community child health with increased difficulty in changing course during training. Competencies can all be acquired in a hospital setting and the requirement to be ‘on-call’ lessens time available for engaging with community child health clinics. Furthermore, trainee paediatricians cover the acute and neo-natal paediatric rotas in their local Trust – experience not useful to community child health. Within community child health specialism has shifted focus away from the whole child. Participants described a fall in available training posts for community child health clinician researchers driven by a lack of practice placements.

Participants attributed some of the above mentioned challenges to there no longer being funding streams which enabled them to maintain a workload split between clinical and research work. They also described an increasing funding bias by central government, universities and grant-making trusts in favour of hospital-based research. This despite the fact that community child health is a relatively new field – needing more rather than less research to establish a robust and comprehensive knowledge-base. The participants also said that clinician-led research is important in community child health because the research questions typically develop to solve clinical and systems gaps in operational knowledge and practice. State funding is the more important because community child health does not benefit from the commercial funding. Furthermore, that a new approach was needed away from narrow specialism and toward the multi-disciplinary, preventative and longer term profile of community child health research.

Participants noted two areas in which reductions in NHS capacity are contributing to a decrease in community child health research. The first is that community child health consultants (and trainees) no longer have time to do research, and the second is that the transfer of public health to local authorities has significantly reduced capacity in the NHS (e.g., the health visiting workforce) for undertaking community child health research.Some participants noted that the withdrawal of joint-funding for clinician researcher posts has restricted access to the academic research databases. Several participants noted that there

has been a set-back in research collaboration with European community child health research colleagues post-Brexit. The final two findings from the interviews were, firstly, that participants were concerned about NHS ethics committees having a medical focus when community child health requires a social focus (with methodologies and risk assessments). Secondly, that a national framework is needed for community child health research – to ensure that research is focused on and able to address the most relevant issues in a timely and consistent way across the country.

DELPHI STUDY

Delphi is a survey technique that uses one or more iterations designed to develop a consensus of opinion amongst a panel of people expert by way of relevant professional and/or experiential knowledge in a particular field. Delphi surveys are usually developed from a literature analysis or from primary data e.g., interviews – as in this research. A Delphi survey usually takes the form of a series of statements which participants are asked agree to/prioritise and/or disagree with and suggest alternatives. For each statement participants were offered a number of suggestions for achieving the statement objective and asked to prioritise them.

The statements aimed to elicit agreement on what might be needed to revitalise community child health research. Five of the six statements and the suggestions offered for taking them forward, were informed by the findings from the interviews. They were:

1) Re-introduction of research training and experience into medical student/post-qualifying training.

2) Funding for community child health projects, fellowships and training posts.

3) Encouragement and support for clinician researchers.

4) Re-integration of existing and undeveloped specialisms into a whole child approach for community child health research.

5) Promoting recognition of the value of community child health research.

A sixth Delphi survey statement did not feature strongly in the interviews due to the profile of the participant sample. The issue was identified in the findings from the RCPCH Workforce Census 2022 Report[2], which looked at the relationship between paediatricians' sex/gender, their primary job type, their work patterns and their caring responsibilities. The Census Report reported that:

- Over three times more female paediatricians than males were working in community (25% v 7.5%);

- Over half community paediatricians were working less than full time (58%) compared to between a fifth and a quarter (20-25%) of general, specialist and general & community paediatricians;

- Whilst there was no significant relationship between being a child carer and work pattern, there was a significant relationship between being an adult carer and sex/gender & work pattern, with a higher-than-expected number of female

[2] RCPCH. *Workforce Census 2022 Report*. Available at: https://www.rcpch.ac.uk/sites/default/files/2022-10/rcpch-workforce-census-2022-full-report.pdf

paediatricians caring for adults, and a higher-than-expected number of paediatricians caring for adults with a less than full time work pattern; and,

- The number of research PAs for paediatricians working less than full time was 0.04 compared to 0.4 for those working full time[3].

These findings appear relevant in terms of their impact on clinician-led research in community child health; and were incorporated into the survey as a question about what a better balance between clinical work, research and caring responsibilities could look like.

See appendices 3 and 4 for the Delphi information sheet and the survey.

The Delphi survey was circulated to 15 community child health clinicians and completed responses were returned by 11 participants; a response rate of seventy-three percent[4]. The responses are summarised as findings in sub-section 3.5, below.

3.4 Facilitators of community child health research

The Delphi survey offered respondents the opportunity both to prioritise the suggested ways forward and also to comment on the statements, the suggestions achieving it and/or on any other issue which they felt should be/should have been, taken into account. Each subsection below, presents the prioritisation of suggestions and then the comments relating to that statement. In the absence of several Delphi rounds/iterations exploring issues raised by respondents in relation to the statements, the commentary is offered as a way of contextualising the degree of consensus described for each statement and its related suggestions.

Two over-arching comments were, firstly that because delivery of health services is devolved to the four nations, the term 'national' bears careful definition so as to promote equity in opportunity across the UK. Secondly, that the statements suggest that things were much better in the past and whilst that might have validity, going forward the aim should be to improve on the past and to innovate for the future.

See appendix 5 for the Delphi survey feedback form.

The next subsections 33.4.1-3.4.6 present the findings; and are summarised in subsection 3.5 below.

3.4.1 Re-introduction of research training and experience into medical student/post-qualifying training

The statement in the survey was**:**

We could re-introduce research training and experience into medical student/post-qualifying training

Prioritisation

[3] RCPCH. *Workforce Census 2022 Report*: Tables 9, 17, 19, 39, 42 & 43.
[4] To maintain rigour, as a guide it is suggested that the response rate for a Delphi round should not fall below 70% (Kilroy and Driscoll 2006).

In terms of re-introducing research training and experience into medical student/post-qualifying training, over eighty percent of respondents thought this could be achieved by establishing sponsorships/fellowships for training in research.

Over three-quarters of respondents agreed that research training and experience could be introduced into medical student/post-qualifying training by re-introducing small research projects. A similar proportion of respondents thought that it could be achieved by changing the current selection criteria for an academic career pathway to focus more on contextually-influenced clinical research.

Just less than three-quarters of respondents agreed that developing a focus on multi-agency research, and research that includes children's community (associative and environmental i.e., contextual) life might promote research in post-qualifying training.

Over two-thirds of respondents thought it could be achieved by including research in requirements for consultants (one of the four pillars advanced practice) and, finally, slightly less than two-thirds of respondents thought it might be achieved by introducing optional additional research modules.

See appendix 6 for a table showing the Delphi study analysis.

Commentary

In summary comments from individual respondents included that:

- Working in the multi-agency context is crucial to support a wider range of multi agency practitioners engage with research that is relevant to them. Consideration should be given to where IPL (Inter-professional Learning) could contribute to promoting multi-agency research and research that includes children's community life. This could usefully include teaching on public health and methodologies – very useful in paediatric training anyway and would allow trainees to gain some methodology skills.

A useful way forward could be to shift the focus on QI (Quality Improvement) projects to group projects with meaningful outcomes. The group aspect could be e.g., a requirement for the team to include a senior, a trainee, a medical student and a MDT (multi-disciplinary team) colleague. Another requirement could be that the projects should include literature reviews demonstrating how the project relates to/takes forward, existing knowledge on the topic.

- It would be helpful to include modules and teaching on public health and methodologies and to promoting systematic reviews as part of community child health QI.

- If an optional research module were introduced it is likely to be ineffective without curriculum support to engage with the module and competencies to be achieved by doing so. This would require support from RCPCH and NHS England (formerly HEE[5]) to facilitate specialty registrars undertaking these modules during their training. It would also need support from ICBs (Integrated Care Boards) and Trusts in England and equivalents on a four-nation basis, to be able to undertake these as consultants.

[5] Health Education England which merged with NHS England in 2023.

- The fact that trainees have limited knowledge of how to conduct quantitative or qualitative research is not just a reflection of lack of training or opportunity. It is also because they do not have time to explore and undertake research. They have training requirements [which could be extended to include research] and clinical work but there are no requirements for Trusts or training programmes to give them the time needed to properly engage with research.

- ACFs (Academic Clinical Fellowships) typically have not yet decided whether they want to specialise in community child health/neurodevelopment and could benefit from more information to make the decision. However, there is only limited NIHR funding for clinical trainees to get time out/have a fellowship/decide whether they are interested. This compares unfavourably with the funding AHPs (Allied Health Professions) can access from the NIHR. A respondent commented as follows:

'As someone who is developing a formal academic career as a consultant – there are very few opportunities to do academic work in training outside of the ACF/ACL pathway – which if you don't make a decision at ST1 to do its hard to continue. Even if you do decide at an early stage – there are few senior researchers visible in this field to support upcoming trainees.'*

** Specialty training level (ST1-8)*

Finally, a respondent noted that no all consultants are necessarily interested in or good candidates for leading research. Though all could be involved in some way.

3.4.2 Funding for community child health projects, fellowships and training posts

The statement in the survey was:

We could make funding available for community child health projects, fellowships and training posts

Prioritisation

In terms of funding for community child health projects, fellowships and training posts, over ninety percent of respondents prioritised introducing ring-fenced funding for practical community child health research.

Over eighty percent of respondents agreed that it might be achieved by establishing an NIHR specialist committee to promote and make funding decisions for community child health research.

Eighty percent of respondents thought that it could be achieved by promoting philanthropic funding for community child health research.

Two-thirds of respondents agreed that developing a national framework for multi-agency contributions to funding would improve funding for community child health projects, fellowships and training posts.

See appendix 6 for a table showing the Delphi study analysis.

Commentary

In summary comments from individual respondents included that:

- Funding to undertake research really important but it needs to be accompanied by (or extended to include backfilling to allow for) allocated time away from clinical work to undertake research.

- The NIHR is promoting mental health and complex conditions/long term conditions. However, in a wider context in which the focus is usually on acute and adult care, this has not extended to community child health (or, to the impact of trauma on child development) so funding remains difficult to access.

- We need more funding at high level for community child health which extends to, population based or epidemiological child health research – to promote prevention including at a community level. This comment was countered by another respondent's concern that this might broaden the focus too much, taking in research which should be the preserve of public health, health services, social care and others.

- Other concerns raised were about the potential unreliability of philanthropic funding; and that establishing a NIHR-specialist committee for community child health research may require more investment than is justified by the returns.

3.4.3 Encouragement and support for clinician researchers

The statement in the survey was:

We could proactively encourage and support clinician researchers

Prioritisation

In summary comments from individual respondents included that:

In terms of encouraging and supporting clinician researchers, over ninety percent of respondents prioritised re-introducing research time into NHS employment contracts.

Over eighty percent of respondents thought clinician researchers could best be encouraged and supported by re-introducing jointly-funded (NHS/universities) clinician researcher posts and/or – in the short term – identifying and funding senior community child health clinician researchers as mentor/supervisors.

Over three-quarters of respondents agreed that encouragement and support could be achieved by introducing a 'cross-over' route into academia for clinicians which recognises their existing capabilities and capacity to undertake research.

Just less than two-thirds of respondents thought it would be encouraging and supportive for clinician researchers to have local specialist inter-disciplinary ethics committees/panels in each area to consider community child health research.

Finally sixty percent of respondents thought clinician researchers would be encouraged and supported if there were targets for NHS management to evidence local research driven service improvement in community child health; and/or if they had access to a local 'floating' experienced research support team.

See appendix 6 for a table showing the Delphi study analysis.

Commentary

In summary comments from individual respondents included that:

- Employers do not accommodate the balance between research and service provision – finding levers to prioritise this would be important. Following from this, time for research needs to be embedded into contracts and monitored at appraisals and performance reviews.

- In a SAPHNA (School and Public Health Nurses Association) survey[6] in 2024, school nurses registered a definite need and interest in community child health research.

- In view of there relatively few community child health research leaders, it might be helpful for community child health researchers to be supervised by seniors with research experience in other disciplines e.g., public health, epidemiology, social care, etc.

- Jointly funded NHS and universities posts would be very helpful. Currently such posts are essentially funded by external bodies (Wellcome/NIHR/MRC) especially in the middle post-CCT (Certificate of Completion of Training) period. This and other suggestions, require commitment from NHS England, ICBs (Integrated Care Boards), and four-nation equivalents so for them to be successful, senior leadership support is needed.

- In response to the suggestion of a 'cross-over' route into academia for clinicians which recognises their existing capabilities and capacity to undertake research, a respondent commented as follows:

'The clinical academic route needs to be evaluated here. You want to promote excellent research. Doctors will need to obtain PhDs and the skills associated, otherwise they will not be able to get funding for projects. Could research be an ST7/8 practical PhD route – then one extra year on top to complete PhD. A 7-8 year postgraduate training plus a PhD is very difficult to manage. If you do child & adolescent mental health you only have six years postgraduate training. For community paediatrics training, you could have a PhD route and specialisation post-MRCPCH (*Membership of the Royal College of Paediatrics and Child Health).'*

Comments cautioning in relation to suggestions included that:

- There is a risk of a low or negative impact if more targets were introduced without first securing time, funding and governance to ensure that they can be well met.

- There may not be a need to establish additional inter-disciplinary ethics committees/panels to consider community child health research; current ethics committees may be operating adequately.

3.4.4 Re-integration of existing and undeveloped specialisms into a whole child approach for community child health research

The statement in the survey was:

We could re-integrate existing and undeveloped specialisms into a whole child approach for community child health research

[6] https://saphna.co/about/inaugural-survey-of-school-nursing-the-forgotten-frontline/

Prioritisation

In terms of re-integrating existing and undeveloped specialisms into a whole child approach for community child health research, over eighty percent of respondents prioritised re-creating a whole child focus including community (associative & environmental) context.

Almost three-quarters of respondents thought that existing and undeveloped specialisms could be integrated into a whole child approach by scoping and publicising widely, the intersection/overlap of acute and community child health and public health.

Just over half of respondents this could be achieved by re-integrating acute and community child health.

See appendix 6 for a table showing the Delphi study analysis.

Commentary

In summary comments about a whole child focus including community (associative & environmental) context were that – with a multidisciplinary approach, there is a host of opportunity in exploring and including social determinants, genetic advances, new data-analysis techniques, big computing, and other as yet under-utilised avenues for child health research.

Comments from individual respondents focused particularly on the suggestion that acute and community child health might helpfully be re-integrated. In summary comments in favour of closer connections between acute and community child health included:

- The splitting of community and acute child health has been disastrous for children as it has created silos that mean there is a divide between consultants such that know little about each other's work. This creates inter-professional difficulties. This is a bigger issue other than just research, but it does extend into the research issues identified in this.

And,

- There is already too much focus on acute child health – we need to be focusing on children in the community/environment as a whole through good epidemiological studies as are done in many resource limited settings – often in conjunction with public health colleagues.

Summary comments questioning the need for closer connections between acute and community child health included that:

- It is not clear why integrating acute and community would lead to more whole-child community child health research – because community child health doctors are trained in acute paediatrics and know acute paediatricians.

- There is no problem with the current speciality – there is a need and pathways. The problem is that much of community child health, especially neurodevelopmental paediatrics, is not taught during training. This is the reason that individuals pay to do the Sheffield BACD (British Academy of Childhood Disability) course – when they are at consultant level.

3.4.5 Promoting recognition of the value of community child health research

The statement in the survey was:

We could proactively promote recognition of the value of community child health research

Prioritisation

In terms of promoting recognition of the value of community child health research, over eighty percent of respondents prioritised revitalising centres of community child health research, with multi-disciplinary university departments/teams. Also, by developing an integrated child health research framework jointly with NHS acute and community specialisms, and local authority public health.

Three-quarter of respondents agreed that recognition of the value of community child health research could be achieved by establishing a national centre of child health action-orientated research. Also, by establishing a national child health acute & community research strategy and network for the universities.

Just over two-thirds of respondents thought recognition of community child health research could be achieved by promoting links into international community child health academic networks. Also, by lobbying for a central government policy shift to promote community child health (ideally integrated with acute child health) nationally.

See appendix 6 for a table showing the Delphi study analysis.

Commentary

In summary comments from one respondent that all the suggestions for putting child health research on the map were important; and from others that:

- It would be helpful to capture and keep under review, the research that is currently occurring in relation to children and young people.

- Many part-time registrars would be happy to engage in a day or more a week of research, if they were not required to pick up extra out-of-hours work alongside the research activity.

- A caveat to focusing too much on international academic networks is that children's life experiences and the healthcare systems and services which support them differ so much across countries.

- University research departments sometimes do not understand applied research – so introducing a 'cross-over' route into academia for clinicians which recognises their existing capabilities and capacity to undertake research would be very helpful.

  Additionally there are not many university academic departments which include community paediatric research. A respondent with a Master of Public Health (MPH) wanted to go on to complete a PhD but reported that PhD opportunities were rare and that there were no local university departments which included community paediatric research.

- Also very helpful would be the establishment of a Health Service Research Centre for community child health. The Centre could promote multi-disciplinary research including e.g., co-ordination with education, education psychology, speech and language therapy etc.

3.4.6 A better balance between clinical work, research and caring responsibilities

The question in the survey was:

If you are working part time because of caring responsibilities and would like to do research/more research… what (if anything) would make it possible for you to extend your working week to include more research time?

Comments in response to this question included that:

- For some clinicians the working week could be extended, but that requires additional funding for an extra 1PA per week.

- For other clinicians research time needs to be included within part-time employment contracts e.g., flexible working and protected research time in Job Plans; rather than the working week being extended. A respondent noted that:

'This is where the problem is. If you are working 60% due to caring responsibilities, there is probably no room to add extra. In my case, I did research (PhD) but ended up doing very little clinical alongside. The key will be to develop an ST4-to-CCT clinical academic pathway which combines PhD and training in one area of community child health e.g., neurodevelopmental paediatrics or physical disabilities.'

- It would be very helpful for there to be easily accessible information about the options for part time academic research and how it can be integrated into a clinical work week. This might include information on available part time PhD-ships and fellowships, examples of how to programme online learning, research and work etc. Networks to facilitate learning from others have managed would also be useful.

3.5 Summary of Delphi findings

The findings from the Delphi survey are summarised here in the form of the statements which were prioritised by eighty percent or more of the respondents (not including the commentary). However, in view the relatively small size of the Delphi sample, mention is also made of the suggestions prioritised by three-quarters of respondents.

In terms of re-introducing research training and experience into medical student/post-qualifying training, respondents thought this could be achieved by establishing sponsorships/fellowships for training in research. Three-quarters of respondents also thought it would help to focus on small research projects and more on contextually-influenced clinical research. Almost three-quarters of respondents agreed with the idea of developing multi-agency research, and research that includes children's community/contextual) life.

To increase funding for community child health projects, fellowships and training posts [over ninety percent of] respondents prioritised introducing ring-fenced funding for practical community child health research. Respondents also thought that an increase in funding might be achieved by establishing an NIHR specialist committee to promote and make funding

decisions for community child health research; and/or by promoting philanthropic funding for community child health research.

In terms of encouraging and supporting community child health clinician researchers [over ninety percent of] respondents prioritised re-introducing research time into NHS employment contracts. Respondents also thought clinician researchers could best be encouraged and supported by re-introducing jointly-funded (NHS/universities) clinician researcher posts and/or – in the short term – identifying and funding senior community child health clinician researchers as mentor/supervisors. Over three-quarters of respondents prioritised introducing a 'cross-over' route into academia for clinicians which recognises their existing capabilities and capacity to undertake research.

Respondents prioritised re-creating a whole child focus, including community (associative and environmental) context, as a way of re-integrating existing and undeveloped specialisms into a whole child approach. Almost three-quarters of respondents also suggested scoping and publicising the intersection/overlap of acute and community child health and public health.

In terms of promoting recognition of the value of community child health research, respondents prioritised revitalising centres of community child health research, with multi-disciplinary university departments/teams. They also thought this could be achieved by developing an integrated child health research framework jointly with NHS acute and community specialisms, and local authority public health. Three quarters of respondents agreed with both establishing a national centre of child health action-orientated research and a national child health acute and community research strategy and network for the universities.

Finally, in terms of what (if anything) would make it possible for clinicians with caring responsibilities to extend their working week to have more research time, comments included that for some clinicians the working week could be extended, but that requires additional funding for an extra 1PA per week. For other clinicians research time needs to be included within part-time employment contracts e.g., flexible working and protected research time in Job Plans. Also helpful would be information about the options for part time academic research and networks of peer-support for undertaking it.

4. Conclusion and recommendations

4.1 Conclusion

As mentioned in the introduction the BACCH Report highlighted the loss of critical mass of research-active community child health professionals over time and the Report identified several key drivers for this. The findings from the interviews and the Delphi study in this research support the BACCH Report's conclusions. This research also supports the recognition of a need to promote an interdisciplinary approach – to include social paediatrics, child development and child population health.

The value of this research lies in the range of options which have been generated as a way forward or 'roadmap' for building or re-building a critical mass of research-active community child health professionals. Information from the interviews generated 19 options supported by least three quarters of the Delphi respondents. There is variation in the amount of influence BACCH has over the options – making some more easily achievable in the short term and/or locally.

4.2 Recommendations

The 19 options identified in this research are set out in table 1 as recommendations B1-B6, for promoting community child health clinician-led research. However the key recommendation – recommendation A. is that BACCH develops an overarching change management plan which provides a framework for tackling recommendations B1-B6.

See appendix 1 for Kotter's Change Management model.

Table 1 Recommendations B1-B6

Overarching action	Activity @80% supported	Activity @75% supported
1. Introduce/re-introduce research training and experience into medical student/post-qualifying training	a) Establish sponsorships/fellowships for training in research.	a) Re-introduce small research projects b) Change the current selection criteria for an academic career pathway to focus more on contextually-influenced clinical research c) Develop a focus on multi-agency research, and research that includes children's community /contextual life
2. Make funding available for community child health projects, fellowships and training posts	a) Introduce ring-fenced funding for practical community child health research b) Establish an NIHR specialist committee to promote and make funding decisions for community child health research c) Promote philanthropic funding for community child health research	
3. Encourage and support clinician researchers	a) Introduce research time into NHS employment contracts b) Introduce jointly-funded (NHS/universities) clinician researcher posts c) In the short term – identify and fund senior community child health clinician researchers as mentor/supervisors	a) Introduce a 'cross-over' route into academia for clinicians which recognises their existing capabilities and capacity to undertake research
4. Integrate/re-integrating existing and undeveloped specialisms into a whole child	a) Create/re-create a whole child focus including community (associative & environmental) context	a) Scope and publish widely, the intersection/overlap of acute & community child health and public health

Overarching action	Activity @80% supported	Activity @75% supported
approach for community child health research		
5. Promote recognition of the value of community child health research	a) Develop/revitalise centres of community child health research, with multi-disciplinary university departments/teams b) Develop an integrated child health research framework jointly with NHS acute and community specialisms, and local authority public health	a) Establish a national centre of child health action-orientated research b) Establish a national child health acute & community research strategy and network for the universities
6. Promote research for clinicians working part time because of caring responsibilities	a) Extend the working week by 1PA or including research time within part-time employment contracts b) Promoting information/support about part time academic research.	

APPENDICES

Appendix 1 Kotter's change management model

John Kotter is the Konosuke Matsushita Professor of Leadership, Emeritus, at Harvard Business School.

Table 2 Kotter's eight steps for change

Steps for change (Kotter, 2012)[7]	Detractors (Rajan & Ganesan, 2017)[8]
1. Create a sense of urgency that is contagious	Allowing too much complacency.
2. Create a strong team powerful enough to guide a big change	Failing to create a sufficiently powerful guiding coalition
3. Create clear, simple, uplifting visions and sets of strategies	Underestimating the power of vision
4. Communicate the vision through simple, heartfelt messages sent through multiple channels so that people begin to buy into the change	Under-communicating the vision by a factor of 10, 100, 1000.
5. Empower people by removing obstacles to the vision	Permitting obstacles to block the new vision
6. Create short-term wins that provide momentum	Failing to create short-term wins
7. Maintain momentum so that wave after wave of change is possible	Declaring the victory too soon
8. Make change stick by nurturing a new culture	Neglecting to anchor changes firmly in the culture

[7] Kotter, J.P. and Cohen, D.S. (2012). The Heart Of Change, Harvard Business Review Press, Boston Massachusetts, USA; p6.
[8] Rajan & Ganesan (2017). A critical analysis of John P. Kotter's change management framework. *Asian Journal of Research in Business Economics and Management*; 7 (7): 181-203.

Appendix 2 Interview information sheet

British Association for Community Child Health Research Project

1. Introduction

This project aims to understand the facilitators and barriers to practice-led research in community child health. The project objective is to support the development of a roadmap for the different ways in which community paediatricians wishing to pursue research in community child health can select impactful research and be supported and funded to pursue it.

The project has been commissioned by the British Association for Community Child Health (BACCH) Research Strategy Working Group as part of their programme of response to indications that clinicians may be experiencing difficulties getting involved in research.

2. Project approach

In summary this project uses a mixed methods qualitative approach, with interviews and a Delphi study to identify the facilitators and barriers to practice-led research in community child health. The project has three stages:

a) Interviews with a small group of clinicians with a range of expertise-by-experience;

b) A Delphi Study (explained below), based on the findings from the interviews; and

c) Analysis of overall findings and a project report with recommendations on a way forward.

The project timeline is for interviews to take place in April/May 2024; for the Delphi Study to run in June/July 2024; and for consultation on emerging findings and final reporting to be complete by September 2024.

3. Project consultant

Dr Christine Christie will be undertaking the activities outlined in the project approach, above. Christine has extensive experience of undertaking qualitative fieldwork with health and care professionals. She has expertise in action research and clinical-practice research. Her area of interest is child and adult (usually women) health and wellbeing, including child death review and emotional/psychological trauma recovery; together with public service design and improvement. Current and recent commissioners include OHID and local authority Public Health, several NHS ICBs, and the Home Office re domestic abuse and suicide.

4. How can you contribute?

We are inviting you to:

a) **Participate in an interview** with Christine, which will be a relatively informal virtual conversation of about an hour**.** You should have received the interview guide along with this information sheet. The questions are just a way of structuring the conversation.

   Please make time before the interview to gather your thoughts about your experience – what worked well, what did not and any insights and suggestions you may have for a good way forward.

b) **Participate in the Delphi study**, which is a questionnaire technique designed to develop a consensus of opinion from a relatively wide group of experts concerning real-world knowledge. The 'knowledge' in this project will reflect the findings emerging from the interviews; supported by the concerns noted by BACCHs which prompted this project.

5. Confidentiality

Your contributions to this research project will be treated as confidential to the project consultant and will be anonymised in emerging findings and in the final project report.

If you contribute sensitive information and it appears that it might be difficult to keep the source confidential, this will be discussed with you first to find an suitable solution.

As participation is voluntary, you do not have to take part; and if you do, you can withdraw your information up to a week after contributing to an interview or the Delphi study.

6. Contacting the consultant and/or the project commissioner

If you have any questions at any time during the project; or if you would like to contribute information and suggestions in addition to an interview or the Delphi consultation, please contact Christine, at:

- Email: christine@chanon.co.uk Mob: 07841 054 204

The project is being commissioned on behalf of BACCHs, by Professor Michelle Heys, Population, Policy & Practice Dept, UCL GOS Institute of Child Health. If you have any questions, comments or concerns, about the Review or the arrangements for the Review, please contact Michelle, at:

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Dr Christine Christie, Independent project consultant, April 2024

Appendix 3 Interview guide

British Association for Community Child Health Research Project

From your expertise into community paediatric research you are likely to have insights which could inform the development of a 'roadmap' for the different ways in which community paediatricians can select and undertake impactful research

The interview conversation will be confidential to the independent reviewer

1. How/why do you think people get involved in research in general in community child health? Has it changed since you became involved?

2. In your own research, what were the critical facilitators/challenges e.g.,

    a) *Developing the research question*

    b) *Acquiring research expertise*

    c) *Support from a supervisor/mentor*

    d) *Support from your employer e.g., time*

    e) *Peer support*

    f) *Funding*

    g) *Regulatory/ethical approval*

    h) *Data collection/accessing the fieldwork population*

    i) *Other systemic factors*

3. How much do you think good community paediatric research depends on the personal qualities and/or trained skills of the paediatrician? or on the NHS service structure, focus and culture?

    Facilitators/challenges might include:

    a) *A funding bias towards London or other big cities*

    b) *A focus on discovery science and clinical research on rare or hospital based disease/services rather than out of hospital care*

c) *Unequal opportunity e.g., gender/caring responsibilities/racism*

4. Do you think there are specialisms/areas in community child health which are more amenable to research than others? if so, which ones and why?

5. What do you think are the top facilitators needed to nurture community paediatric research e.g.,

    a) *A culture of valuing research as a contributor to NHS services*

    b) *Training/support to undertake research*

    c) *Mentors and role models*

    d) *Time (PAs) allocated for research*

    e) *Funding options*

    f) *Flexible regulation/governance*

    g) *Recognised research career pathways*

    h) *Researcher confidence in working across-sectors in terms understanding, partnership and/or patient movement e.g., academia; VCS*

    i) *Cross-disciplinary research understanding/partnership/movement: e.g., medical, psychological & social perspectives and expertise*

    j) *A framework for showcasing and embedding research outcomes*

6. Do you have any other comments; or suggestions for the facilitation / promotion of community paediatric research?

Thank you for sharing your time and your expertise

Dr Christine Christie, Independent project consultant, April 2024

Appendix 4 Delphi information sheet

British Association for Community Child Health Research Project

1. Introduction

This project aims to understand the facilitators and barriers to practice-led research in community child health. The project objective is to support the development of a roadmap for the different ways in which community paediatricians wishing to pursue research in community child health can select impactful research and be supported and funded to pursue it.

The project has been commissioned by the British Association for Community Child Health (BACCH) Research Strategy Working Group as part of their programme of response to indications that clinicians may be experiencing difficulties getting involved in research.

3. Project approach

The project's mixed qualitative methodology includes interviews and a Delphi-style approach to identify the facilitators and barriers to practice-led research in community child health.

The project has three stages. In the first stage (completed in early summer 2024), information was gathered (via interviews) from established community child health clinician researchers. This second stage seeks to engage the wider child health community (during autumn 2024). It builds on the first stage by seeking consensus on the first stage findings and suggestions for a way forward. Stage three involves analysis of overall findings and a project report with recommendations on a way forward (due in spring 2025).

4. Stage 1 findings

The first stage findings included the facilitators and challenges to community child health research. Based on the challenges, five areas of activity were identified with potential for revitalizing the community child health research-active community. The areas and the activities are listed in schedule 1, below.

4. Project consultant

An independent consultant, Dr Christine Christie, is undertaking this project. Christine has extensive experience of qualitative fieldwork with health and care professionals. She has expertise in action-research and clinical-practice research. Her area of interest is child and adult (usually women) health and wellbeing, including child death review and emotional/psychological trauma recovery; together with public service design and improvement. Current and recent commissioners include OHID and local authority Public Health, several NHS ICBs & Provider Trusts, and the Home Office re domestic abuse and suicide.

4. Project consultant

An independent consultant, Dr Christine Christie, is undertaking this project. Christine has extensive experience of undertaking qualitative fieldwork with health and care professionals. She has expertise in action research and clinical-practice research. Her area of interest is child and adult (usually women) health and wellbeing, including child death review and emotional/psychological trauma recovery; together with public service design and improvement. Current and recent commissioners include OHID and local authority Public Health, several NHS ICBs, and the Home Office re domestic abuse and suicide.

5. How can you contribute?

We are inviting you to:

c) **Participate in the project's Delphi-style stage 2.** Delphi is a questionnaire technique designed to develop a consensus of opinion from a relatively wide group of experts concerning real-world knowledge. The 'knowledge' in this project is the findings emerging from the stage 1 interviews; supported some information from the RCPCH Census 2022 Report[9] and by the concerns noted by BACCHs which prompted the project.

We are seeking your views as to which of the areas in the stage 1 findings you think should be prioritised and whether there are areas and/or activities which have been missed.

6. Confidentiality

Your contributions to this research project will be treated as confidential to the project consultant and will be anonymised in emerging findings and in the final project report.

If you contribute sensitive information and it appears that it might be difficult to keep the source confidential, this will be discussed with you first to find an suitable solution.

As participation is voluntary, you do not have to take part; and if you do, you can withdraw your information up to a week after contributing to an interview or the Delphi questionnaire.

7. Contacting the consultant and/or the project commissioner

If you have any questions at any time during the project; or if you would like to contribute information and suggestions in addition to an interview or the Delphi consultation, please contact Christine, at:

- Email: christine@chanon.co.uk Mob: 07841 054 204

The project is being commissioned on behalf of BACCHs, by Professor Michelle Heys, Population, Policy & Practice Dept, UCL GOS Institute of Child Health. If you have any questions, comments or concerns, about the Review or the arrangements for the Review, please contact Michelle, at:

- Email: m.heys@ucl.ac.uk Mob: 07541381106

Schedule 1

Stage 1 findings: areas of activity

[9] https://www.rcpch.ac.uk/sites/default/files/2022-10/rcpch-workforce-census-2022-full-report.pdf

Within the trajectory for a career in community child health research, there appear to be several elements key to initiating and developing clinician researcher engagement and productivity. These include:

1. Research training and experience

i. Research included in training: training used to include a mandatory research component, *"the MSc was a gateway to research".* This includes having time within the competencies programme to explore research as an option.

ii. Choosing research: individuals tend to choose to specialize in community child health later in their clinical careers than for other specialisms; and in consequence they identify a desire to undertake community child health research later in their careers than for other specialisms. This

iii. Practice placements: with the decrease in the profile and popularity of community child health, and the reduction in centres of research into community child health, there has been a parallel fall in available training posts for community child health clinician researchers.

2. Funding for community child health research

iv. Funding for posts: clinician researchers used to be funded by flexible funding streams from both the NHS and the universities – enabling them to maintain a workload which was split between clinical and research work. This changed when the NHS withdrew funding for research work, and universities started requiring the posts they fund to be 100% focused on academic work.

v. Funding models and decisions: in terms of funding for research, community child health appears to be disadvantaged in three related respects:

- funding models for research projects have followed the high specialization/narrow focus of acute child health and small pockets of specialism (e.g., neurodiversity) in community child health. These funding models tend to exclude accommodate the multi-disciplinary, preventative and longer term profile of community child health research;

and similarly,

- funding decisions for individual research fellowships are modelled on acute child health and the individuals which puts community child health applicants at a disadvantage when compared those from acute child health because the former usually commence their specialization in community child health applicants and their research into the field later. This means that they do not have comparable track records in terms of clinical reputation and research activity and publications

finally,

- funding decisions are taken by people who do not have the necessary community child health knowledge and experience (see also the points on profile, roles and mentors, ethics and strategy).

3. Supporting clinician researchers

vi. NHS capacity: clinician researchers now struggle with workload pressure, their clinical caseloads, and do not have programmed activity (PA) time set aside from their clinical work in which to undertake research.

vii. Role models, mentors and supervisors: there used to be thriving centres of community child health research comprising a partnership between the NHS Trusts and local university. These teams were led by clinician researchers with senior roles in both clinical and academic spheres, and in these roles they could inspire, demonstrate and support good community child health research.

viii. Access to research publications: withdrawal of joint-funding for clinician researcher posts has restricted access to the academic research databases, limiting ability to improve practice and extend existing research.

vi. Ethics: community child health is very context dependent and as a result community child health research can be 'social' rather than 'medical'. Following from this community child health research methodology, population samples and other issues can differ significantly from medical research. Ethics committees do not yet have the understanding to cope well with this.

4. Re-integrating specialisms

vii. Increasing specialization: there used to be opportunity for fluid shifts of focus between acute and community child health. This allowed individuals to experience both. However, this is no longer the case. In addition, there has been an increasing specialism within community child health, with an emphasis on narrowly defined spheres of interest e.g., neurodisability, looked after children or safeguarding. For both community and acute child health this means that there is now almost no focus on the health of the whole child.

5. Promoting community child health research

viii. Community child health profile: a relatively prominent public profile for any specialism is helpful in attracting, engaging and sustaining career interest. The public profile of community child health, whilst never very high, has diminished significantly over time. Contributory to this demise is the lack of high profile, well-respected professors and other senior clinician academics in community child health.

ix. A national framework: community child health research, and the structures, systems and funding supporting do not sit within a framework which clearly articulates how it is positioned between acute child health and population health; between the NHS England and local government Public Health.

x. International collaboration: post-Brexit there has been reduced research collaboration with European community child health research colleagues, limiting funding opportunities, fieldwork opportunities and stimulation of ideas and perspectives.

Dr Christine Christie, Independent project consultant, August 2024

British Association for Community Child Health (BACCH) Research Project

Stage 2: a Delphi approach

Context: a recent BACCH report highlighted the loss of critical mass of research-active community child health professionals over time. In response BACCH Research Strategy Working Group10 commissioned and independent consultant to undertake a small project to understand the facilitators and barriers to clinician-led research in community child health.

Aim: the project aims to inform the development of a roadmap to support community child health clinicians and practitioners to engage in impactful community child health research.

Progress: in the first stage of the project information was gathered (via interviews) from established community child health clinician researchers. In this second stage of the project the first stage findings have been synthesized into five areas of activity with potential for revitalizing the community child health research-active community.

A Delphi approach: this second stage uses a Delphi approach, key elements being – recognizing the value of your collective expert view, aiming for consensus, building on first stage responses, and affording all respondents anonymity.

Invitation: this Delphi-style approach recognizes your experience and seeks your views as to which of the areas of activity should be prioritised and whether there are areas and/or activities which have been missed.

[10] The BACCH Research Strategy Working Group remit includes: refining the scope of community child health research; mapping existing successful UK community child health research activity; developing a methodology and process to prioritise community child health research areas; and developing a plan to promote practice-led research in community child health.

Confidentiality: your responses will be confidential to the independent consultant, and your anonymity maintained in any internal and external reports.

In the table below there are five statements about areas of activity with potential for revitalizing the community child health research-active community.

Please rate the area and the activities on a scale of 1 – 5, where in your view, 1 is lowest priority and 5 is highest priority.

Please use the (expanding) Comment box to provide additional information on your priorities and to make any new suggestions

Area and activities with potential for revitalizing the community child health research-active community	**Rating scale**				
1. We could re-introduce research training and experience into medical student/post-qualifying training Potential ways of achieving this could be to:	**1**	**2**	**3**	**4**	**5**
a) Introduce optional additional research modules	1	2	3	4	5
b) Develop a focus on multi-agency research, and research that includes children's community (associative & environmental i.e., contextual) life	1	2	3	4	5
c) Re-introduce small research projects	1	2	3	4	5
d) Establish sponsorships/fellowships for training in research	1	2	3	4	5
e) Change the current selection criteria for an academic career pathway to focus more on contextually-influenced clinical research	1	2	3	4	5

Area and activities with potential for revitalizing the community child health research-active community	Rating scale				
f) Include research in requirements for consultants (one of the four pillars advanced practice)	1	2	3	4	5
Comment:					
2. We could make funding available for community child health projects, fellowships and training posts Potential ways of achieving this could be to:	**1**	**2**	**3**	**4**	**5**
a) Introduce ring-fenced funding for practical community child health research	1	2	3	4	5
b) Develop a national framework for multi-agency contributions to funding	1	2	3	4	5
c) Establish an NIHR specialist committee to promote and make funding decisions for community child health research	1	2	3	4	5
d) Promote philanthropic funding for community child health research	1	2	3	4	5
Comment:					

Area and activities with potential for revitalizing the community child health research-active community	Rating scale				
3. We could proactively encourage and support clinician researchers Potential ways of achieving this could be to:	**1**	**2**	**3**	**4**	**5**
a) Re-introduce research time into NHS employment contracts	1	2	3	4	5
b) In the short term – identify and fund senior community child health clinician researchers as mentor/supervisors	1	2	3	4	5
c) Introduce a 'cross-over' route into academia for clinicians which recognises their existing capabilities and capacity to undertake research	1	2	3	4	5
d) Re-introduce jointly-funded (NHS/universities) clinician researcher posts	1	2	3	4	5
e) Establish 'Floating' experienced research support teams	1	2	3	4	5
f) Have local specialist inter-disciplinary ethics committees/panels in each area to consider community child health research	1	2	3	4	5

Area and activities with potential for revitalizing the community child health research-active community	Rating scale				
g) Develop targets for NHS management to evidence local research driven service improvement in community child health	1	2	3	4	5
Comment:					
4. We could re-integrate existing and undeveloped specialisms into a whole child approach for community child health research Potential ways of achieving this could be to:	**1**	**2**	**3**	**4**	**5**
a) Re-integrate acute and community child health	1	2	3	4	5
b) Re-create a whole child focus including community (associative & environmental) context	1	2	3	4	5
c) Scope and publish widely, the intersection/overlap of acute & community child health and public health	1	2	3	4	5
Comment:					

Area and activities with potential for revitalizing the community child health research-active community	Rating scale				
5. We could proactively promote recognition of the value of community child health research Potential ways of achieving this could be to:	**1**	**2**	**3**	**4**	**5**
a) Develop an integrated child health research framework jointly with NHS acute & community specialisms, and local authority public health	1	2	3	4	5
b) Establish a national child health acute & community research strategy and network for the universities	1	2	3	4	5
c) Establish a national centre of child health action-orientated research	1	2	3	4	5
d) Revitalise centres of community child health research, with multi-disciplinary university departments/teams	1	2	3	4	5
e) Lobby for a central government policy shift to promote community child health (ideally integrated with acute child health) nationally	1	2	3	4	5
f) Promote links into international community child health academic networks	1	2	3	4	5
Comment:					

Area and activities with potential for revitalizing the community child health research-active community	Rating scale
6. **If you are working part time because of caring responsibilities and would like to do research/more research…** What (if anything) would make it possible for you to extend your working week to include more research time?	
Comment:	

Any other comments/suggestions:

Thank you for your thoughts and the time you have taken to contribute to this important project

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Dr Christine Christie, Independent project consultant, August 2024

Appendix 6 Delphi study analysis

For each of the first five statements a breakdown of how Delphi participants prioritsed the suggestions is set out in a table with a numerical [& percentage] score. The maximum score for any option was 55.

Table 3 Delphi study analysis

Area and activities with potential for revitalizing the community child health research-active community	**Rating scale**
1. We could re-introduce research training and experience into medical student/post-qualifying training Potential ways of achieving this could be to:	
d) Establish sponsorships/fellowships for training in research	46 (84%)
c) Re-introduce small research projects	43 (78%)
e) Change the current selection criteria for an academic career pathway to focus more on contextually-influenced clinical research	43(78%)
b) Develop a focus on multi-agency research, and research that includes children's community (associative & environmental i.e., contextual) life	39 (71%)
f) Include research in requirements for consultants (one of the four pillars advanced practice)	38 (69%)
a) Introduce optional additional research modules	34 (61%)
2. We could make funding available for community child health projects, fellowships and training posts Potential ways of achieving this could be to:	
a) Introduce ring-fenced funding for practical community child health research	50 (91%)
c) Establish an NIHR specialist committee to promote and make funding decisions for community child health research	48 (87%)
d) Promote philanthropic funding for community child health research	44 (80%)
b) Develop a national framework for multi-agency contributions to funding	37 (67%)
3. We could proactively encourage and support clinician researchers Potential ways of achieving this could be to:	
a) Re-introduce research time into NHS employment contracts	52 (95%)
d) Re-introduce jointly-funded (NHS/universities) clinician researcher posts	47 (85%)

b) In the short term – identify and fund senior community child health clinician researchers as mentor/supervisors	45 (82%)
c) Introduce a 'cross-over' route into academia for clinicians which recognises their existing capabilities and capacity to undertake research	43 (78%)
f) Have local specialist inter-disciplinary ethics committees/panels in each area to consider community child health research	34 (62%)
g) Develop targets for NHS management to evidence local research driven service improvement in community child health	33 (60%)
e) Establish 'Floating' experienced research support teams	33 (60%)
4. We could re-integrate existing and undeveloped specialisms into a whole child approach for community child health research Potential ways of achieving this could be to:	
b) Re-create a whole child focus including community (associative & environmental) context	45 (82%)
c) Scope and publish widely, the intersection/overlap of acute & community child health and public health	40 (73%)
a) Re-integrate acute and community child health	31 (56%)
5. We could proactively promote recognition of the value of community child health research Potential ways of achieving this could be to:	
d) Revitalise centres of community child health research, with multi-disciplinary university departments/teams	47 (85%)
a) Develop an integrated child health research framework jointly with NHS acute & community specialisms, and local authority public health	46 (84%)
c) Establish a national centre of child health action-orientated research	42 (76%)
b) Establish a national child health acute & community research strategy and network for the universities	41 (75%)
f) Promote links into international community child health academic networks	38 (69%)
e) Lobby for a central government policy shift to promote community child health (ideally integrated with acute child health) nationally	37 (67%)
6. If you are working part time because of caring responsibilities and would like to do research/more research…	
a) What (if anything) would make it possible for you to extend your working week to include more research time?	See comments