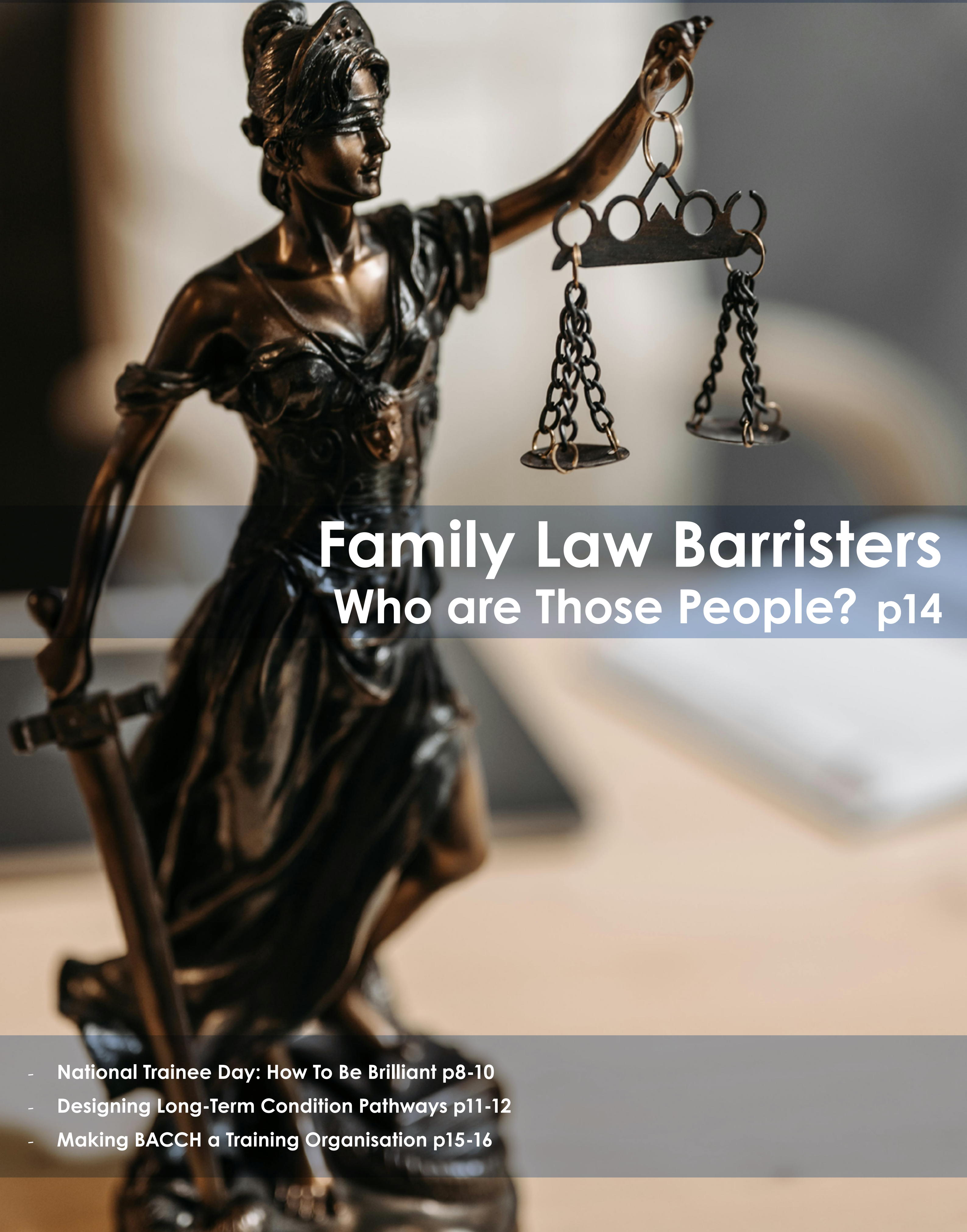
BACCHNEWS

BACCH
British Association for Community Child Health

June
26



Family Law Barristers
Who are Those People? p14

- National Trainee Day: How To Be Brilliant p8-10
- Designing Long-Term Condition Pathways p11-12
- Making BACCH a Training Organisation p15-16

Contents and Contacts

Table of Contents

Clinical

Public Health

Safeguarding

Education & Training

Wellbeing

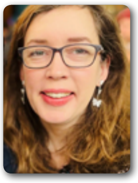
The British Association for Community Child Health (BACCH) is an organisation representing professionals working in paediatrics and child health in the community. It is a specialty group of the Royal College of Paediatrics and Child Health.

BACCH welcomes new members!

Benefits of membership

- 'BACCH News', BACCH's quarterly flagship magazine: paper copy posted to all members; e-version available to download for members only via the website. *(Student members will NOT receive a paper copy of the Newsletter.)*
- Monthly email updates.
- Reduced delegate rates to BACCH conferences.
- Option to subscribe to the Journal Child: Care, Health and Development, for the reduced rate of £20 per year. *(Not available for those who join as overseas members or student members.)*
- Regional Coordinators organise local meetings and represent members' views to BACCH Council.
- Members' only content on the BACCH website.

For membership information contact:



Lucy Doig
Executive Officer
Tel: *020 7092 6082*
Email: *bacch@rcpch.ac.uk*

5–11 Theobalds Road, London WC1X 8SH.

BACCH is an incorporated company (06738129) limited by guarantee and a registered charity 1129758 in England and Wales and registered charity SC054695 in Scotland.

MORE ONLINE AT *www.bacch.org.uk*

BACCH Newsletter Contact Information

BACCH EC Officers/Members www.bacch.org.uk/pages/executive-council

Chair	David Vickers	david.vickers@nhs.net
Treasurer	Alice Setti	alice.setti@nca.nhs.uk
Convenor	Heather Jarvis	heather.jarvis1@nhs.net
Assistant Convenor	Vacant*	
Newsletter Editor	Jemma Wright	bacchnewseditor@gmail.com
Joint Academic Convenors	Ian Male	ian.male@tiscali.co.uk
	Christiane Nitsch	cnitsch@nhs.net
SAS rep	Lindsey McKenna Maxwell	lindsey-m-mckenna@doctors.org.uk
Specialty Training	Emma Bradley	emma.bradley12@nhs.net
Workforce Officer	Kim Blackwell	kim.blackwell@nhs.net
Trainee Reps	Kimberley Hallam & Claire Stewart	bacch@rcpch.ac.uk
APPM	Jill Yates	jill.x.yates@nhslothian.scot.nhs.uk
BAPA	Jo Harris	bapa@rcpch.ac.uk
BACD	Catherine Tuffrey	bacd@rcpch.ac.uk
BACAPH	Simon Lenton	simonlenton@doctors.org.uk
CPSIG	Jane Armstrong	cpsig@rcpch.ac.uk
PMHA	Bo Fischer	bofischer@yahoo.com

BACCH Regional Coordinators www.bacch.org.uk/regional-coordinators

East of England	Dr Ankit Mathur & Dr Prabhu Rajendran	Ankit.Mathur@wsh.nhs.uk prabu.rajendran@nhs.net
East Midlands	Vacant*	
Kent, Surrey & Sussex (KSS)	Dr Paul Wright	paulwright@nhs.net
London	Dr Hilary Toulmin & Dr Carrie Williams	hlmt2@cam.ac.uk (Hilary T) carrie.williams@ucl.ac.uk
Mersey & Cheshire	Dr Rajiv Mittal	rmittal@nhs.net
Northern England	Dr Christine Powell	Christine.powell6@nhs.net
Northern Ireland	Vacant*	
North West England	Dr Bunmi Lawson	blawson@nhs.net
Thames Valley	Dr Rachel Weerasinghe	Rachel.Weerasinghe@ouh.nhs.uk
Scotland (& SACCH)	Dr Alison McLuckie	Alison.mcluckie@nhslothian.scot.nhs.uk
South West England	Dr Saras Hosdurga	s.hosdurga@nhs.net
Wales	Dr Elizabeth Nickerson	Elizabeth.Nickerson@wales.nhs.uk
Wessex	Vacant*	
West Midlands	Dr Kate Harvey	kate.harvey7@nhs.net
Yorkshire & Humber	Dr Sharon Bowring	s.bowring@nhs.net

*To apply for vacant roles, see:
https://www.bacch.org.uk/articles/category/26-nominations

Editor
Jemma Wright
Email: *bacchnewseditor@gmail.com*

Trainee Editors
Bethany Davies
Email: *bethany.davies19@nhs.net*

Ashra Omr
Email: *ashra.omr1@nhs.net*

Design
Paul Davy at *pauldavy@mac.com*

Published by
CKN Print *www.cknprint.co.uk*

Publishing 2026/7

Submission deadline		Publication date	
15 May	‘26	15 June	‘26
15 August	‘26	15 Sept	‘26
15 November	‘26	15 Dec	‘26
15 February	‘27	15 March	‘27

Advertisement rates for 2026/27

	Commercial	Charity/Not for profit/NHS jobs advert rate
Back page	*£600*	*£300*
Full page	*£450*	*£225*
Half page	*£250*	*£125*
Quarter page	*£130*	*£65*
Insertions (A4 supplied to us)	*£500*	*£250*
Insertions (A4 printed by us)	*From £530*	*From £265*

All enquiries to the BACCH office:
bacch@rcpch.ac.uk

Image credits:
pexels.com

From the Trainee Editor

Hello all,

As we move towards summer and the days finally begin to stretch out, there's something wonderfully hopeful about seeing more light creeping into our mornings and evenings. Even if the weather is still hedging its bets, I hope this edition brings a welcome sense of brightness.

During a recent trip to Milan, I came across a display about Maria Montessori, whose work has seen a resurgence in documentaries and exhibitions over the past few years. One line attributed to her stayed with me: *'The child is both a hope and a promise for mankind.'* It's a sentiment that feels especially resonant in Community Child Health, where we're reminded daily that children aren't just future adults – they're whole people right now, shaping us as much as we shape them.

That spirit of learning from children is reflected throughout this edition. We're delighted to include a fantastic piece on the *How to Be Brilliant* training day, which I was lucky enough to attend. Hearing directly from young people and their families was phenomenal, and a powerful reminder of why our work matters.

We also have valuable contributions on key clinical topics such as enuresis, alongside a thoughtful spotlight on Dr Jo Gifford – whose steady wisdom, generosity, and longstanding commitment to child health have influenced so many of us. I've had the privilege of working directly with her, and those experiences remain some of the most enjoyable and formative of my training.

And in a special addition, we're featuring a piece from a family law barrister who also happens to be my sister. Proof, perhaps, that even with the same upbringing, siblings can take entirely different paths – one of us learning to navigate clinic corridors, the other navigating court corridors. At least it means we can swap stories without ever running out of material!

Across the country, colleagues continue to lead inspiring, innovative work, and we're thrilled to showcase just a glimpse of it here. We hope you enjoy this issue, and as always, we welcome your thoughts and contributions for future editions.

Bethany Davies
BACCH News Trainee Editor

From the Chair

I hope you've all been enjoying the last few days of May and the welcome good weather. My only complaint has been running a paediatric clinic in a non-air-conditioned room, where every family kindly reminded me it was much cooler out in the waiting area!

Earlier in the month, I had the pleasure of spending three days in Birmingham at the RCPCH Annual Conference. As always, BACCH and many of our affiliated groups delivered excellent sessions, but it was particularly encouraging to see how much of the wider programme spoke directly to community paediatrics. The Child Protection Special Interest Group, together with the College Child Protection Committee, also ran an outstanding session. A highlight was a thoughtful presentation on reimagining child protection through a social lens – recognising the profound impact of systemic issues, poverty, deprivation, and inequality on children and families. My key takeaway was that our systems may need to adapt to better identify and understand these factors in our everyday contacts. Too often, we respond to failures by adding complexity, which can inadvertently distance us from effective protective action. I was also struck by the idea of the 'culturally sensitive paediatrician': someone who understands the wider world, applies a socioeconomic lens, and remains aware of their own privilege and limitations.

It was a particular pleasure to see three community paediatricians awarded Honorary Fellowship of the College – the first time our specialty has been so strongly represented. Warm congratulations to Mitch Blair (London), Liz Marder (Nottingham) and Doug Simkiss (Birmingham). Pictured above. Their awards are richly deserved and serve as a timely reminder: if you have a colleague who has made a significant contribution to paediatrics and child health, please consider nominating them. Without nominations, our specialty will not be represented.

The conference also brought several challenges for us to reflect on. It opened with a plenary exploring the deterioration in children's mental health, suggesting that part of the issue may lie in the widening of diagnostic categories to include a much broader group of children. Dame Uta Frith, recently interviewed by the Times Educational Supplement, made a similar observation regarding ASD – arguing that the term now encompasses both those with severe autism and those with much milder difficulties. While this line of thinking doesn't offer immediate solutions, it may help us better understand the dramatic rise in referrals and the resulting waiting times we are all grappling with.

The meeting closed with a debate on age boundaries – specifically when children's services should end and adult services begin. There was no definitive answer, though there was a sense that 18 years may be more appropriate, while acknowledging the significant challenges this poses, particularly in inpatient settings.

By the time this newsletter reaches you, we will have held a Strategy Session with our Executive Committee. We will be considering several key questions: how to ensure BACCH truly reflects all four nations; what we believe are the core components of a community paediatrician's role; and how we can best support the development of teams. As the focus on community care continues to grow, it is essential that this includes meaningful investment in paediatric medical, nursing, and allied health professional roles beyond the traditional acute-focused model.

Dr David Vickers
BACCH Chair

Clinical

Assessment and management of enuresis in the bladder clinic

Introduction

According to the International Children's Continence Society (ICCS), enuresis is defined as intermittent (i.e. not continuous) wetting during sleep in children after their fifth birthday. The term nocturnal can be added for clarity (i.e. enuresis and nocturnal enuresis are synonyms). Daytime wetting is termed urinary incontinence. If children wet during sleep and during the day, they would receive two diagnoses: enuresis and urinary incontinence.[1]

Nocturnal enuresis is generally considered a multifactorial disease associated with a complex interaction of somatic, psychosocial, and environmental factors.[2] Children with one affected parent face a 44% likelihood of developing enuresis, and those with two affected parents have a 77% likelihood.[3,4]

Classification

Enuresis is classified as:

1. Monosymptomatic enuresis (MNE): bedwetting is the sole symptom.
2. Non-monosymptomatic enuresis (NMNE): bedwetting along with additional daytime symptoms, such as wetting, urinary frequency, or urgency.[5]

Monosymptomatic enuresis can be further classified as:

- Primary, where the child has never experienced a prolonged dry period.
- Secondary, where bedwetting recurs after at least 6 months of dryness.[5]

Aetiology is described as:

- *Primary enuresis:* Idiopathic, nocturnal polyuria, maturational delay, disorder of sleep arousal, small bladder capacity, detrusor overactivity, cystitis, constipation, neurogenic bladder, structural abnormalities (urethral obstruction, ectopic ureter), psychological, diabetes insipidus.[2]
- *Causes unique to secondary enuresis:* Diabetes, seizure disorder, obstructive sleep apnoea[6], chronic kidney disease, pinworms, primary polydipsia.

History

- *Night-time urinary symptoms:* number of bedwetting episodes in a week, single or multiple episodes/night, volume of wetting, awakenings at night, access to toilet, snoring
- *Night-time routine:* bedtime, time of last drink, last visit to toilet
- *Day-time symptoms:* urgency, frequency, urinary stream
- *Pain on micturition*
- *Constipation:* Straining, type of stool in Bristol stool chart, fluid intake
- *Development:* autism, ADHD, learning disability
- *Birth history:* delayed passage of meconium, maternal diabetes mellitus
- *Family history:* of bedwetting, kidney diseases, neurodevelopment concerns

Examination

- Measurement of blood pressure
- Inspection of external genitalia (especially the urethral opening)
- Palpation in the renal and suprapubic areas
- Palpation of abdomen for faecal mass
- Thorough neurologic examination of the lower extremities, including gait, muscle power, tone, sensation, reflexes, and plantar responses
- Inspection and palpation of the lumbosacral spine
- Inspection of the skin in the genital area looking for rashes or lesions that might be caused by constant wetness

Investigations

- Urine dipstick
- Bladder ultrasound scan – measure pre- and post-void volumes, rectal diameter. A thickened bladder wall can be indicative of a hypertrophy of the bladder wall as a sign of bladder dysfunction, or it can be due to UTIs.[1]
- Uroflowmetry with bladder scanning (helpful in screening patients suspected of having voiding dysfunction, neurogenic bladder, or urethral obstruction).
- MRI spine when there is abnormal neurologic examination finding of the lower extremities or a visible lumbosacral spine defect.[7]

Normal voided volume = (age + one) multiplied by 30 (in millilitres)

Figure 1: Calculation of normal voided volume

Management

Children with daytime and nocturnal symptoms usually benefit from treating the daytime wetting first.

Patient and Caregiver Education

- Explain that bedwetting is not the child's fault.
- Have adequate fluid during the day.
- Avoid drinking caffeine-based drinks (such as colas, coffee, tea) before sleep.
- Avoid drinking large volumes of fluid before bedtime.
- Avoid nappies or pull-on training pants, except for special occasions away from home, as it can hinder the child's motivation to get up and void at night.
- The child should try to void 4 to 7 times daily. Children should pass urine just before going to bed and practice double voiding.
- Child should have a toilet pass to allow unrestricted bathroom access in school.
- Bowel and bladder diary: Parents to fill the diary to maintain a record of fluid intake, urine output and bedwetting on 2 consecutive nights.

Enuresis alarms: first-line treatment for bedwetting, high long-term success rate, involves a significant commitment from the child or young person and parents/carers.[1]

Medications

- *Desmopressin:* a synthetic analogue of ADH, medication of choice for treating MNE, consider for sleepovers and school trips. Available as Desmotab 200 micrograms, sublingual DesmoMelt 120 micrograms. Advice to restrict fluids 1 hour before taking desmopressin to 8 hours after.[3]
- *Imipramine:* significant anticholinergic effects with additional central effects of functioning in the frontal lobes at the inhibitory centres of the brain or on the default mode network in children suffering from nocturnal enuresis. Adverse effects are dry mouth, gastrointestinal symptoms and occasional behavioural changes. Contraindicated in children with a family history of early cardiac death or who have any ***evidence*** of cardiac disease.[1]
- *Anticholinergics (oxybutynin, tolterodine, solifenacin):* used in bladder overactivity[1], adverse events are dry mouth, constipation, and urinary retention.
- *Mirabegron:* Stimulation of beta 3 detrusor receptors to cause detrusor relaxation. Caution should be taken in patients with stage 2 hypertension, as well as those with a history of 'long QT' interval.[8]

Neuromodulation or neurostimulation devices: modulate detrusor muscle contractions, stimulate pelvic floor muscle contractions. Currently there is insufficient information for using this modality in treating enuresis.[1]

Botulinum toxin A: Used in patients with detrusor overactivity refractory to all anticholinergics. Increases bladder capacity allowing for a greater bladder volume.[1]

References

1. Franco I, von Gontard A, De Gennaro M. Evaluation and treatment of nonmonosymptomatic nocturnal enuresis: A standardization document from the International Children›s Continence Society. *Journal of Pediatric Urology*, 2012; 9, 234-43.
2. Dang J, Tang Z. Pathogenesis and brain functional imaging in nocturnal enuresis: A review. *Exp Biol Med* (Maywood). 2021 Jul;246(13):1483-1490.
3. Graham KM, Levy JB. Enuresis. *Pediatr Rev.* 2009 May;30(5):165-72; quiz 173.
4. Thurber S. Childhood Enuresis: Current Diagnostic Formulations, Salient Findings, and Effective Treatment Modalities. *Arch Psychiatr Nurs.* 2017 Jun;31(3):319-323.
5. Ramakrishnan K. Evaluation and treatment of enuresis. *Am Fam Physician.* 2008 Aug 15;78(4):489-96.
6. Pedersen MJ, Rittig S, Jennum PJ, Kamperis K. The role of sleep in the pathophysiology of nocturnal enuresis. *Sleep Med Rev.* 2020 Feb;49:101228.
7. Ferrara P, Magli G, Malavolta E, Procaccini E, Massimi L, Gatto A. Not only enuresis: do not disregard organic disorders. *Acta Biomed.* 2023 Dec 05;94(6):e2023223.
8. R. Nasution, A. Husein and K.P. Adhyatma. Efficacy and safety of mirabegron in pediatric population: A systematic review. *International Journal of Surgery* Open 37 (2021) 100412.

Dr Harshita Jagwani
ST5 Grid Community Paediatrics Registrar
Sunshine House Children
and Young People's Development Centre, London

Case Report: Hypokalaemia and Rumination Syndrome

Case Report

A 12-year-old boy presented to the emergency department with a year long history of nocturnal effortless vomiting after eating. There was an increased frequency of vomiting in the previous few weeks since returning to school after the holidays, with concerns of weight loss from the 75th centile to 25th-50th centile. He had a background of autism, learning disabilities, and attended a specialist school. On presentation to the emergency department the child was visibly distressed with head banging, but hydration status appeared normal. A capillary gas showed metabolic alkalosis (pH 7.602, potassium K^+ 3.3mmol/L, sodium Na^+ 135mmol/L, ionised calcium Ca^{2+} 1.11mmol/L, chloride Cl^- 77mmol/L, anion gap 11.1 mmol/L, BE 21.6mmol/L). The child tolerated oral fluids and ondansetron; however due to his ongoing distress he went home with ondansetron, safety-net advice about oral fluid intake, and a telephone consultation planned for the next day. The follow-up telephone consultation reported he was not tolerating ondansetron, and had worsening lethargy and pallor, so the child was admitted to the paediatric ward.

On attendance bloods were sent for a gas, haematology and biochemistry, and results showed K^+ 1.7mmol/L, Na^+ 127mmol/L, Cl^- 76mmol/L, bilirubin 47. Cardiac telemetry demonstrated possible ST depression with U waves, so a 12-lead ECG was conducted, demonstrating prolonged QT-interval 550ms. Due to significant electrolyte imbalance and ECG changes the child was cannulated and IV fluids initiated to replace sodium and potassium (0.9% sodium chloride with 5% glucose + 20mmol potassium chloride in 500ml bag) at normal maintenance rate. The Northwest Transport Service were contacted for ongoing management support, and oral potassium supplementation at 1mmol/kg was started.

Due to the child's learning difficulties and distress at being in a hospital environment he did not tolerate cardiac monitoring whilst IV fluids were being administered, so a repeat ECG was completed the following morning, with no further QTc prolongation noted. Blood gas monitoring was continued overnight, and by morning the levels showed K^+ 3.4mmol/L, with Na^+ 138mmol/L. The child had further biochemistry testing, normal urine electrolytes, normal ECG and normal chest x-ray the following morning. An abdominal x-ray demonstrated features of constipation. Unfortunately, the child could not tolerate a CT head without sedation, and this was not available locally.

The child was discharged home once blood potassium levels were stable within the normal range, with plans to re-check his bloods within 1 week and periodically after this in the community, and outpatient paediatric follow-up. An MRI head under general anaesthetic was requested as an urgent outpatient appointment, to rule out central causes of vomiting. However, the child re-presented via the emergency department 4 weeks later with increasing frequency of vomits (6-7 times per night) with 24-hour history of abdominal pain. His blood gas continued to show a metabolic alkalosis with hypokalaemia (pH 7.572, K^+ 2.0mmol/L, Na^+ 134mmol/L, ionised Ca^{2+} 1.05mmol/L, BE 20.3mmol/L), and hypokalaemic changes on ECG including flattened T-waves, U waves and absent p-waves in some leads. IV and oral potassium replacement were commenced, and no acute abdominal pathology identified on abdominal ultrasound scan. The child was discharged home once he had adequate oral intake and normal stabilised potassium levels, with a plan for twice weekly bloods in the community. Laxatives were started for constipation.

The child had three further admissions to paediatric inpatient ward over the next 4 weeks due to constipation, vomiting and hypokalaemia requiring IV replacement. He had 3.5kg weight loss over this timeframe. An MRI head and abdominal scan demonstrated no medical causes for the vomiting. Extensive blood and urine investigations were normal, with no evidence of renal tubulopathy, Gittelman or Bartter Syndrome. The child was discussed with the tertiary gastroenterology team, who reported a similar case in another autistic child who was subsequently diagnosed with rumination syndrome. Gastroenterology advice was to start the child on a trial of baclofen, refer to CAMHS for support, and provide advice regarding behavioural therapy including diaphragmatic breathing. Gastroenterology would arrange an outpatient review with consideration for endoscopy.

Since starting on the baclofen, the child has required no further inpatient admissions for potassium replacement therapy, the frequency of vomiting has reduced to once every 2-3 days, and potassium levels have normalised.

Rumination Syndrome

Rumination syndrome is a rare condition with a worldwide prevalence of 2.8%.[1] It is characterised by effortless regurgitation of recently ingested food and drink which can then be chewed, re-swallowed, or expelled, with symptoms present over a period of at least 4 weeks.[2] The ICD-11 and DSM-V diagnostic criteria are listed in the table overleaf.[3-5]

Continues overleaf

	DSM-5 criteria	ICD-11 criteria
Description	Repeated regurgitation of food which may be re-swallowed or spat out	Intentional and repeated regurgitation of ingested food which may be spat out, chewed or re-swallowed.
Frequency of symptoms	Not specified	Several times per week
Duration of symptoms	> 1 month	Several weeks
Other considerations	Regurgitation not accounted for by medical condition Diagnosis only if developmental age > 2 years	

Complications of rumination syndrome include malnutrition and weight loss, dehydration, and electrolyte imbalance. Investigations are not necessary except to rule out underlying medical causes (as in the case above), as rumination syndrome is an acquired behavioural condition.[5]

Management focuses on good explanation of the diagnosis and understanding the condition. First-line treatment involves behavioural therapies, including implementing diaphragmatic breathing.[5-6] There has also been a case-study which recommends chewing gum after a meal to prevent regurgitation,[7] although that was not deemed appropriate for the patient in this case due to his behavioural issues. Medical and surgical interventions are not normally recommended in rumination syndrome; however, baclofen can play a beneficial role by increasing the resting tone of the lower-oesophageal sphincter and reducing regurgitation,[8] although may cause unwanted side effects at higher doses.[5]

Conclusion

We discuss the case of a 12-year-old boy with autism and learning disabilities who presented with a one-year history of effortless nocturnal vomiting, with an acute increase in vomiting frequency resulting in significant hypokalaemic hyponatraemic hypochloraemic metabolic alkalosis, requiring IV electrolyte replacement. After repeated admissions and episodes with significant electrolyte imbalances, a provisional diagnosis of rumination syndrome was given. Rumination syndrome is a rare acquired behavioural condition whereby ingested food and drink is regurgitated after meals. In this case there was an improvement of symptoms following regular baclofen use.

Dr Kathryn Newell | Paediatric ST5 trainee
Northwest (Manchester) Deanery

Dr Fiona Eaton | Consultant Paediatrician in Community Paediatrics
Royal Lancaster Infirmary

Dr Salman Imran | Consultant Paediatrician
Royal Lancaster Infirmary

Acknowledgements from Dr Newell: I would like to thank the young person and the family discussed in the case report for their consent and willingness for us to discuss their case on this platform, to support all our learning. My thanks also go to Dr Imran and Dr Eaton as supervising consultants for this case.

No funding or competing interests to declare.

References

1. Sperber AD, Bangdiwala SI, Drossman DA, *et al*. Worldwide prevalence and burden of functional gastrointestinal disorders, results of Rome Foundation global study. *Gastroenterology* 2021;160:99–114.doi:10.1053/j.gastro.2020.04.014 pmid: ***http://www.ncbi.nlm.nih.gov/pubmed/32294476***
2. Foundation R. *Rome IV criteria the Rome Foundation*. 4th edn, 2016. ***https://theromefoundation.org/rome-iv/rome-iv-criteria/***
3. WHO. *Rumination-regurgitation disorder*. 11th edn, 2021. ***https://icd.who.int/browse11/l-m/en#http%3a%2f%2fid.who.int%2ficd%2fentity%2f1205760590***
4. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed, Text Revision. American Psychiatric Association Publishing; 2022:374-375.
5. Sasegbon A, Hasan SS, Disney BR, *et al.* Rumination syndrome: pathophysiology, diagnosis and practical management. F*rontline Gastroenterology* 2022;13:440-446. ***https://fg.bmj.com/content/13/5/440***
6. Chitkara DK, Van Tilburg M, Whitehead WE, *et al.* Teaching diaphragmatic breathing for rumination syndrome. *Am J Gastroenterol* 2006;101:2449–52. doi:10.1111/j.1572-0241.2006.00801.x pmid: ***http://www.ncbi.nlm.nih.gov/pubmed/17090274***
7. Weakley MM, Petti TA, Karwisch G. Case study: chewing gum treatment of rumination in an adolescent with an eating disorder. *J Am Acad Child Adolesc Psychiatry* 1997;36:1124–7.doi:10.1097/00004583-199708000-00020 pmid: ***http://www.ncbi.nlm.nih.gov/pubmed/9256592***
8. Grossi l, Spezzaferro M, Sacco lF, *et al*. Effect of baclofen on oesophageal motility and transient lower oesophageal sphincter relaxations in GORD patients: a 48-h manometric study. *Neurogastroenterol Motil* 2008;20:760–6. doi:10.1111/j.1365-2982.2008.01115.x
9. Children's Hospital of Philadelphia. Rumination Syndrome (patient information) Rumination Syndrome | Children's Hospital of Philadelphia, ***https://www.chop.edu/conditions-diseases/rumination-syndrome***

Neurodevelopmental Follow-up in Community Paediatric Clinics: Why This Work Matters

Community paediatric clinics increasingly sit at the point where early neonatal survival meets later developmental reality. As more infants born extremely preterm or affected by significant neonatal complications survive into childhood, the developmental questions families bring are changing. Increasingly, the child referred for review is not one with obvious severe disability, but one whose development is progressing unevenly, walking but not climbing confidently, using words but not gestures, coping well at home but struggling in nursery, or showing sensory and behavioural differences that become more noticeable over time.

What makes this particularly challenging is that many of these children initially appear reassuring. They may leave neonatal services medically stable, with no immediate neurological concerns, yet their developmental profile begins to unfold gradually across the second year of life. For clinicians, this means follow-up cannot simply focus on milestone recording or discharge decisions, but on recognising developmental patterns while they are still emerging.

The children most commonly attending these clinics are those already recognised as being at increased developmental risk: infants born before 30 weeks' gestation, those with birth weight below 1500g, babies who experienced neonatal encephalopathy, therapeutic hypothermia, neonatal seizures, significant hypoglycaemia, intraventricular haemorrhage or prolonged neonatal intensive care.[1] Although many enter follow-up through neonatal pathways, community paediatric services increasingly provide the longer-term developmental surveillance after neonatal discharge.

Current National Institute for Health and Care Excellence guidance recommends structured developmental follow-up for infants born preterm who are considered at higher risk, with formal developmental assessment by two years corrected age and continued developmental awareness beyond infancy.[2,5] This remains important because early infancy can be deceptively reassuring. Developmental vulnerability often becomes clearer only when movement quality, communication and social interaction become more sophisticated.

What Neurodevelopmental Follow-up Looks Like in Practice

A neurodevelopmental follow-up clinic is rarely about formal testing alone. Much of the assessment begins before the examination itself. Watching how a child enters the room, separates from a parent, explores toys, changes position or responds to voice often provides the earliest developmental clues.

Spontaneous movement may reveal subtle asymmetry before tone is formally assessed. The quality of reaching, transitions between positions, or how a child steadies themselves while sitting often tells more than isolated milestone reporting. Play may reveal whether gestures are emerging appropriately, whether shared attention is present, and how a child uses interaction to regulate unfamiliar situations. Feeding history often adds important context, particularly where sensory differences, oral motor difficulty or behavioural rigidity are already emerging.

For this reason, several developmental domains must be considered together: motor development, communication, social interaction, behaviour, regulation, feeding and sensory profile frequently overlap, and it is their relationship that becomes clinically informative. In younger infants, assessment often centres on posture, movement quality, symmetry and transitions. In older infants and toddlers, greater emphasis falls on gesture, play development, joint attention, language progression and behavioural flexibility.

Corrected age remains essential until two years of age, as developmental interpretation can change significantly when age correction is overlooked.

The quality of these clinics is often strengthened considerably when developmental findings are interpreted within a multidisciplinary setting. Many clinics include a community paediatrician working alongside physiotherapy, occupational therapy, speech and language therapy and, where available, specialist nursing input.

This multidisciplinary approach matters because each professional often notices something slightly different. A physiotherapist may identify mild truncal instability or delayed balance reactions in a child who otherwise appears broadly reassuring. An occupational therapist may recognise sensory defensiveness, fine motor planning difficulty or early regulation concerns before these become functionally obvious. Speech and language colleagues frequently detect delayed communicative intent before expressive language delay becomes clear.

The paediatrician's role is then to bring these observations together with neonatal history, parental concerns and developmental trajectory. This is particularly valuable because many children attending these clinics sit in a grey area between reassurance and diagnosis. They may not yet meet clear criteria for cerebral palsy, autism spectrum disorder or developmental disorder, but repeated multidisciplinary review often clarifies whether developmental surveillance should continue.

A recent UK survey of neonatal neurodevelopmental follow-up services highlighted considerable variation in developmental tools and MDT delivery, with many neonatal pathways ending earlier than families often expect[1].

A Child Seen in Follow-Up

A boy born at 28 weeks' gestation following severe intrauterine growth restriction was referred for neurodevelopmental review because of prematurity, prolonged respiratory support and feeding difficulties during infancy.

At 10 months corrected age he was sitting independently, babbling and transferring toys well. Neurological examination was reassuring, and there were no obvious concerns regarding his tone or any asymmetry. His parents described him as generally settled, although they felt he disliked sudden changes in routine and preferred familiar environments.

He returned six months later as part of planned follow-up.

By sixteen months corrected age he had started walking but remained cautious in movement and avoided climbing. During consultation he used few gestures and showed limited shared attention during play. Nursery had recently commented that he often played alone and became distressed in noisy group situations.

When reviewed jointly in MDT clinic, several small findings became more meaningful together. Physiotherapy identified mild balance difficulty and delayed protective responses. Speech and language assessment suggested delayed communicative intent rather than isolated speech delay. Occupational therapy highlighted sensory defensiveness around sound and texture.

No single finding suggested major neurodisability, but together they justified early therapy input and repeat developmental review. By two years corrected age he had mild expressive language delay and sensory regulation difficulties but had entered support pathways before concerns became functionally more significant.

This is often where these clinics add greatest value: not identifying severe pathology but recognising developmental vulnerability while intervention can still begin early.

What These Clinics Commonly Pick Up

Over time, similar developmental patterns recur. Common findings include subtle asymmetry, delayed balance and climbing, reduced gesture and pointing, slower expressive language, sensory sensitivity, behavioural rigidity, immature play and reduced reciprocal interaction.

Often no single feature appears striking in isolation. It is the combination, persistence and developmental trajectory that become clinically important. Repeated review is therefore often more informative than one isolated assessment. A child who appears reassuring at one year may look very different by 18 months, when communication, play and motor planning should be progressing more clearly.

Important Points to Consider

One of the most valuable lessons from running neurodevelopmental follow-up clinics is that reassurance should rarely rest on a single clinic encounter. Development is dynamic, particularly in infants who begin life with recognised neurological vulnerability. A child who appears reassuring at one review may look quite different six months later.

This is particularly true in children born preterm or following significant neonatal complications, where developmental differences often emerge gradually rather than presenting as clear delay early on. Recent follow-up data continue to show that some children who appear broadly age-appropriate in infancy later demonstrate milder motor, language or executive difficulties by preschool age, particularly those born at earlier gestations or with neonatal brain injury.[2]

Families who have already navigated neonatal care are often highly observant of subtle developmental change, and parental comments such as '*Something feels different*' should be taken seriously.

A careful neonatal history continues to shape developmental interpretation long after discharge. MRI findings, intraventricular haemorrhage grade, neonatal seizures, feeding difficulties and

Continues overleaf

prolonged respiratory support often help explain later developmental phenotype. Early feeding and regulation difficulties may also correlate with later sensory and communication differences.[3]

Observation before formal examination is often more informative than the examination itself. Nursery information is equally valuable, as children who appear settled in clinic may struggle in noisier, more demanding environments. Functional observations across settings improve early identification of milder neurodevelopmental difficulty.[4]

Most importantly, we need to remain comfortable with uncertainty. Not every child requires an immediate diagnosis; many benefit most from thoughtful developmental watching over time.

Conclusion

As neonatal survival continues to improve, community paediatric clinics are increasingly caring for children whose early medical vulnerability does not always translate into major neurodisability, but often into subtler developmental differences that only become clear over time. Many of these children will not present with a single diagnosis early on; instead, they require careful developmental interpretation across repeated reviews as communication, behaviour and functional demands evolve.[5]

Neurodevelopmental follow-up is therefore no longer simply an extension of neonatal care, but an increasingly important part of core community paediatric practice. Its value lies in recognising emerging developmental patterns early enough that intervention, surveillance and family support can begin before difficulties become more firmly established.

Dr Sarah Thomas
Paediatric Registrar, University Hospital Lewisham

References

1. Marcroft C, et al. Neonatal neurodevelopmental follow-up in the UK: a survey of current practice and future recommendations. *Archives of Disease in Childhood Fetal and Neonatal Edition*. 2025.
2. National Institute for Health and Care Excellence. Developmental follow-up of children and young people born preterm. *NG72. London*: NICE; 2017.
3. Novak I, Morgan C, Adde L, et al. Early, accurate diagnosis and early intervention in cerebral palsy. *JAMA Pediatrics*. 2017.
4. Romeo DM, Ricci D, Brogna C, Mercuri E. Use of the Hammersmith Infant Neurological Examination in infants at neurological risk. *Developmental Medicine and Child Neurology*.
5. British Association of Perinatal Medicine. Follow-up care recommendations for high-risk infants.

National Trainee Day

HOW TO BE BRILLIANT
Neurodiversity and Neurodisability
A national training day for CCH/Neurodisability trainees
on how to get it right - led by our children and young people

This year's national trainee study day looked very different.

Whilst most of our trainee teaching is now delivered online to improve accessibility for trainees across the country, we kept our face-to-face study day, but completely changed who taught it. Run jointly as a BACCH and BACD trainee day, we moved away from traditional lectures and instead handed the stage to our families, children and wonderfully neurodivergent young people to teach us what it really means to 'be brilliant'.

What followed at the RCPCH on 28th April was one of the most powerful trainee events many of us have experienced. Throughout the day, families spoke openly about navigating healthcare systems, fighting to be heard, balancing exhaustion with advocacy, and the small acts of kindness from professionals that completely changed their experiences of care. Again and again, speakers reminded us that children are far more than diagnoses, pathways or clinic letters and that the best healthcare professionals are often the ones who simply take the time to listen.

Zyann and Tanaysha

The day began with Tanaysha sharing the realities of parenting three neurodiverse children whilst navigating systems that are often difficult to access and rarely designed with families in mind. She spoke honestly about the practical and emotional pressures families manage behind the scenes: balancing appointments, school, childcare, sensory needs and emotional regulation, often whilst trying to advocate for support. She talked about the children who 'fall through the gaps' and struggle without meeting thresholds for support and highlighted the importance of flexibility, accessibility and truly listening to families' needs.

Zyann spoke confidently and honestly about being autistic and having ADHD, describing it as 'good' because it makes him 'more creative' and gives him 'more aura'. He also reflected on how personal diagnoses can feel, explaining that whilst his friends know, he prefers to keep some things private to avoid 'school drama'. Alongside this, he spoke about the challenges of sensory overload in crowded public spaces and transport. His confidence, humour and complete certainty in who he was completely shifted the tone in the room, reminding us that neurodiversity is not something young people necessarily want 'fixed', but understood.

Adrian and Grace K

Grace spoke about raising Adrian, who has cerebral palsy, whilst navigating abuse, stigma and repeated battles to be heard within healthcare systems in a way that moved the entire room. Through a powerful poem, she described the hidden emotional burden many parents carry, sitting in meetings where their child becomes reduced to scores and needs whilst trying to stay strong enough to advocate for them. A strong theme throughout was humanity. Grace reminded us that children are not diagnoses or NHS numbers, but individuals with personalities, strengths and joy. Her reflections challenged trainees to approach families with curiosity, humility and compassion, and reinforced how much simple things like learning and using a child's name, listening properly, believing parents and asking parents how they are doing can really matter.

Adrian joined us, at his mother's side supporting her. He gave us his amazing smile – as Grace said, the best smile in the world.

Grace T

Grace shared a remarkable session on self-advocacy, disability and transition into adulthood. Using her communication device alongside a BSL interpreter, she challenged trainees to think differently about disability and encouraged us to move beyond purely medicalised views of neurodiversity. Grace spoke openly about living with autism and a genetic syndrome, highlighting the barriers created not by disability itself, but by systems and environments that are not designed inclusively. She reminded us how important it is to ask young people directly about their strengths, goals and identities and not just their needs. Grace also shared a beautiful wheelchair dance performance which completely captivated the room. It was such a powerful reminder of the creativity, joy and talent that can so often be overlooked when we focus only on diagnoses. Her honesty, humour and confidence left a lasting impression on everyone there.

Breege

Breege, Ruairí's mum, shared a deeply thoughtful and moving reflection on children's palliative care and the realities of parenting a child with complex medical needs and uncertainty. She spoke honestly about how frightening the idea of palliative care initially felt as a parent, and how many families associate hospices with being places to die, rather than places to live. Through Ruairí's story, Breege challenged many of those assumptions. She described how children's hospices became places of joy, support, respite and memory-making for their family, somewhere Ruairí could simply be a child and where the whole family felt cared for. She reflected on the importance of reframing palliative care not as 'giving up', but as helping children and families live as fully and comfortably as possible so that they do not delay that decision to engage and miss out on making those memories.

Her session also highlighted the emotional burden families carry whilst navigating multiple specialties, difficult decisions and uncertainty about the future. She reminded trainees how important honest communication, continuity and compassionate relationships can be, particularly when families are living with ongoing complexity.

Charlotte and Heidi

Charlotte and her mum Heidi brought warmth and plenty of paper confetti to the afternoon sessions. Charlotte happily shredded paper throughout much of the talk, creating a joyful reminder that inclusive spaces for children should be just that – and absolutely part of our training. Heidi shared powerful reflections on raising a non-verbal autistic child with complex needs and spoke about how transformative it can be when professionals genuinely adapt care around the individual child. One particularly memorable story described a paediatrician sitting beside Charlotte on the floor, joining in with paper play to help her feel calm enough for an examination. Heidi's talk reinforced how flexibility, creativity and listening to parents can completely transform healthcare experiences for children and families.

Zara

Zara gave a deeply honest and reflective session exploring the realities of parenting neurodivergent children as a neurodivergent parent, navigating systems shaped by privilege, bias and shame. She spoke openly about how difficult 'speaking up' can be for families, particularly when parents are already physically and emotionally overwhelmed, and reflected on the hidden shame many families carry when they feel judged, dismissed or blamed for their child's difficulties. A particularly powerful theme throughout her talk was privilege – recognising that some families are better equipped to navigate healthcare, education and diagnostic systems than others. Zara reflected on how factors such as confidence, language, education, finances and previous experiences with professionals can completely shape a family's ability to advocate for their child. She challenged trainees to think carefully about the families who may appear 'quiet', disengaged or overwhelmed in clinic settings, reminding us that this is often not lack of interest, but the result of exhaustion, fear or previous negative experiences. Her reflections encouraged trainees to approach families with greater compassion and curiosity, rather than assumptions, and to recognise the courage it can take simply to attend appointments and continue asking for help. It was a powerful reminder that equitable care means understanding not only the child in front of us, but also the wider systems and pressures affecting the family around them.

Anaiyah and Rebecca

Rebecca shared Anaiyah's journey through intellectual disability, autism, epilepsy and attending a specialist school with incredible honesty. Alongside discussing hospital admissions, seizures and medical complexity, she also beautifully brought Anaiyah's personality into the room – her love of pink, grapes and Peppa Pig! Her session reminded us that behind every complex medical history is a child with joys, preferences and individuality, and a family trying their very best to navigate extraordinarily difficult circumstances.

A particularly important part of Rebecca's talk focused on communication and the assumptions often made about non-verbal children. She reflected on how easy it can be for professionals to speak around children rather than to them, or to underestimate their understanding simply because they communicate differently. Rebecca reminded trainees that communication is far more than spoken language and highlighted the importance of taking time to understand each child's individual ways of expressing themselves, their preferences and how they show comfort, distress or joy.
She showed some of the visual aids Anaiyah is learning to use to communicate and reinforced how meaningful patience, listening and adapting communication can be for families – particularly during stressful healthcare interactions where children who communicate differently can so easily be overlooked.

Carrie

Carrie closed the day with a reflection that brought together both her professional and lived experiences. As a consultant community paediatrician and parent, she spoke about how differently healthcare feels when it is your own child, and how vulnerable even medically knowledgeable parents can feel during moments of uncertainty and fear. A strong theme was the importance of noticing the subtleties – the quieter concerns, the things that may not immediately stand out on paper or during brief appointments, but which can still have a profound impact on a child and family's life. She spoke thoughtfully about how children can appear to be 'coping' externally whilst still struggling significantly beneath the surface, and how easy it can be for subtle difficulties to be overlooked when they do not fit obvious thresholds or expectations. Her reflections highlighted the lasting impact of compassionate professionals who take the time to listen carefully, communicate honestly and recognise the emotional realities families are living with – a fitting close to a day centred around listening more closely, thinking more holistically and recognising that the smallest observations and interactions can have the greatest impact on children and families.

The Real Impact of Inviting our Patients to be Trainers

Perhaps one of the most powerful parts of the day came afterwards, in the messages we received from families and students. Families described feeling 'part of the bigger picture', 'grateful and humbled' that people had listened to their journeys and proud that their stories might help improve care for future children and families. One parent wrote that it 'fills my heart to know I've made an impact', whilst another reflected that the event had been 'such a positive experience'.

A huge part of the day's success was the team of neurodivergent medical students recruited to support our families before, during and after the event. Paired 1:1 with families speaking, they provided the reassurance, understanding and friendly face at the door that was crucial for enabling participation, whilst also helping create a calm and welcoming environment for our children and young people. It was equally powerful hearing the impact the experience had on the students themselves as learners. Several described the day as 'monumental as a piece of education', whilst others said they would 'happily do it all again'. Including medical students in this way – not only as learners, but as facilitators of lived experience teaching – is an opportunity with clear mutual benefit that we should all consider more widely.

Continues overleaf

What became very clear is that this type of learning changes people in a way traditional lectures often cannot.

This is not simply patient involvement added onto training as an afterthought. It is a reminder that families are experts in their own experiences and should be central to how we train future paediatricians. These conversations challenge assumptions, build empathy, and help trainees understand the realities families live every day far beyond clinic walls.

It is important to acknowledge that the event nearly did not happen at all. Coordinating accessibility requirements for multiple wheelchair users on the sixth floor of the RCPCH challenged systems that had simply never hosted a day like this before – we are so grateful to the RCPCH and BACCH teams for working through these barriers. This is perhaps the clearest reminder of why events like this matter so much. Our patients and families should not be occasional visitors within medical education; they should be central to it.

How to Be Brilliant reminded all of us that the future of paediatric training cannot be built on clinical knowledge alone. It must also be built on listening better, thinking differently and having the humility to learn directly from the children and families we serve.

Recordings from the event will be available to view via the ***members' section of the BACCH website*** from early June.

Claire Stewart | *BACCH National Trainee Rep*

Charlotte Sayer | *BACD National Trainee Rep*

A Letter of Gratitude From Grace

To 77 Medical Trainees Who Listened, Felt, and Will Never Forget

Dear Doctor,
I am writing to you – yes, to you personally – because what happened in that room was not ordinary. You gave me something I did not expect when I walked through that door: you gave me your full attention, your open heart, and in some cases, your tears.

I came to speak about my son Adrian and what our journey has looked like from the other side of the clinical table. I did not know if you would listen. I did not know if it would matter. But 77 of you sat in that room – and every single one of you stayed. Every single one of you heard him.

What you showed me that day.

I have stood in many rooms. Hospital corridors, waiting areas, therapy sessions, school meetings. Most of the time, I had to fight to be heard. I had to prove that I knew my son. I had to explain myself over and over again to people who had already decided what Adrian was before I finished my sentence. But you were different. You leaned in. Some of you put down your pens. Some of you nodded.

Some of you – and I will carry this for the rest of my life – some of you cried. Not out of pity. Out of understanding. And that is the rarest, most powerful thing a professional can offer a parent.

You showed me that the next generation of doctors is ready to listen. And that – for families like mine – changes everything.

The five things I hope you carry with you always

1. A child with CP is a human being – not a set of numbers

   Adrian is 8 years old. He has the most gorgeous smile you will ever see. He makes his brother Ryan laugh every single day. He has a future he is already imagining. Before you open the file, before you read the scores – remember that. He is a person first.
   Always.

2. Always ask the parent how they are doing

   It is a five-second question. It costs nothing. But to a mother who has not slept, who is navigating systems that were not built for her, who is carrying everything alone – those five words are medicine. 'And how are you doing?' Please. Never skip it.

3. Avoid repetitive questions – they bring trauma

   Every time a new doctor asked me to start from the beginning, I relived the worst moments of our journey. Read the notes. Trust what was written. A parent who has to tell their child›s story from scratch in every new room is not receiving care – they are being re-injured.

4. The parent knows the child more than any doctor ever will

   I have lived with Adrian every hour of his life. I noticed the change three weeks before it appeared on any scan. My observations are not anecdote – they are data. Trust us. We are not obstacles to the diagnosis. We are the most important part of it.

5. Your compassion is a clinical skill – use it

   The tears some of you shed that day were not a weakness. They were evidence that you are exactly the kind of doctor that families like mine need. Do not let the system train that out of you. Protect it. It will make you a better clinician every single day of your career.

Adrian – the smile that changed a room of 77

A personal note

I did not come into that room as an expert. I came as a mother. I came with the only credential that matters in the world of a child with cerebral palsy – twenty-four hours a day of loving him, fighting for him, and refusing to let the world reduce him to a score on a page.

When some of you cried, I did not feel sorry for you. I felt hopeful. Because a doctor who can be moved by a family›s story is a doctor who will never forget that behind every chart is a person. Behind every referral is a mother who has been waiting. Behind every diagnosis is a child who just wants to be seen.

You gave me a standing ovation. But I want you to know – the standing ovation belongs to Adrian. To my brother Edward, who never left. To Ryan, who makes Adrian laugh every single day. And to every family out there still fighting for their child in rooms that do not yet have doctors like you.

Go and be those doctors. That is the greatest thank-you you could ever give me.

For the 77

You came to learn the science of the brain,
the synapses, the pathways, and the signs,
but somewhere in that room you learned again
that medicine is read between the lines.
You learned that charts are not the whole of things,
that numbers cannot hold what love has known,
that every child who enters on a file
is someone's world – not just a case to own.

Some of you wept – and that was not a flaw,
that was the best of medicine, alive,
the moment science bowed to something raw:
a mother's voice, a boy who chose to thrive.

Go now and carry what you felt that day,
into the wards, the clinics, and the years,
say every name, ask every carer: how are you?
and let yourself be moved – past all your fears.
For Adrian sat in that room without a word
and taught you more than textbooks ever can:
that every child deserves to be fully heard,
and every parent – seen as more than a carer plan.

Public Health

Public Health in Pictures:

Designing Long-Term Condition Pathways

Community child health is fundamentally a long-term condition specialty. Much of our work involves supporting children and young people with enduring neurodevelopmental, physical, emotional or social difficulties across childhood and adolescence.

However, every long-term condition begins somewhere. The short-term condition pathway described in last edition's BACCH News: *Public Health in Pictures* article represents the initial phase of a longer journey. Some children improve and leave the pathway entirely, while for others the early presentation evolves into a long-term condition requiring ongoing review, adaptation and transition planning.

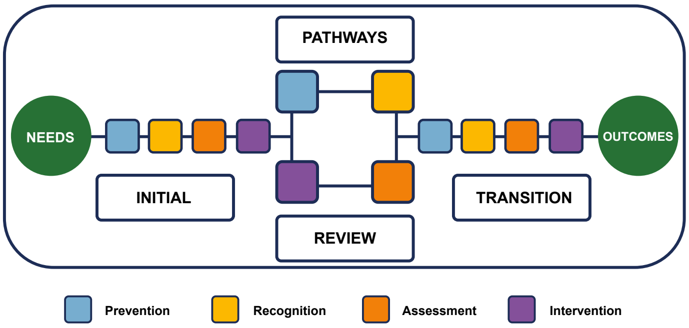
Long-term condition pathways can therefore be thought of as three connected phases:

- Initial pathway
- Review pathway
- Transition pathway

Each phase contains the same core components:

- Prevention
- Recognition
- Assessment
- Intervention

The challenge for integrated care systems is to ensure that all parts of the pathway are in place and working together effectively to achieve the best possible outcomes. Tackling the determinants outside the health service will be covered in the next article on life course pathways.

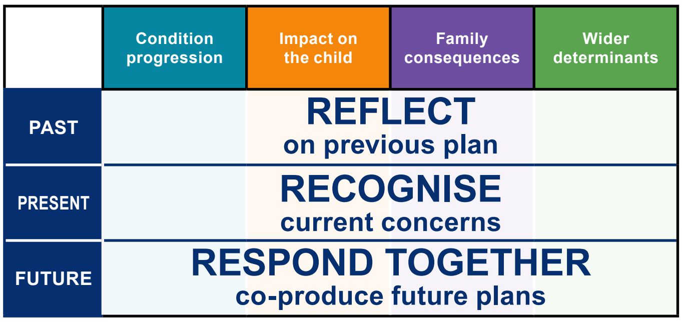


Implications From Shorter-term to Longer-Term Care

In a short-term pathway, the goal is largely reactive - recognition of a problem, timely assessment, intervention and recovery. Long-term conditions are different. The focus shifts from cure toward maintaining wellbeing, reducing comorbidities and preventing disability or disadvantage over time. This requires a more proactive and anticipatory model of care.

The frequency of the review process depends upon the natural history of the condition and the timeline for the actions within the care plan. The review pathway exists to identify emerging problems, assess their impact comprehensively and develop an effective management plan before difficulties escalate into a crisis. In practice, proactive care means looking forward rather than simply responding to concerns or events after they occur. Families frequently describe feeling as though they are 'lurching from crisis to crisis' when systems are reactive rather than proactive.

A useful principle is to consider which clinical, developmental or social issues are likely to emerge before the next review cycle and incorporate these into an anticipatory care plan. Figure 2 offers a simple structure for the review consultation. It starts by reflecting on the previous plan, then recognising current concerns, before responding together with agreed next steps. Across each stage, clinicians should consider condition progression, the impact on the child, family consequences and wider determinants of health.



	Condition progression	Impact on the child	Family consequences	Wider determinants
PAST	**REFLECT** on previous plan			
PRESENT	**RECOGNISE** current concerns			
FUTURE	**RESPOND TOGETHER** co-produce future plans			

Continues overleaf

Down syndrome is one example where this approach can help clinicians anticipate health surveillance needs, developmental progress, family pressures and school or community support before the next review cycle.

Looking Beyond the Condition

Long-term conditions rarely affect only the child. Their impact extends across family life, education, employment, finances and social participation. Some conditions, such as cerebral palsy, may require significant modification of the physical environment through adaptations, mobility support or specialist seating. Others, such as autism spectrum disorder or ADHD, may require changes within the educational or social environment to reduce stress and improve participation. In the safeguarding world changes in parental health and behaviour may need to be addressed, for example, substance misuse, domestic violence or mental health concerns.

These examples illustrate the importance of addressing the wider determinants of health alongside the long-term condition and close collaboration with other organisations within the local integrated care network to create the concept of 'the team around the family.' This reflects the wider public health understanding of health and disease discussed in previous articles: outcomes are shaped not only by the condition itself, but also by the interaction between host, agent and environment.

The Review Phase

The review phase is often the longest part of the journey for families and may continue over many years. The review consultation should not simply monitor the condition, but should reflect on the previous plan, recognise current concerns and respond together with an anticipatory plan. This means considering the condition, the child, the family and the wider environment at each review.

A good review consultation should therefore ask:

- How is the condition progressing?
- How is the child's daily life, development or participation affected?
- How is the family coping, and what pressures or strengths are present?
- What wider environmental, educational, social or service factors are helping or hindering progress?
- What is likely to be needed before the next review?
- What can we do together now to prevent future harm or disadvantage?

While some long-term conditions require meticulous and consistent clinical care, it is often family capacity and wider environmental issues that limit the achievement of better outcomes. For example, poverty has implications for nutrition, housing, transport and opportunities in school, so enquiring and signposting to benefit advice and local support services should be part of future care planning.

The Transition Phase

The transition phase represents a major change in the child or family's life. In some conditions, transition may involve movement from active treatment into remission or palliative care. For many children with long-term conditions the transition will be from hospital to home, from home to school, transition between schools, or from schools to higher education/apprenticeships/employment. Each will have their unique issues that require proactive recognition, assessment and interventions to ensure preparation for life as an adult and seamless care.

The purpose of the transition pathway is therefore to anticipate likely future events early enough for preventative action to occur. Well-designed transition pathways prevent avoidable deterioration and reduces the risk of disadvantage accumulating during major life changes. Structured approaches such as Ready Steady Go provide a practical example of how transition planning can help young people with long-term conditions prepare for adult life and adult services.

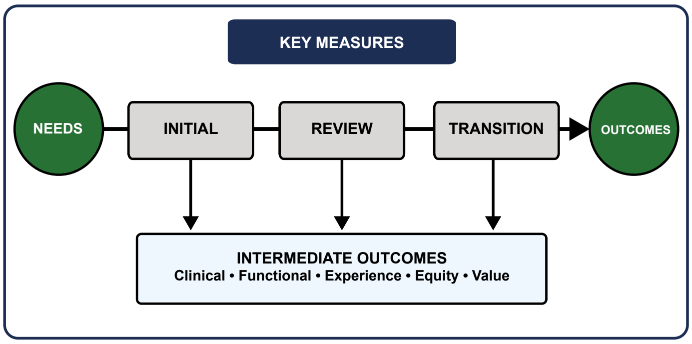
Measuring Whether Long-Term Condition Pathways Work

From a commissioning and service design perspective, the key questions become: 'Are all the parts in place and working well together?' and 'Is the network achieving expected outcomes?'

Long-term condition pathways should function as a connected system rather than isolated episodes of care. This raises important questions about measurement and quality assurance. Traditionally, healthcare systems have been measured around episodes of care rather than integrated pathways, making it difficult to identify weak points across the whole journey.

Patient-reported outcome and experience measures are in early development, and they should capture the impact of long-term conditions on family life, participation or wellbeing.

Understanding pathway quality therefore requires consideration of clinical outcomes, functional outcomes, the family and child's lived experience, equity of access, and system productivity and value



Measuring outcomes across similar services is the first step toward understanding the productivity and value theme that runs through the 2025 NHS 10-Year Plan.

Long-term condition networks should function as learning systems. Their purpose is not only to deliver care, but also to identify and strengthen the weakest links within the wider system. Clinicians therefore have an important role beyond individual consultations: contributing to pathway design, identifying gaps in care, supporting quality improvement, collaborating across organisations and promoting equitable access, experience and outcomes.

Ultimately, improving outcomes for children with long-term conditions requires more than excellent clinical care alone. It requires coordinated systems where prevention, recognition, assessment and intervention are aligned across the whole pathway.

More on equity and measuring outcomes in future articles in the series!

Dr Claire Stewart | National BACCH Trainee Rep

Dr Simon Lenton | Co-Chair, BACAPH

Safeguarding

Trauma-Informed Care in Community Paediatrics: Why Our Everyday Communication Matters

Trauma-Informed Care has become an increasingly prominent concept across health and social care, but its practical meaning within Community Paediatrics is still taking shape. We work with children whose developmental trajectories are shaped not only by genetics and neurobiology, but by relationships, environments and early experiences. Research from the first 1,000 days shows that early stress can influence emotional regulation, attention, sensory processing and health outcomes through both relational pathways and biological mechanisms such as stress-system calibration and epigenetic change.[1,2]

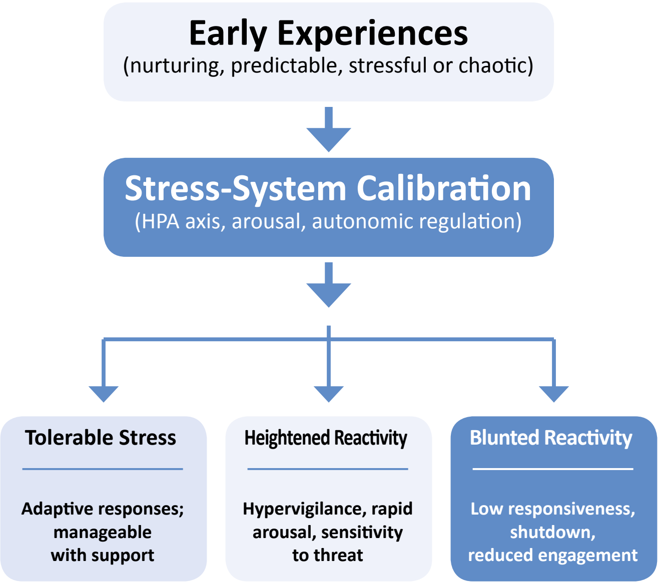


Figure 1: Early Stress and the Developing Stress-Response System[1]

Trauma-Informed Care encourages us to shift from 'What is wrong?' to 'What has happened, and what does this behaviour communicate?'[3] It emphasises safety, trust, collaboration, empowerment and cultural humility (*Figure 2*). In practice, this means being curious about the child's context, recognising the impact of chronic stressors such as poverty, housing instability or parental mental health difficulties, and understanding that behaviours often reflect adaptations to earlier environments rather than deliberate choices. It also means being mindful of the emotional tone we use, the assumptions we make, and the way we frame children and families in our documentation.

One area where Trauma-Informed principles are particularly relevant – but often overlooked – is written communication. Clinic letters are not simply administrative summaries; they are part of the child's story. They are shared with schools, social care, CAMHS and of course with the child and family themselves. Language that focuses primarily on deficits or behaviour can inadvertently reinforce stigma or shame, risking 'reinscribing' the problems in a way that subtly blames children or families for the suffering they have experienced due to structural inequalities,[4] whereas language that acknowledges needs, relational patterns and/or developmental context can support shared understanding and compassion and support growth and resilience.[5-7]I am undertaking a piece of work using a qualitative, discourse analysis-informed approach to explore how Trauma-Informed principles appear in routine new-patient clinic letters. Rather than auditing accuracy or structure, the analysis focuses on tone, framing, language choices and the implicit meanings that shape how children and families are represented. A sample of consultant-written letters is being coded, with attention to strengths-based language, emotional meaning, and how early life stress or adversity is made sense of, in relation to the concerns families brought to the consultation. The aim is to think about our written communication and identify opportunities to make communication with families more developmentally attuned and Trauma-Informed.

Figure 2: Substance Abuse and Mental Health Services Administration (SAMHSA) Trauma Informed Principles[3]

This qualitative lens has already highlighted the importance of stepping back and looking at our letters with fresh eyes – something that is surprisingly difficult when analysing colleagues' writing, as it is easy to read generously and assume positive intent. Being reflexive about this tendency has been an important part of the process.

The next stage of the project focuses specifically on how early adversity and the first few years of life are represented in our documentation. This includes whether clinicians draw on developmental or epigenetic frameworks, whether early stress is contextualised or left unexplored, and how we can strengthen our written communication to better reflect Trauma-Informed practice. Evidence from developmental neuroscience and paediatrics shows that early relational experiences shape stress-response systems and longterm outcomes,[1] yet this understanding is not always visible in the way we write.

Ultimately, Trauma-Informed Care is not a separate intervention; it is a way of thinking and communicating that can be woven into every aspect of our work. As community paediatricians, we are uniquely placed to understand the interplay between early experiences, neurodevelopment and environment. Ensuring that our letters reflect this understanding is a small but meaningful step towards more compassionate, equitable and developmentally attuned care.

Continues overleaf

References

1. Shonkoff JP, Garner AS; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129(1):e23246.
2. National Scientific Council on the Developing Child. *Excessive stress disrupts the architecture of the developing brain: Working Paper 3*. Center on the Developing Child, Harvard University; 2014.
3. Substance Abuse and Mental Health Services Administration (SAMHSA). *SAMHSA's concept of trauma and guidance for a Trauma-Informed approach*. Rockville, MD: SAMHSA; 2014.
4. Comeau, L., 2015. Re-inscribing whiteness through progressive constructions of 'the problem' in anti-racist education. In *Revisiting The Great White North? Reframing Whiteness, Privilege, and Identity in Education (Second Edition)* (pp. 179-188). Rotterdam: SensePublishers.
5. Bath H. The three pillars of Trauma-Informed Care. *Reclaiming Children and Youth*. 2008;17(3):1721.
6. Marsac ML, Kassam-Adams N, Hildenbrand AK, Nicholls E, Winston FK, Leff SS, et al. Implementing a Trauma-Informed approach in pediatric healthcare networks. *JAMA Pediatr*. 2016;170(1):707.
7. Masten, A.S., 2001. Ordinary magic: Resilience processes in development. *American psychologist*, 56(3), p.227.

Dr Bethany Davies | Community Paediatric ST5 Registrar
Sirona Care and Health
University Hospitals Bristol and Weston NHS Foundation Trust

Dr Tom Allport | Community Paediatrician
Sirona Care and Health
University of Bristol

Family Law Barristers: Who are Those People?

Doctors and lawyers are often coupled together in the mind of the public, in popular culture and in general discussion. There is a perception that both these roles are high-paying, glamorous jobs in sleek environments with numerous colleagues and seemingly unlimited time and resources. Whilst for some members of both professions this is akin to the truth, for many the Grey's Anatomy/Suits portrayal is far from reality. Both professions (particularly those working in publicly-funded fields) have a lot in common, but many of these similarities relate to being underpaid, overworked, under-valued, suffering secondary trauma, and fighting against a constant barrage of political and personal criticism and misunderstanding whilst trying to serve, help and protect some of the most vulnerable members of our society.

My sister is a community paediatric registrar, and I am a family, public law, and Court of Protection barrister. As we have both developed in our profession, I have been struck by the similarities in the challenges we have faced, and the overlap in issues we deal with. Despite this, there appears to be some lack of understanding of how each of our respective jobs operate.

I hope, in this piece, to give an overview of how the law operates in the one of the areas where I most encounter paediatricians and paediatric evidence – public children law, more commonly known as care proceedings – and to give some examples of where the work of paediatricians can become relevant to making important decisions which will affect these children, and families, throughout their lives.

How do care proceedings work?

Barristers generally get brought into a case when it is in court. In standard care proceedings, this is usually as a result of an application made by a local authority, who will in most cases seek either an 'interim care order' or an 'interim supervision order', and put before the court (increasingly not in a formal separate document) an interim care plan, setting out proposed arrangements for the child during proceedings.

The former gives parental responsibility to a local authority, which they will share with, but can override that of, the parents.[1] In many cases, but not always, a local authority will seek to remove the children from the parents (or who they are living with) and place them with assessed family members or stranger foster carers.

The latter order requires the local authority to advise, assist and befriend the child (and, by extension, the family), but does not result in a sharing of parental responsibility. In most cases, this is used to underpin continued placement at home, but where concerns continue to exist.

The first step to obtaining one of these orders is to establish that the 'threshold criteria' are met. This is that the court has reasonable grounds to believe the child is suffering, or is likely to suffer, significant harm, and that harm is attributable to either the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or the child's being beyond parental control.[2]

Following this being established, the court then considers the necessity and proportionality of any order (even if the criteria are met), and whether, if a child is being removed from the family home, the high test of immediate harm is met.[3]

During proceedings, there will likely be a number of assessments, potentially of both parents and children, before the local authority proposes a final care plan for the children, and indicates if it will seek a final care, supervision, or other orders (such as a placement order, a prelude to adoption). The test for obtaining the former two is the same as from the interim versions, save that the test no longer involves 'reasonable grounds to believe', but must be proven on the balance of probabilities i.e. more likely than not. As with interim orders, this is not the end of the matter – the court will need to consider the necessity and proportionality of the key aspects of any plan, including where the child will live and contact with family members, following an analysis of the viable options for the child.[4]

Due to limited resources, there are delays in listing proceedings, so many families may wait months for a decision, despite a statutory expectation that, absent necessity, proceedings are disposed of within 26 weeks. [5] Hearings may be listed urgently, with barristers receiving details and evidence very shortly (my record is about 25 minutes!) before they commence, particularly at the start of proceedings when a local authority may seek urgent removal of a child from their home.

How does the work of paediatricians feature in care proceedings?

Evidence originating from paediatricians can play a role at all stages, including before court proceedings are even contemplated and when public bodies make decisions about whether to initiate child protection procedures. Examples can include:

- *Notes from community or hospital-based paediatricians*, setting out a history of any injuries, frequency of presentation, behaviour of parents and carers, and other factors which are relevant to the care provided to the child.
- *Child protection medicals*, which can be essential in proving facts, or establishing 'reasonable grounds'. The relevance is not just limited to conclusions on the injuries, but the consistency and detail of reporting of parents, along with their demeanour.
- *Expert assessments* of the children ordered by the court to help inform decisions.
- *Non-court ordered assessments*, usually taking place as a result of the NHS referral process, which set out the needs of the children, establishing how they can be met and assisting in concluding whether a parent or other carer can meet them.

Accurate, descriptive and thorough recording therefore forms a key part of the work we do in public children law. Your work could become relevant beyond a single contact or incident. So, despite the lack of similarity to a shiny Netflix drama, the work paediatricians do every single day is extremely important, in ways that are probably not even foreseen at the time.

Rebecca Davies | Barrister, Field Court Chambers
Email: rebecca.davies@fieldcourt.co.uk

Education & Training

Making BACCH a Training Organisation

In 2025, the BACCH Executive Committee and Council agreed to develop BACCH as a training organisation. Of course, in some senses, we have always been a training organisation, but our current ambition is twofold: to strengthen what we offer in the devolved nations and regions of England, and to develop a national training programme for all members. In this article I will update on how the plan is developing, so you can look out for what may be relevant for you.

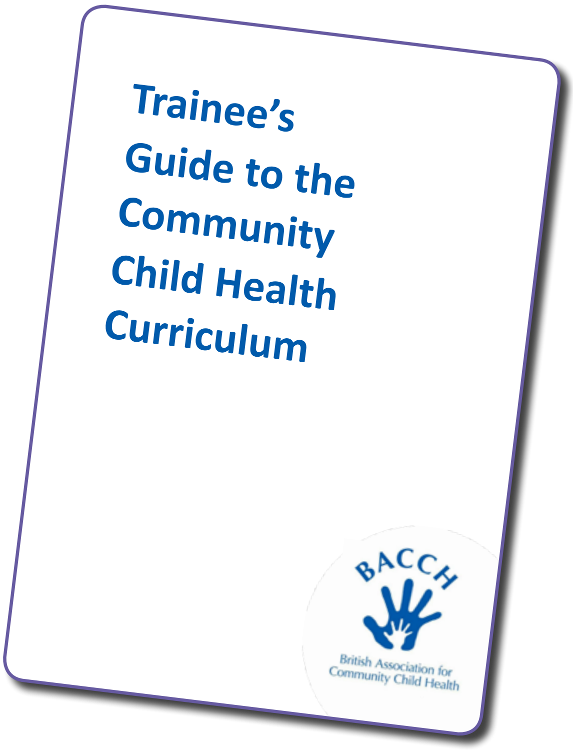
To oversee this plan, we have created a BACCH Education and Training Committee that reports to the BACCH Executive Committee. It has two SAS doctor reps, two consultant reps, an Advanced Practitioner rep, and a rep for consultants who came into Community Child Health from another paediatric discipline.

Taking the national programme first, there are four sequential steps to developing our offer.

Step one is a **curriculum** to focus our training on the most-needed learning. In 2025, the national trainee group took the Community Child Health Grid learning objectives from Progress Plus and expanded them to illustrate how the learning can be achieved. This document is available on the RCPCH website: ***https://www.rcpch.ac.uk/sites/default/files/2025-06/trainee_guide_to_the_cch_curriculum.pdf***

The trainee group are now working on the same for the Progress Plus generic learning objectives, and these two documents will provide the foundation of our training.

However we are concerned to ensure that our training meets every professional group's learning needs, and so the BACCH Education and Training Committee mapped the learning objectives for SAS doctors undertaking the CESR process, and the Centre for Advancing Practice – Paediatric and Child Health capability and curriculum framework for Advanced Practitioners onto the trainee curriculum. It was encouraging to see that these three documents align closely, and I think our tier 1 training should meet the needs of all three clinical groups well. We also mapped the Council for Disabled Children's Special Educational Needs and Disability Training Assurance Framework for Health Professionals onto our learning objectives. I will come back to the learning needs of consultants and tier 2 and tier 3 courses later in this article.


Trainee's
Guide to the
Community
Child Health
Curriculum

Step two is to broaden access to our **free trainees' webinar series** so that more BACCH members can access training in an easy manner. Our National Trainee Representatives have developed a weekly webinar programme which runs every Wednesday lunchtime and cycles through four themes: clinical case discussions; 'Lightning Learning' events focused on curriculum-based topics; population health; and research. The primary audience for these sessions has been trainees, but SAS doctors, APs and AHPs are also warmly invited to attend. The joining link should have been shared with relevant networks by the time you read this article, but please email bacch@rcpch.ac.uk if you have not received it. For details of all upcoming sessions see ***https://www.bacch.org.uk/pages/events.***

Step three of our four-step plan is **BACCH short courses**. We are creating a tiered approach to short courses; tier 1 (as explained above) is aimed at the learning needs of trainees, SAS doctors and APs, although others are welcome too. We envisage a three-year rolling programme of short courses that cover the entire curriculum, and we are starting later this year with short courses on Paediatric Palliative Care (with the Association for Paediatric Palliative Medicine) and Child Public Health (with the British Association of Child and Adolescent Public Health). In general, we will provide these courses online to increase their ease of access to clinicians across the four nations and cut out travel time and costs.

Tier 2 courses are aimed at early career consultants who want to develop their expertise in a specific area; imagine the training needed for a new named role in safeguarding or children in care, or a Designated Clinical Officer role in special educational needs.

Continues overleaf

We expect these courses to be for smaller groups and will be face-to-face. Our first tier 2 course is developed with the British Academy of Childhood Disability and is aimed at consultants seeking to develop a district level service for children with neurofibromatosis type 1. This is due to run on 5th November 2026 at the RCPCH offices in London.

Tier 3 short courses will be developed for consultants seeking a strategic role in a CCH area such as designated doctor for safeguarding or looked after children or Designated Medical Officer for special educational needs and disability. Like tier 2 courses, we expect tier 3 courses to be in-person events, and we will start these in 2027.

The final step in this four-step plan for national education and training is the creation of a **distance learning programme**, primarily for clinicians from abroad. Community Child Health services are very different across the globe, and we are not yet convinced that there is an international market for this type of provision. So, this final step is really in the market research stage and may never happen; if it does, it will be some years hence.

The second BACCH education and training ambition is to strengthen and standardise what we offer in the devolved nations and regions of England. BACCH has had a devolved nation and England regional structure for many years. In some places this is vigorous and healthy, with regular educational days where teams from across the nation or region meet, share practice ideas and are encouraged.

However, in other places none of this exists and, having met with a trainee rep from one such region, I can tell you that this can feel isolating and discouraging. In some places whole committees exist that create six-monthly educational days, but in other places the BACCH regional representative organises events on their own and this can be a daunting task. In one area the regional rep delegates the organising to local CCH teams on rotation, so an individual team may organise an event every few years. With the enormous clinical pressure on everyone, there are a number of regional rep posts that have been unfilled for years and it seems that one of the major impediments to people applying is the challenge of organising a meeting from scratch and managing the financial aspect.

Emma Grindrod started as BACCH's first Education and Training Administrator in February and one of her roles is to support devolved nation/English regional reps in delivering regional meetings. After a series of interviews with current representatives, the support offer is set out below and the income from these meetings will go towards paying for Emma's time.

Standard Event Plan for BACCH Regional Meeting

Responsibility of Regional Coordinator and/or Regional Trainee Reps

- Set date for event
- Identify and book suitable venue (BACCH Executive Officer to pay venue invoice)
- Invite and liaise with speakers
- Draft the programme
- Promote event within the region through non-BACCH channels e.g. NHS networks

Responsibility of BACCH Education & Training Administrator

Before event

- Liaise with the Regional Coordinator/trainee reps
- Invite sponsors and pass details to Finance & Membership Administrator for her to raise invoices
- Set up event booking page on BACCH website and create ticket types (ensuring the form collects data on dietary requirements for in-person events)
- Add event programme to booking page when received from Regional Coordinator
- Monitor attendee numbers and send final attendee list (with dietary requirements if in-person) to Regional Coordinator ahead of the event
- Create and circulate Teams link for online events
- Promote event through BACCH channels e.g. mailouts to members in relevant region/social media

During event

- For online events: ensure attendees are let in from the lobby. The Administrator will ensure the event is co-owned by the regional coordinator and any other local organisers to undertake the online processes in case the Administrator is not working on that day.
- Deal with any email and phone queries as they arise
- The Administrator would not usually be expected to attend regional events in person

After event

- Draft feedback form and send to attendees
- Collate feedback for speakers and draft thank you letters
- Provide attendance certificates when requested

Financial

- Standard ticket prices for a regional event will be implemented
- BACCH will cover speaker travel expenses for in-person events under the same terms and conditions as are used for speakers at the ASM.
- BACCH will also cover a speaker honorarium of up to £100 (or equivalent compensation in e.g. vouchers) if requested by the regional representative.
- All profits from regional events will be held centrally by BACCH and put towards the salary of the Education & Training Administrator.

We think this should take much of the hassle out of being a regional rep. In addition, I would encourage people to explore the committee structure; this works very well in both Scotland and the West Midlands as examples.

As I close this update for you, I do have some challenges for you. Please look out for training opportunities that may be relevant to you and sign up. Please share any short course ideas you have with us, and if you have training expertise, please do get in contact. If you are in a region that is not meeting together regularly, please consider whether, with the BACCH support afforded by Emma, you could volunteer to kick start your area by becoming a Regional Coordinator; your trainees will really thank you.

Dr Doug Simkiss
Chair, BACCH Education and Training Committee

Trainee Update: BACCH Launches New National Trainee Guide for Community Child Health Training

In response to calls from trainees for greater consistency, transparency and equity within CCH training, BACCH has developed a new Trainee's Guide to Community Child Health Training – a comprehensive national resource covering many of the practical and professional aspects of training that sit alongside the formal curriculum.

The guide was developed following the BACCH National Trainee Survey conducted in November, which highlighted considerable variation in trainee experiences across the UK. Trainees described differences in induction processes, supervision, clinic exposure, safeguarding opportunities, on-call commitments and access to educational experiences, alongside uncertainty regarding what should reasonably be expected from a CCH training placement. In response to this feedback, we worked collaboratively with CSAC and a national working group of trainees to produce practical guidance aimed at improving consistency in expectations and supporting trainees throughout their training journey, while also sharing examples of good practice from departments across the country.

The guide brings together practical advice, trainee experience and national perspectives to help trainees navigate placements more confidently and make the most of available learning opportunities. It includes detailed sections on induction standards, community workload structure, pathways to independent clinics, out-of-hours commitments, rota expectations, how to use the BACCH curriculum guides, recommendations for ePortfolio, ARCP and CSAC processes, study leave, wellbeing, out of programme opportunities and requirements for approaching consultant practice. Practical examples of good practice and trainee 'top tips' are included throughout, drawn directly from trainee experiences across the UK.

The document has now been formally approved by the Community Child Health CSAC and the BACCH Education and Training Committee and will be presented to the BACCH Executive Committee for ratification on 2nd June 2026.

As trainee representatives, we hope this guide helps trainees feel supported, informed and empowered throughout CCH training. Most importantly, we hope it helps promote more equitable training experiences nationally and encourages trainees to advocate for the opportunities and support they need to thrive as future community paediatricians.

We would like to sincerely thank Dr Rushvini Ambihaipahan, CSAC trainee representative, and all members of the trainee working group who contributed their time, ideas and experiences to the development of this important resource.

The guide will be made available to trainees and supervisors following ratification by the BACCH Executive Committee.

Dr Claire Stewart
and Dr Kimberley Hallam
National BACCH Trainee Representatives

Wellbeing

Recipe

Pizza

Tell me who does not love pizza, and I will eat humble pie! Here is a simple recipe that tastes better than bought or takeaway pizza at a fraction of the price and not an Ultra Processed product in sight.

A nod to my Italian heritage for thin crispy pizza. Child's play needed and no previous baking experience necessary. Good for days when 'relaxing at home' or when doing other chores.

Mixture can be mixed in a flash and left for a few hours.

A pizza stone is ideal and a good investment, but round/rectangular baking pan can also be used.

3 Golden Rules

1. **Be careful not to kill yeast by water being too hot or touching salt**
2. **Never add all the water at once**
3. **Make sure you are accurate with measurements**

Oven measurements are for convection ovens. If you have a fan, it is usually 20'C lower.

Basic ingredients for 1 pizza (serves 2 hungry adults or 4 as a starter, though recipe can be doubled)

- 250g strong white bread flour
- 5g / 1 tsp salt (preferably fine sea salt)
- 15ml /1 tablespoon olive oil
- 160-170 ml water body temperature (if you put your finger in water, you don't feel temperature)
- ½ teaspoon or 1/2 7g sachet active yeast
- Small handful of cherry tomatoes (8-10)
- Bunch of basil
- Grated mozzarella cheese in packet as ball usually is too watery and makes pizza soggy
- Toppings of choice, amount to a small handful
- Baking parchment to bake pizza on stone or oil to oil a baking pan

Continues overleaf

Steps

1. Put salt in bowl, add flour then yeast, oil and then most of body temperature water – mix till a shaggy dough with a spatula. You may not need all the water.

2. 10 minutes for kneading to make a smooth ball, if mindfulness being practised expending energy.

Or no knead – fold the dough with spatula at intervals of 15 minutes for an hour, like tucking a child in with a blanket in bed, until smooth (this is my preferred method).

3. Cover bowl with cling film/clean shower cap or damp kitchen towel.
   3a. Dough is like a newborn baby, likes to be kept warm to rise till double in size (can take 1 hour in warm weather or a 2+ hours on a cold day).
   3b. I have left this longer, but this is fine as taste of dough improves.

Turn your oven on. If using a pizza stone, place in oven as it needs to warm up for 40 minutes at 230'C.
   4a. If no stone, you can use same temperature for at least 30 minutes.

4. Place tomatoes in an oven-proof dish, sprinkle with salt and drizzle of olive oil and place on pizza stone or oven to roast whilst oven is heating up.
   5a. Remove when stone ready or oven has preheated for at least 30 minutes.
   5b. Tomatoes will look charred but don't worry, take them out and wait about 5 minutes to cool before smashing with a fork or spoon to make your rustic sauce.
   5c. Please wear an apron as tomatoes can be cheeky and squirt out on your clothes.

5. Knock back (apologies for baker's terminology). Deflate dough by giving bowl a tap on counter and it should deflate – shape into a ball with floured hands on worktop and allow to rest for 10 minutes so that dough can relax as it can be resistant like a defiant toddler.

6. Once rested, place on parchment and stretch/roll out to a circular pizza.
   7a. If using a pan, stretch to fit pan that has been lightly oiled to prevent sticking.

7. Place tomato sauce, grated mozzarella and topping of choice (remember less is more) and lastly torn basil leaves on top.

8. Place on pizza stone with baking parchment – taking 10-12 minutes to bake.
   9a. If using a baking sheet with sides, place in oven and bake 20-25 minutes till golden.

9. Remove, cut and enjoy. Bon appetito!

Dr Flaudia Petrone
Community paediatrician by day
and obsessive baker the rest of the time

Spotlight: Jo Gifford

Dr Jo Gifford is a Consultant Community Paediatrician in Coventry and Designated Doctor for Child Safeguarding Coventry & Warwickshire. She is the current Child Sexual Abuse Expert Lead on the RCPCH Child Protection Standing Committee, and RCPCH rep on the FFLM Academic Committee. She is Project Co-Lead on the Physical Signs of Child Sexual Abuse 3rd Ed purple book.

1. Describe your job in three words.
Three words? From a community paediatrician safeguarding specialist? I can write you a good 12-page report with three-word headlines…

- Three job roles: clinical, designated, college
- Doing the job: Interesting, varied, [a] privilege
- Essentials for job: compassion, communication, energy
- Rewards of job: impact, fulfilment, satisfaction
- How job feels: Found my niche

2. Who has been your greatest inspiration and why?
My Mum taught me to meet people where they are without judgement, and my Dad taught me how to craft language; both those are the absolute foundations of doing my job effectively.

I have been so lucky to have had lots of inspirational teachers and mentors over the years. Geoff Debelle supervised my very first Child Protection Medical Assessments, and Jean Price taught me everything I know about child sexual abuse (I joke she *groomed* me for this role). Their dedication, knowledge, and commitment to *the voice of the child* continue to inspire me daily, along with the fantastic friends and colleagues I work with currently.

Community and Safeguarding Paediatricians are, as a group, some of the loveliest, kindest, most inspirational people on the planet. I learn daily from colleagues.

3. What has been your biggest challenge of your career and how did you overcome it?
Learning to 'stay in lane', while robustly advocating for children. Early on in my career, I sometimes felt I had failed children when thresholds or standards of proof weren't met. Child protection cases are complex, and even *the best* medical report is only one part of the picture; I have learnt from mentors, and by experience and reflection on specific cases, to get better at boundaries, at respectful challenges where appropriate, and at being confident in my role.

4. What is the highlight of your working day?
When children and families are smiling (or at least relieved) as they leave the clinic; when they feel it was worthwhile talking with me. And when I press *send* on a task well-completed – crossing tasks off the list is job satisfaction!

5. What is the best advice you have received so far as a doctor?
Strong words softly spoken.
The harder the message, the kinder the tone of the delivery needs to be, without diluting the directness of the content. This goes for breaking bad news, for challenging opinion, or asking the difficult questions. [Shout-out to Cathy Hill – you were the master of this – I watched and learnt.]

6. What is the single, most encouraging thing that one of your colleagues can do to make your day?
Tell me I am doing a good job or I was helpful. We all get job satisfaction out of feeling like we do something well. Also, on clinic days, if you are going to the WRVS coffee shop, mine's a large tea…

7. After a hard day at work, what is your guilty pleasure?
There is no guilt in joy. You can't pour from an empty cup, so recharge without apology.

My energisers are an early night and good sleep, music and dancing like no one's watching, and pottering in my garden (especially barefoot on a sunny day). My other half and I have recently discovered weekend over-30s afternoon indie clubbing. It's been a whole new lease of life for us: once a month we dance like it's the late 90s and can still be asleep by 10pm.

My self-indulgences are cocktails, a good sports massage (as I carry stress in my shoulders), and spending far too much on flowers and plants that I don't actually have time to pot out. Gardening catalogues have to be hidden from me, and my patio looks like a plant nursery.

8. If you had a superpower, what would it be and why?
I would love to be able to fly or teleport. Teleporting because it would save loads of time and would be super useful; flying just for the sheer freedom and sensory pleasure of it. Self-duplication for multitasking would also be amazing.

My actual superpower is probably some ADHD traits to go with my dyslexia. It brings a hyperfocus that means I can work 16 hours straight to a deadline… at least, that is, once I get over the procrastination phase where I do literally *anything and everything else* before 'locking in'. My best work is done as *both* the procrastination tasks *and* the brinkmanship tasks. Give me a deadline. I will meet it, but only just.

9. What advice would you give to inspire the next generation of community paediatric trainees?
Play to your strengths and work out what motivates you. Community Paediatrics is such a diverse speciality, no two careers are alike.

10. Finally, if you were stranded on a desert island, what three luxury items would you take with you?
A hammock, some sort of solar-powered frozen daiquiri maker (assuming the island has a good supply of mangos), and some audiobooks on 1.5 speed. I love being busy, but I also love stopping. The rescue team can take their time.

Events Calendar

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

BACCH National/Regional events

Date	Event	Location
10 Jun 2026	SACCH Webinar: Neurodevelopmental Conditions ***https://www.bacch.org.uk/events/sacch-webinar-neurodevelopmental-conditions***	Online
17 Jun 2026	SACCH Webinar: Palliative Care ***https://www.bacch.org.uk/events/sacch-webinar-palliative-care***	Online
02 Jul 2026	BACCH West Midlands Summer Meeting ***https://www.bacch.org.uk/events/west-midlands-bacch-summer-meeting-west-bromwich***	West Bromwich
16-17 Sep 2026	BACCH ASM 2026 ***https://www.bacch.org.uk/asm***	Cardiff
04 Nov 2026	BACCH South West Regional Meeting ***https://www.bacch.org.uk/events/bacch-south-west-regional-meeting-2026-taunton***	Taunton
26 Feb 2027	Yorkshire & Humber Regional Meeting 2027 ***https://www.bacch.org.uk/events/yorkshire-humber-regional-meeting-2027***	Wakefield

BACCH Trainee Events

Date	Event	Location
17 Jun 2026	Population Health Problems: SUDIC ***https://www.bacch.org.uk/events/population-health-problems-sudic***	Online
24 Jun 2026	Research Ready: Inference in Statistics ***https://www.bacch.org.uk/events/research-ready-inference-in-statistics***	Online
01 Jul 2026	Clinical Case Discussions ***https://www.bacch.org.uk/events/clinical-case-discussions---***	Online
15 Jul 2026	Trainee Study Morning: Child Death ***https://www.bacch.org.uk/events/trainee-study-morning-child-death***	Online
15 Jul 2026	Population Health Problems: Vaping ***https://www.bacch.org.uk/events/population-health-problems-vaping***	Online
22 Jul 2026	Research Ready: Getting Into Qualitative Research ***https://www.bacch.org.uk/events/research-ready-getting-into-qualitative-research***	Online

Affiliate group events

Date	Organisation	Event	Location
24 Jun 2026	BAPA	BAPA Forum and Peer Review ***https://www.bacch.org.uk/events/bapa-forum-peer-review***	Online
12-13 Nov 2026	APPM	Conference 2026 ***https://www.appm.org.uk/events/appm-conference-2026/***	Birmingham

External events

Date	Organisation	Event	Location
28 Jun 2026	University of Sheffield	2026 International HNRNP Gene Family & Research Summit ***https://www.bacch.org.uk/events/2026-international-hnrnp-gene-family-research-summit***	Sheffield
6-7 Jul 2026	South Tees NHS Foundation Trust	15th Tees Neuro-developmental Paediatrics Symposium ***https://www.bacch.org.uk/events/tees-neuro-developmental-paediatrics-symposium-2026***	Durham
24-25 Sep 2026	George Still Forum	Annual Meeting 2026 ***https://www.bacch.org.uk/events/george-still-forum-annual-meeting-2026***	London

Jennifer Dennis Award

The Down Syndrome Medical Interest Group (DSMIG) are delighted to announce that the Jennifer Dennis Research Award for research in healthcare to children with Down Syndrome will be awarded later this year (2026).

Jennifer was a principal founding member of Down Syndrome Special Interest Group and remained central to its activities for two decades, eventually standing down from active involvement in 2015. She sadly passed away in 2023.

This Award encourages research that advances specialist medical management or health outcomes of children with Down Syndrome.

The Award includes a monetary prize of £350, free DSMIG membership for one year and free attendance at the DSMIG winter scientific symposium. Shortlisted finalists will be asked to present at the Winter DSMIG Symposium In Edinburgh on 20/11/26.

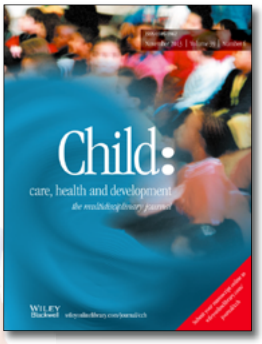
Applications from **all** healthcare professionals are welcome. Applicants should submit an abstract (up to 500 words) detailing their research, and how this will have an impact on improving the lives of individuals with Down syndrome. **Submissions should be made by 1st September 2026.**

For further information and to make an application, please visit:
www.dsmig.org.uk/about-dsmig/jennifer-dennis-research-award-3-2/

Available with your BACCH Membership
See the journal online at:
www.interscience.wiley.com/journal/cch

Official Journal of BACCH

Edited by:
Jan Willem Gortert
Impact Factor 2021: **2.508**



Child: care, health and development is an international, peer-reviewed journal which publishes papers dealing with all aspects of the health and development of children and young people. We aim to attract quantitative and qualitative research papers relevant to people from all disciplines working in child health. We welcome studies which examine the effects of social and environmental factors on health and development as well as those dealing with clinical issues, the organization of services and health policy. We particularly encourage the submission of studies related to those who are disadvantaged by physical, developmental, emotional and social problems.
The journal also aims to collate important research findings and to provide a forum for discussion of global child health issues.

WILEY

For more information or to view online content visit
https://onlinelibrary.wiley.com/journal/13652214

Community Child Health needs you!

Become an AAC Assessor Today

RCPCH
Royal College of Paediatrics and Child Health
Advisory Appointments Committee
This is to certify that
Dr XX

Be involved from **start to finish.**
- Approve the job description
- Take part in shortlisting
- Sit on the interview panel

You'll receive a certificate for each panel you sit on to **evidence your CPD** and you'll be entitled to **remuneration for your time**

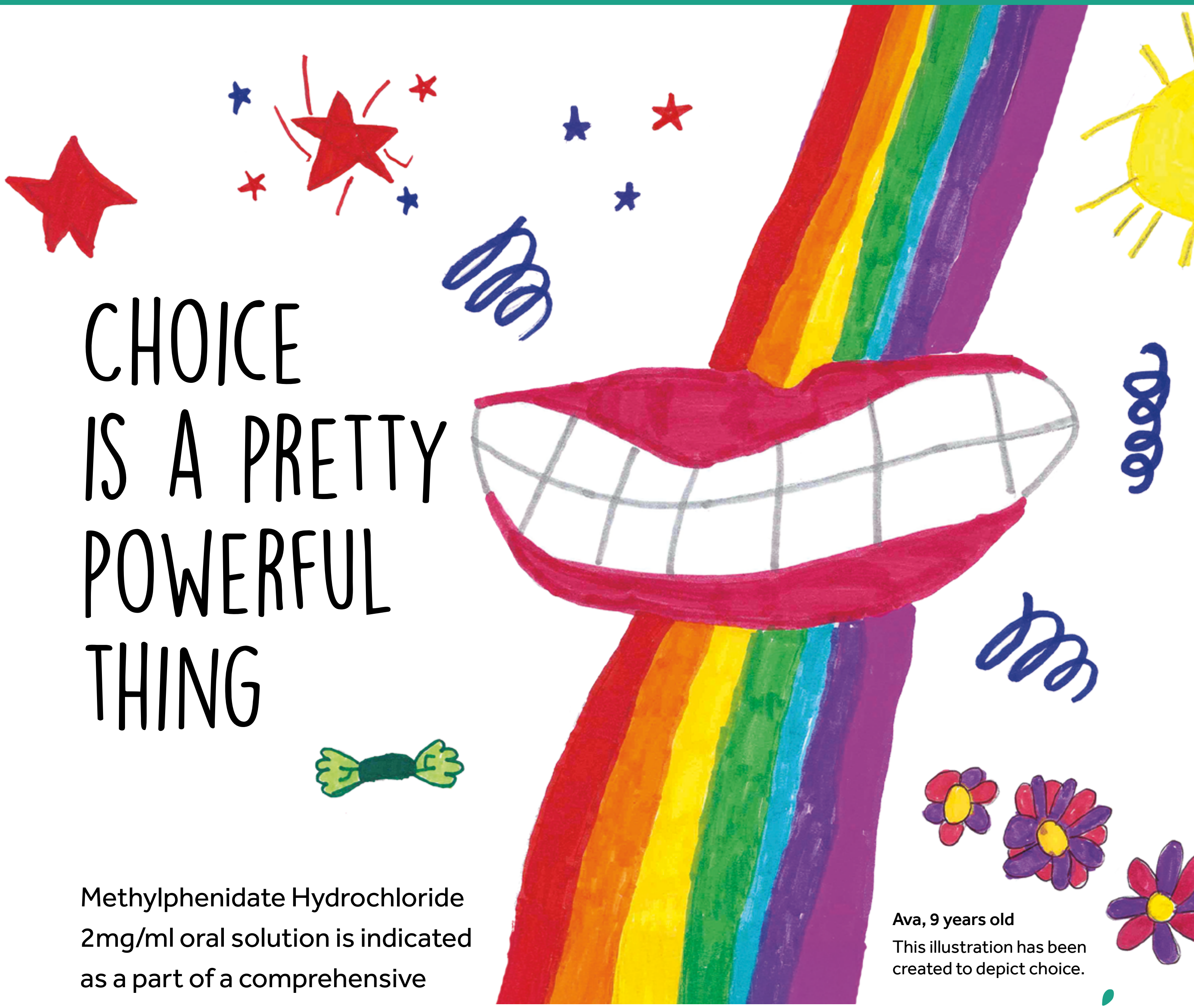
Help to quality assure the standards for recruiting Community Child Health Consultants!

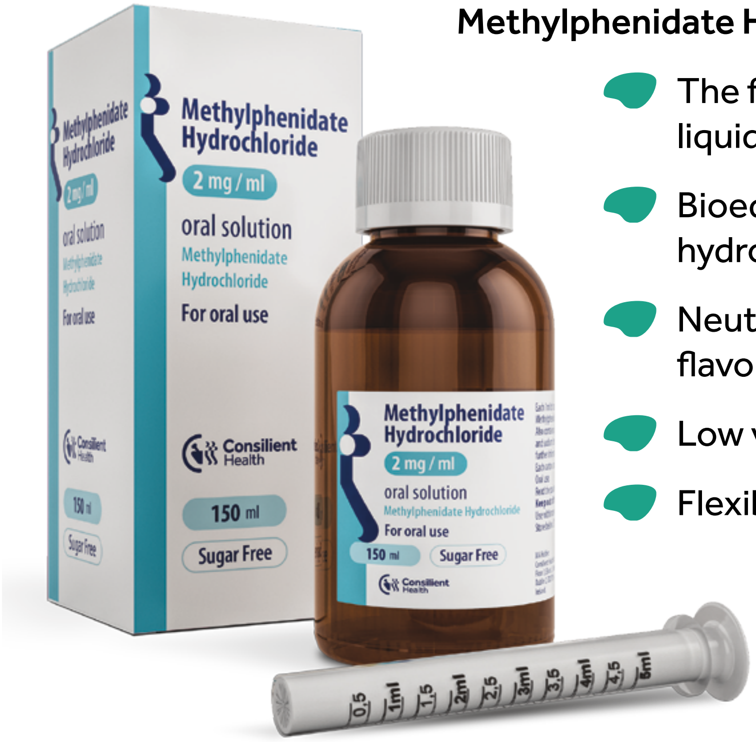
We offer AAC Training Days – 3 times a year
- Workshops – scenarios
- Presentations from internal/external speakers
- CPD certificates of attendance

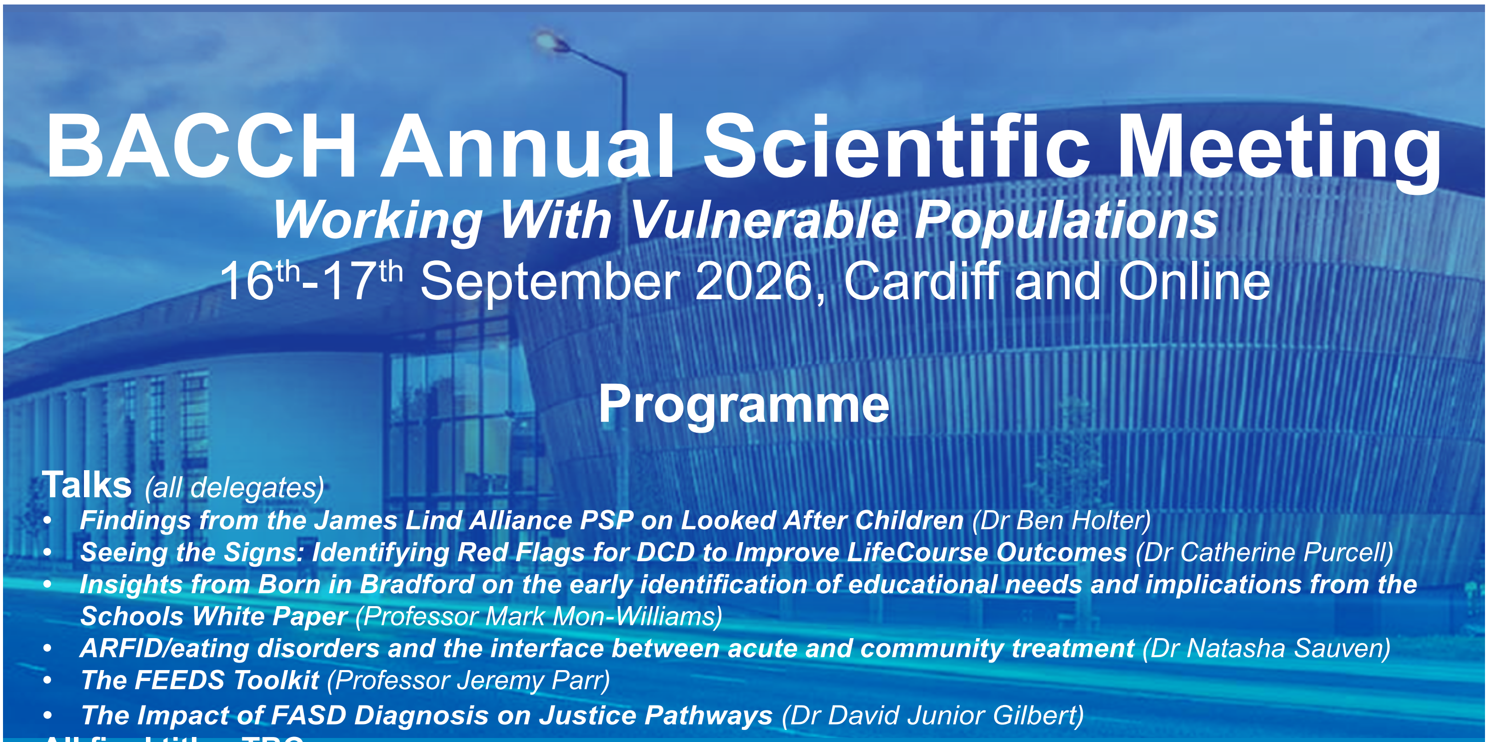
Contact the AAC team at aac@rcpch.ac.uk

Note that you need to have spent 2 years as an NHS consultant in a substantive position in order to be eligible

For more information, please scan the QR code or visit
rcpch.ac.uk/resources/your-role-rcpch-aac-college-assessor


CHOICE
IS A PRETTY
POWERFUL
THING


Methylphenidate Hydrochloride
2 mg / ml
oral solution
Methylphenidate Hydrochloride
For oral use
Consilient Health
150 ml
Sugar Free
0.5
1ml
1.5
2ml
2.5
3ml
3.5
4ml
4.5
5ml



BACCH Annual Scientific Meeting

Working With Vulnerable Populations

16th-17th September 2026, Cardiff and Online

Programme

Talks *(all delegates)*

- ***Findings from the James Lind Alliance PSP on Looked After Children*** *(Dr Ben Holter)*
- ***Seeing the Signs: Identifying Red Flags for DCD to Improve LifeCourse Outcomes*** *(Dr Catherine Purcell)*
- ***Insights from Born in Bradford on the early identification of educational needs and implications from the Schools White Paper*** *(Professor Mark Mon-Williams)*
- ***ARFID/eating disorders and the interface between acute and community treatment*** *(Dr Natasha Sauven)*
- ***The FEEDS Toolkit*** *(Professor Jeremy Parr)*
- ***The Impact of FASD Diagnosis on Justice Pathways*** *(Dr David Junior Gilbert)*

All final titles TBC

Personal Practice Workshops *(in-person plus selected workshops broadcast for online delegates)*

- ***ADHD Taskforce - implications for delivering ADHD services***
- ***AI in autism/neurodevelopmental assessment***
- ***Barriers to accessing autism diagnosis in preschool children***
- ***CSAC and Trainees' workshop (topic TBC)***
- ***Down Syndrome (topic TBC)***
- ***Integration of Paediatric Lifestyle Medicine into Community Child Health***
- ***Measures That Matter in an Integrated System***
- ***Paediatric Audiology (topic TBC)***
- ***Paediatric Palliative Medicine (topic TBC)***
- ***PMHA: Supporting parents and their autistic children through anxiety treatment***
- ***CPSIG: Safeguarding (topic TBC)***
- ***Advanced Practice (topic TBC)***
- ***Early Years Practitioners***

Abstract submissions

Abstracts are a vital part of the BACCH ASM and offer an opportunity for delegates at all levels to share their research at a national conference. We welcome submissions from members and non-members for oral and poster presentations.

Abstract submission deadline is 1 July.

Further information & booking

In-person and virtual attendance options are available:

- ***In person: lectures, abstract presentations, afternoon workshops, posters, annual dinner & dance and catch up with colleagues***
- ***Virtual: lectures and abstract presentations, selected workshops***

BACCH members can book at reduced rates, including further discounts for trainees, medical students and AHPs.

WWW.BACCH.ORG.UK/ASM