British Association for Community Child Health

BACCH FAQs on CCH services for Commissioners and Health Boards

Consultant paediatricians in community child health (CCH) are almost unique in that they provide a consultant-led service for children and families working outside hospital settings – an idea ahead of its time and fully in line with the NHS Long Term Plan.

A CCH service is generally delivered by a multidisciplinary team working closely with other agencies, for example education, social care and the voluntary sector. The multidisciplinary team generally includes paediatricians, children's nurses and a range of allied health professionals (AHPs) providing therapy. The CCH team will also work closely with child mental health services, hospital-based paediatric services and primary care teams and the exact division of clinical roles will vary from place to place.

These frequently asked questions refer specifically to the commissioning of the work undertaken by paediatricians within these teams and predominantly cover:

- developmental disorders and disabilities,
- behavioural presentations of neurodevelopmental disorders (e.g. Autism, ADHD)
- complex health needs (including end of life care), including statutory SEND roles
- safeguarding concerns, those who are "Looked After" or being adopted, including designated and named doctor roles
- child public health

Q1. What do community paediatricians do?

Table 1 shows the range of services, including statutory services, provided by community paediatricians. Statutory services are those that all HBs/CCGs/commissioners must deliver as part of their statutory/legal obligations. Covering All Bases provides information on each of these topics including relevant legislation/guidance, service design and likely workforce requirements available here: (https://www.rcpch.ac.uk/resources/covering-all-bases-community-child-health-paediatric-workforce-guide) (page numbers given in the Table)

Service or condition	Page
Vulnerable children and families	
A: Safeguarding medical assessments (physical abuse, neglect)	43
B: Child sexual abuse (forensic and historic)	45
C: Statutory role - Designated doctor for safeguarding / Lead paediatrician for child protection	47
D: Statutory role - Named doctor for safeguarding / Paediatrician with special interest in child protection	48
E: Statutory role – Child death service	49
F: Statutory role – Medical Adviser for Fostering and Adoption	51
G: Looked After Children (LAC)	52
H: Statutory role – Designated LAC doctor	55
I: Statutory role – Named LAC doctor	56
Children with neurodevelopmental conditions	
J: Autism Spectrum Disorders (ASD)	57
K: Attention deficit hyperactivity disorder (ADHD)	59
L: Other developmental conditions (including neurodevelopmental conditions but excluding ASD and ADHD, which are dealt with above)	61
M: Special educational needs and Disability (SEND) service	63
N: Designated medical officer for SEND - England only	65
Other conditions	
O: Paediatric audiology/audiovestibular medicine	66
P: Visual impairment	68
Q: Constipation, soiling, urinary incontinence	70
R: Long term medical conditions	71
S: Mental health and behavioural problems	72
T: Childhood immunisation	74
U: Healthy child programmes (including screening)	76
V: Palliative care services	77

Source: Covering All Bases RCPCH 2017

Q2. How many do we need?

The RCPCH and BACCH recommended in 2017 that, on average, 2.4 community paediatricians per 100,000 total population are needed to meet demand. However this is an average figure. True need will vary depending on the local configuration of services which will need to be taken into account when designing local services. In particular, the overlap with CAMHS (for neurodevelopmental services), general paediatrics (for continence and long-term conditions like epilepsy), public health and palliative care will need to be considered to ensure comprehensive coverage while avoiding duplication.

Q3. Can we calculate how many we need?

Yes. RCPCH & BACCH have developed two options:

a) If you have robust activity figures for the service, the calculator at (https://www.rcpch.ac.uk/resources/covering-all-bases-community-child-health-paediatric-workforce-guide) will calculate the required workforce for you
b) If you do not have robust activity figures, the calculator at (https://www.bacch.org.uk/publications/other_service_improvement.php) will estimate the number of clinical appointments required based on likely disease prevalence for your population. Note that this is only an estimate and does not include patient administration or statutory lead roles. We strongly recommend you use actual activity figures where possible

Q4. Can we use skill mix in community paediatrics?

Community paediatricians already work in multidisciplinary and multiagency teams. Teams also have a higher proportion of SAS grade paediatricians than many other secondary care teams. However the RCPCH/BACCH Directory of Innovative Practice at (https://www.rcpch.ac.uk/resources/covering-all-bases-community-child-health-paediatric-workforce-guide) also has several examples of extended roles for other staff substituting for paediatricians within care pathways.

Q5. How do we know what Designated or Named doctors should be doing?

Advice on Designated and Named roles are available and referenced in the appropriate section of Covering All Bases.

Q6. What's the difference between CAMHS and community paediatrics?

Community paediatricians are trained in paediatrics and then subspecialise in community child health. They are trained to assess, diagnose and manage neurodevelopmental and disabling conditions and, in particular, their impact on educational needs. The incidence of behavioural difficulties in neurodevelopmental difficulties is much higher than the neurotypical population. Community paediatricians have expertise in managing this behaviour within the context of a neurodevelopmental condition. When behaviour difficulties become more complex, effective management requires access to psychological therapies and, sometimes, psychotropic medication which most community paediatricians are not trained to use. As they usually do not have direct access to therapy or psychology support, community paediatricians will usually refer to CAMHS for access to these treatments. Where there is a diagnostic dilemma, community paediatricians may request a psychiatry opinion.

There is a wide range of other emotional and behavioural problems which present during childhood and adolescence i.e. specific mental health conditions incl emotional disorders (including depression, anxiety, phobias); behavioural disorders in pre-schoolers (food selectivity; sleep disorders; tantrums); eating disorders (anorexia, bulimia, obesity); conduct disorders; oppositional defiance disorder, psychosis; self- harm and substance misuse. While community paediatricians may often identify children and young people with these conditions during their work, due to the overlap with neurodevelopmental disorders, they are not usually trained to assess and treat them. Some children and young people with neurodevelopmental conditions initially present with behavioural disturbance and may therefore present to CAMHS. Where there are concerns about development, especially at a younger age, or comorbid physical difficulties, CAMHS will usually refer to community paediatrics for appropriate management.

There is therefore overlap and interplay between community paediatrics and CAMHS in assessing and managing neurodevelopmental conditions. These services and commissioners should work closely to avoid duplication or gaps in commissioning. Community paediatricians and CAMHS professionals have different competences and it can sometimes be appropriate for both professionals to be involved.

Q7. How is community paediatrics funded?

The Covering All Bases survey showed that nearly 60% were funded by uncapped block contract, nearly 30% by capped block and just over 12% by a mixture of block and PBR. There is no current national tariff for community paediatrics except for Initial Health Assessments for Looked After Children. There is however pilot work on developing currencies.

Q8. How do I benchmark against other CCH services?

- The BACCH service standards are available here: https://www.bacch.org.uk/policy/documents/BESTFinal.pdf .
- Routine statistics for CCH services are collected nationally via the Community Services Data Set. However, this programme is only now being rolled out nationally and not all Trusts are able to submit data. The currency pilot mentioned in Q7 is piloting this data collection in participating Trusts.
- There are quality standards linked to the PBR payments for Looked After Children available here: https://improvement.nhs.uk/documents/1046/Guidance_on_currencies_with_a_national_price.pdf .
- Trusts/Health Boards can participate in annual benchmarking through the NHS Benchmarking Network, which includes clinical activity, staffing and financial information: https://www.nhsbenchmarking.nhs.uk/home. Most UK organisations are members of the Network.
- Covering All Bases (Ch 7) has recommendations for the information services should be collecting.
- BACCH also has a service review tool which can be used to collate information (available here: https://www.bacch.org.uk/policy/payment_by_results.php).
- BACCH does not conduct external reviews. However the RCPCH conducts external reviews of community paediatric services for commissioners and/or Trusts when invited to do: https://www.rcpch.ac.uk/work-we-do/workforce-service-design/invited-review-service .

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