Covering all bases Community Child Health: A paediatric workforce guide

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Community Child Health: A paediatric workforce guide

RCPCH 2017

BACCH
British Association for
Community Child Health

RCPCH
Royal College of
Paediatrics and Child Health
Leading the way in Children's Health

Covering all bases

Community Child Health:
A paediatric workforce guide

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Contents

Contents........3

Abbreviations........5

1 Introduction........7

1.1 Synopsis........7

1.2 What is community child health (CCH)?........9

1.3 Background and approach to the project........10

2 Methodology........13

2.1 Literature review........13

2.2 Call for evidence for examples of innovative practice........14

2.3 UK survey of CCH services........14

2.4 RCPCH Workforce Census........15

2.5 Evidence from invited reviews........15

2.6 Stakeholder engagement events........15

3 Findings........16

3.1 Literature review........16

3.2 Call for evidence........20

3.3 UK survey of community child health services........24

3.4 RCPCH Workforce Census........34

3.5 Evidence from invited reviews........35

3.6 Stakeholder engagement........37

4 Service planning framework........38

4.1 What community paediatricians do........38

4.2 Service planning........38

4.3 Organisational arrangements........39

4.4 Team and individual job planning........39

4.5 Performance monitoring and quality improvement........40

5 Components of a CCH service........41

Vulnerable children and families 43

Children with neurodevelopmental conditions 57

Other conditions and services 66

Child public health 74

6 Workforce calculator 78

6.1 Rationale 78

6.2 How the calculator works 79

6.3 Calculator examples 81

6.4 UK demand for community paediatricians 84

7 Information recording guidance 85

7.1 Activity and demand data 85

7.2 Information that should be available to all CCH services 85

7.3 Population and activity data 86

7.4 Clinical performance related data 86

8. Signposting 87

RCPCH Invited Reviews Service 87

RCPCH Workforce Team 87

NHS Benchmarking 87

Appendices 88

Appendix 1: Steering group and stakeholders 88

Appendix 2: Literature review search terms 90

Appendix 3: Literature review evidence table 91

Appendix 4: The national call for evidence form 93

Appendix 5: The reviewing proforma used for assessing the submissions from the call for evidence 95

References 96

Abbreviations

ADHD	Attention deficit hyperactivity disorder
ADI	Autism Diagnostic Interview
ADOS	Autism diagnostic observation schedule
AHP	Allied health professional
ASD	Autism spectrum disorder
AVM	Audiovestibular Medicine
BAAF	British Association for Adoption and Fostering
BAAP	British Association of Audiovestibular Physicians
BACCH	British Association for Community Child Health
BACD	British Academy of Childhood Disability
BAPA	British Association of Paediatricians in Audiology
BMA	British Medical Association
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical commissioning group
CCH	Community child health
CCT	Certificate of Completion of Training
CDOP	Child death overview panel
CHIMAT	National Child and Maternal Health Intelligence Network
CMV	Cytomegalovirus
CSA	Child sexual abuse
CSAC	College Specialty Advisory Committee
CYP	Children and young people
DCC	Direct clinical care
DCO	Designated Clinical Officer
DFE	Department for Education
DH	Department of Health
DISCO	Diagnostic interview for social and communication disorders
DMO	Designated Medical Officer
DNA	Did not attend
EHCP	Education, health and care plan
F to F	Face to face
FFLM	Faculty of Forensic and Legal Medicine
GP	General Practitioner
HCP	Healthy Child Programme
HEE	Health Education England
IHA	Initial health assessment

IP	Immunisation programme
LAC	Looked after children
LFFLM	Licentiate of the Faculty of Forensic & Legal Medicine
LSCB	Local Safeguarding Children Board
LTC	Long term condition(s)
MASH	Multi Agency Safeguarding Hub
MDT	Multidisciplinary team
NICE	National Institute for Health and Care Excellence
NSPCC	National Society for the Prevention of Cruelty to Children
PA	Programmed activity
PBR	Payment by results
PMLD	Profound and multiple learning disabilities
PRUDIC	Procedural response to death in infants
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RNIB	Royal National Institute of Blind People
RTT	Referral to treatment
SARC	Sexual Abuse Referral Centre
SAS	Staff, associate specialist and specialty doctors
SEN	Special educational needs
SEND	Special educational needs and disability
SFR	Statistical first release (Department for Education)
SIGN	Scottish Intercollegiate Guidelines Network
SPA	Supporting professional activity
SSPAU	Short-Stay Paediatric Assessment Unit
SUDI(C)	Sudden unexpected death in infancy/childhood
SVI	Severe visual impairment
VI	Vision Impairment
VINCYP	Vision impairment network for children and young people
WNB	Was not brought
WTE	Whole time equivalent

1 Introduction

1.1 Synopsis

This suite of documents provides an evidence-based toolkit for planning the paediatric element of modern community child health (CCH) services, including public health and statutory services for safeguarding; child death reviews and the care of looked after children and those with special educational needs or disabilities. It sets out the range of services that may be included for a local population, interprets the latest national and professional guidance for the various components of a service and provides benchmarking data and a calculator to determine the estimated paediatric workforce required to deliver a high quality, efficient and effective service for children young people and families.

Since the British Association for Community Child Health (BACCH) published guidance for community paediatric workforce planning in 1999[1] the NHS has changed substantially. The recommendation of 4.5 paediatricians per 100,000 children has not been achieved. In 2017 the RCPCH Census indicated that fewer than half this number of community paediatricians are in post, and there is an 8.5% vacancy rate at consultant level[2]. Our members are concerned that increasing needs, higher expectations, long waits, vacancies and the risk of 'burnout' amongst skilled professionals mean services may not be safe for those children who need CCH services.

The nature and relative volumes of childhood illness have changed since 1999; for example a significant rise in the recognition of neurodevelopmental disorders including autism spectrum disorders (ASD) and attention deficit hyperactivity disorder (ADHD), presentation of mental health problems and greater reporting and awareness of safeguarding issues. Many of these trends are signposted in the British Medical Association (BMA) report Growing up in the UK (2016)[3] and the Royal College of Paediatrics and Child Health (RCPCH) report State of Child Health (2017) highlighting the impact of inequality and child poverty on health[4].

CCH services include a range of statutory and non-statutory functions, all of which require doctors to be part of a wider multidisciplinary team and many of which require liaison across health, social care and education teams. Some of the functions, particularly around 'behaviour problems' are split between paediatricians and child and adolescent mental health services (CAMHS) or other specialist teams but by default many families, general practitioners (GPs) and social and education professionals refer to the CCH team when they have concerns. The paediatrician's leadership role in diagnosis, advocacy and care planning across the multi-disciplinary team is often underestimated or neglected; paediatricians are a valuable resource with expertise in decision making and holistic advocacy but should work in a way that makes the best use of their skills and expertise - with other health professionals (specialist nurses, therapists, primary care) playing their part in the ongoing care and support of children and their families.

This document and the associated resources will help service planners, paediatric teams and associated clinicians to talk together and plan how their service will meet demand going forward. This will enable the skills and knowledge of the paediatrician to be harnessed to best effect whilst developing other professionals to provide ongoing care. There is evidence about the current national situation, summarised guidance on standards and National Institute for Health and Care Excellence (NICE)/Scottish Intercollegiate Guidelines Network (SIGN) guidance and practical examples from teams that have designed new ways of working.

Our aim is to stimulate conversations, encourage paediatricians to take advantage of the opportunities to develop their services and themselves, and, primarily, to improve the outcomes for infants, children young people and families.

The project has produced:

1. Survey evidence on the extent and nature of service delivery across the UK showing what is provided where, activity levels and clinical time needed, providing benchmarking data to plan delivery (Chapter 2, Chapter 3 and website).
2. A service planning framework for designing and planning a community paediatric service (Chapter 4).
3. Details of the components of CCH including links to relevant guidance, literature and best practice (Chapter 5).
4. A workforce calculator to allow services and planners to determine their paediatric workforce requirements. (Chapter 6 and website).
5. Examples of innovative practice to inspire services to improve (website).

These meet the need expressed by our members and service planners for modern guidance that is evidence based and credible. We will continue to develop and refine content as a result of feedback and engagement by those involved in taking services forward. The next few years will see further changes in health service organisation and management, funding and patterns of ill health, together with development in the way paediatricians work and the availability of expertise. We are keen to hear your views and work with you to explain, refine and improve the resources. To get in touch, email workforce@rcpch.ac.uk.

1.2 What is community child health (CCH)?

CCH is one of seventeen paediatric subspecialties, providing specialist secondary care, predominantly in out of hospital settings, including schools. Paediatricians working in CCH (community paediatricians) have broad skills covering paediatrics and child health with specialist skills in the care of vulnerable families, children with long-term conditions and child public health. This includes children with developmental disorders and disabilities, those with complex health needs (including end of life care), special educational needs, behavioural presentations of neurodevelopmental disorders and those where there are safeguarding concerns, who are looked after or who are in the process of being adopted. They also provide expertise for the healthy child programme (HCP) and immunisation programme (IP), as well as programmes to reduce future morbidity or mortality, for example, injury prevention or reduction in obesity. For ease, we will use the term community paediatricians throughout this document to refer to those paediatricians working within CCH services.

Community paediatricians are consultants, trainees or staff, associate specialist and specialty (SAS) doctors who after medical training have had years of paediatric training including the assessment of infants, children and young people in hospital, with additional training in safeguarding, child sexual abuse, child public health, neurodisability including ASD and ADHD and their associated comorbidities. Community paediatricians are confident seeing children and young people (CYP) in locations outside hospitals and closer to children's homes and communities, visiting nurseries, schools and colleges and liaising with other care providers on behalf of their under 18 population.

While the services provided can vary significantly between localities, depending on local commissioning arrangements particularly with CAMHS, community paediatricians provide assessment, diagnosis, management and long term oversight of children, with an emphasis on prevention, continuity of care and multi-agency working including with education and social care. They have a vital role in planning and implementing local strategies to improve the health of all children in their area including safeguarding policy, universal and targeted lifestyle programmes and tackling local social determinants.

Some community paediatricians work in the highly specialised areas of audiology, managing children with severe hearing loss, or palliative care for those with life limiting illness, and others work within fully integrated trusts or health boards, supporting colleagues on the general paediatric rota.

A number of statutory roles are also usually provided by community paediatricians relating to child protection, child death, looked after children and those with special educational needs. These vary slightly across the four nations of the UK in terms of nomenclature and function.

CCH as a subspecialty – the current workforce

In 2015 the UK had 690 paediatric consultants who spent 100% of their time as community paediatricians, including 271 paediatricians who worked in a specialised area such as audiology. They represent 17.3% of the consultant paediatric workforce. There are a further 175 consultants who work both in general and community paediatrics (4.5% of the total consultant paediatric workforce). In addition 523 SAS doctors work in community paediatrics representing almost 65% of SAS doctors in paediatrics.

8.5% of community paediatric consultant posts were vacant in 2015, compared to a 3.8% vacancy rate for all paediatric consultants.

While the modal age group of general paediatric consultants is 40-44, community consultants are more likely to be between 45 and 54.

CCH as a subspecialty was included in the national training numbers 'grid' scheme for specialty training in 2015 with 24 trainees being recruited that year. A further 24 were recruited in 2016 and 20 in 2017. There were 81 doctors who completed their Certificate of Completion of Training (CCT) in Paediatrics with CCH between 2011 and 2015.

1.3 Background and approach to the project

This project arose in response to demand from community paediatricians, managers and service planners to set out what a typical community paediatric service should and should not include, the roles of the paediatricians and an estimate of the workforce and skills required to deliver the service.

An effective child health service comprises a strong team working closely together and involving:

- paediatricians
- CAMHS professionals
- allied health professionals (AHP) - physiotherapists, occupational therapists, speech and language therapists, dieticians
- health visitors,
- school nurses (public health nurses)
- general practitioners (GPs)

- doctors working in paediatric audiology[i],
- community children's nurses
- specialist nurses (ADHD, ASD, epilepsy, safeguarding, looked after children (LAC) and palliative care)

Team working across organisational boundaries is essential especially with education and social services[5].

Changes to the structure of the NHS in England[6,7] have left pathways of care fragmented with teams managed by different organisations with different ways of working and a range of outcome and performance monitoring requirements. This project aimed to analyse as far as possible how CCH services were currently being provided, assess recent evidence and research data and provide practical guidance and tools for service review and improvement. Whilst recognising that community paediatricians work as part of a multi-professional/multi-agency team, this project focused on the contribution of the paediatricians.

The work began in 2015 as collaboration between BACCH and the RCPCH, with a steering group comprising RCPCH staff and officers from both organisations (see Appendix 1). The project comprised five main elements:

- Literature review
- Call for evidence
- A national survey of the structure and activity of CCH services across the UK
- Two stakeholder engagement events
- Evidence from RCPCH invited reviews

Drawing on the information gathered through above sources, four elements together aim to support service planners, paediatricians and colleagues in defining and designing an effective CCH service. These comprise:-

- **Results from the survey of CCH services** (Chapter 3). The UK wide survey provides information on services provided by organisations, clinical leadership, activity, waiting times and other benchmarking data.
- **Service planning framework** (Chapter 4) including the key elements that underpin an effective service. This is designed for clinicians, managers, planners and

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[i] A general term including audiovestibular medicine/paediatric audiology trained consultants.

commissioners to consider together, facilitating dialogue and service improvement. This builds on the Family Friendly Framework published by BACCH in 2014[5].

- **Service component templates** (Chapter 5). These provide a starting point for discussion by clinicians, managers and planners to decide how local provision of the service will be achieved. In individual localities, some of the elements may be provided by other services and teams such as CAMHS, so these templates provide options and descriptions to aid local definition and resourcing.
- **Workforce calculator** (Chapter 6) to help teams and commissioners demonstrate the paediatric staffing required for delivery of services. It should be used in conjunction with detailed dialogue with the clinical team to ensure that the full demand on the service is identified and that nursing and therapy support is being used as much as possible, under the oversight of the paediatricians, so their expertise is used as effectively as possible.

2 Methodology

2.1 Literature review

A literature review was undertaken to source relevant articles and research on CCH. Search criteria were identified by the working group based on the project aims and multiple search terms were used (details in Appendix 2). These come under three key areas:

- pathway development
- workforce planning and staffing
- service design and modelling

Exclusion criteria focussed on key aspects of study design:

- Paediatric population only:
    - only studies of children and young people from 0-18 years and 364 days
    - studies of children and young people 0-25 were included but not studies exclusively of young adults 19-25
- Focus and date of the research excluded studies which:
    - feature a clinical intervention not a service intervention
    - concerned an acute medical problem or care in hospital
    - related to in-patient settings, short-stay paediatric assessment unit (SSPAU), or tertiary paediatric centres
    - related to acute illness or relate to dental care
    - related to acute paediatric outpatients or paediatric subspecialist services
    - had outcomes relating to staff training
    - were published before 1997
- Research provenance:
    - Excluded if outside of the set area (outside of UK, Europe, US, Canada, Australia, New Zealand)
    - Excluded papers not published in English
- Removal of any duplicate papers

The review was conducted as follows:

- OVID was used to search three key medical and health databases (Medline, HMIC, EMBASE)
- Following the database search, an initial title screen was carried out by two members of the CCH project team to identify any obviously irrelevant papers based on the exclusion criteria
- Two members of the working group screened the abstracts based on the exclusion criteria
- In addition to the papers found through the database search, the CCH project's UK wide call for evidence and a hand search of papers found further relevant papers which were included in the abstract screen
- Full paper reviews were undertaken by 10 reviewers from the CCH stakeholder group. Data on study design, intervention, participant characteristics, relevant outcomes and risk of bias was extracted and collated into evidence tables (Appendix 3)

2.2 Call for evidence for examples of innovative practice

A national call for evidence requested examples of service modelling, workforce planning initiatives and innovative practice in all areas of community paediatric and child health services. The aim was to identify where these had made a difference to patient outcome, clinical effectiveness, service efficiency and/or patient experience.

The call for evidence comprised ten questions (Appendix 3) and was sent or presented to all UK CCH clinical leads, BACCH members, Executive Committee and Council, and RCPCH members.

Two members of the CCH working group reviewed the submissions in full using literature search criteria to ensure only examples relevant for the project were taken forward (Appendix 4).

All calls for evidence submissions were categorised into different areas of CCH work and used to build the evidence base to support the project.

2.3 UK survey of CCH services

The survey was sent to 187 community clinical leads in April 2016 through Survey Monkey©. The survey was designed to capture data relating to 2015/16 activity in all the major clinic types alongside broader service arrangements. This ran broadly concurrently to, and linked with, the biennial RCPCH workforce census and covered some of the information previously captured in the workforce census.

Three reminders were sent and there were regular updates in BACCH E-News, in addition, BACCH regional co-ordinators contacted and encouraged their local leads to contribute and individual support was provided for clinical leads where requested. The survey was closed in early November 2016. Data was downloaded and analysed in MS Excel.

2.4 RCPCH Workforce Census

The RCPCH 2015 Workforce Census was launched across all UK paediatric services in September 2015. This included questions about staffing, organisational structure, lead and statutory roles and safeguarding which complement the organisation survey that forms part of this project. Where appropriate, data from the census has been incorporated into this report and a short summary of key findings as they relate to community paediatrics is included in the results section.

2.5 Evidence from invited reviews

RCPCH Invited Reviews provide bespoke assessments of paediatric service provision, team working and individual practice. Details are set out on www.rcpch.ac.uk/invitedreviews. In the four years to December 2016, 22 reviews had been conducted involving community paediatric services. Whilst confidential, these detailed reviews of services provided perspective and understanding of the breadth of services, challenges of teamwork and management and key issues which were explored in the project.

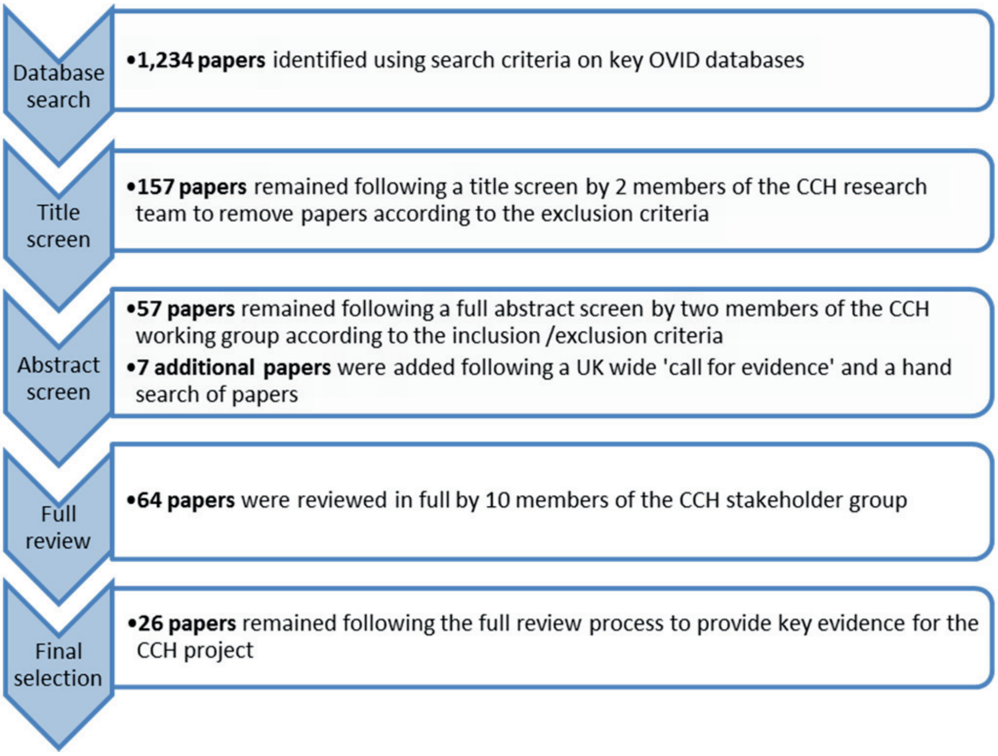
2.6 Stakeholder engagement events

A stakeholder reference group was established by invitation, nomination and volunteering through a request in the call for evidence materials. A list of stakeholders is in Appendix 1. Two half-day engagement events for stakeholders were held in January and June 2016 which examined the reality of services in practice, and provided an opportunity to test whether the aims and potential outputs of the project were in line with the needs of colleagues working in or with community paediatric teams.

3 Findings

3.1 Literature review

The search located 1,234 papers, which were screened and then reviewed by an expert group and reduced to 26 relevant papers which contributed to the project's evidence base. A summary of the different review stages is included below (Figure 1).



- **1,234 papers** identified using search criteria on key OVID databases
- **157 papers** remained following a title screen by 2 members of the CCH research team to remove papers according to the exclusion criteria
- **57 papers** remained following a full abstract screen by two members of the CCH working group according to the inclusion /exclusion criteria
- **7 additional papers** were added following a UK wide 'call for evidence' and a hand search of papers
- **64 papers** were reviewed in full by 10 members of the CCH stakeholder group
- **26 papers** remained following the full review process to provide key evidence for the CCH project

Figure 1: Literature search summary

The papers selected for full review were assessed based on study design, participant characteristics, relevant outcomes, the specified intervention, and risk of bias. The reviewers were asked to classify the studies according to the related area of CCH work. There were 15 categories to select from, listed in order of most common classification.

(1) Neurodevelopment / disabilities
(2) Service evaluation and improvement
(3) ADHD / ASD
(4) Mental health
(5) Safeguarding
(6) Complex health needs
(7) Child public health
(8) Long term conditions
(9) Looked after children
(10) Palliative care
(11) Teaching / training
(12) Adoption / fostering
(13) Audiology
(14) Child death pathway
(15) Research

The full list of relevant papers cross-referenced with the area of CCH work the study relates to is shown in Table 1.

Table 1: Relevant literature

	Author(s) & Title	Safeguarding	LAC/Adoption / fostering	ADHD/ASD	Neurodisability/ complex needs	Mental health/CAMHS	Audiology/Visual impairment	Long term conditions	Child public health	Child death pathway	Palliative care	Teaching / training	Research	Service /pathway design	Skill mix	Transition
1	Blair M. **The need for and the role of a coordinator in child health surveillance/promotion. (2001)**								X					X		
2	Blair M.E., Pullan C.R., Rands C.E., Crown N. **Community paediatrics moves on - An analysis of changing work patterns 1994-97. (2000)**													X		
3	Camden C., Wilson B., Kirby A., Sugden D., Missiuna C. **Best practice principles for management of children with developmental coordination disorder (DCD): results of a scoping review. (2015)**				X									X		
4	Campbell L., Keegan A., Cybulska B., Forster G. **Prevalence of mental health problems and deliberate self-harm in complainants of sexual violence. (2007)**	X				X								X		
5	Clemente C., McGrath R., Stevenson C., Barnes J. **Evaluation of a waiting list initiative in a child and adolescent mental health service. (2006)**					X								X		
6	Cotton L., Brazier J., Hall D.M., Lindsay G., Marsh P., Polnay L., Williams T.S. **School nursing: costs and potential benefits. (2000)**													X		
7	Crane, L., Chester, J.W., Goddard, L., Henry, L.A. and Hill, E.L. **Experiences of autism diagnosis: A survey of over 1000 parents in the United Kingdom. (2015)**			X												
8	Dalzell J., Nelson H., Haigh C., Williams A., Monti P. **Involving families who have deaf children using a Family Needs Survey: A multi-agency perspective. (2007)**						X							X	X	
9	Danvers L., Freshwater D., Cheater F., Wilson A. **Providing a seamless service for children with life-limiting illness: experiences and recommendations of professional staff at the Diana Princess of Wales Children's Community Service. (2003)**										X			X		

	Author(s) & Title	Safeguarding	LAC/Adoption / fostering	ADHD/ASD	Neurodisability/ complex needs	Mental health/CAMHS	Audiology/Visual impairment	Long term conditions	Child public health	Child death pathway	Palliative care	Teaching / training	Research	Service /pathway design	Skill mix	Transition
10	Edwards M.O., Barber M.A. **Roles and responsibilities of the paediatrician in a child development team: A case-based discussion. (2011)**				X									X	X	
11	Gray L., Gibbs J., Jolleff N., Williams J., McConachie H., and Parr J. R. **Variable implementation of good practice recommendations for the assessment and management of UK children with neurodisability. (2015)**				X									X		
12	Hall C.L., Newell K., Taylor J., Sayal K., Hollis C. **Services for young people with attention deficit/hyperactivity disorder transitioning from child to adult mental health services: A national survey of mental health trusts in England. (2015)**			X		X								X		
13	Hazell P.L., Tarren-Sweeney M., Vimpani G.V., Keatinge D., Callan K. **Children with disruptive behaviours II: Clinical and community service needs. (2002)**					X								X		
14	Horsburgh M., Smith V., Kivell D. **South Auckland community paediatric nursing service: a framework for evaluation. (2002)**							X							X	
15	Kelly C., Allan S., Roscoe P., Herrick E. **The mental health needs of looked after children: An integrated multi-agency model of care. (2003)**		X											X		
16	Macdonald W., Bradley S., Bower P., Kramer T., Sibbald B., Garralda E., Harrington R. **Primary mental health workers in child and adolescent mental health services.(2004)**					X								X	X	
17	Moosa F., Sandhu T. **Transition from children's to adult services for patients with ADHD: A model of care. (2015)**			X		X								X		
18	Parr J.R., Jolleff N., Gray L., Gibbs J., Williams J., McConachie H. **Twenty years of research shows UK child development team provision still varies widely for children with disability. (2013)**				X									X	X	

	Author(s) & Title	Safeguarding	LAC/Adoption / fostering	ADHD/ASD	Neurodisability/ complex needs	Mental health/CAMHS	Audiology/Visual impairment	Long term conditions	Child public health	Child death pathway	Palliative care	Teaching / training	Research	Service /pathway design	Skill mix	Transition
19	Payne H., Butler I., Waterston T. **Improving the health care process and determining health outcomes for children looked after by the local authority. (1998)**		X													
20	Salmon G., Cleave H., Samuel C. **Development of multi-agency referral pathways for attention-deficit hyperactivity disorder, developmental coordination disorder and autistic spectrum disorders: Reflections on the process and suggestions for new ways of working. (2006)**			X	X		X							X	X	
21	Savage M. **Children with special needs --2: Early Support Pilot Programme. (2004)**				X											
22	Schofield D., Fuller J., Wagner S., Friis L., Tyrell B. **Multidisciplinary management of complex care. (2009)**				X									X	X	
23	Watkin P. **Postneonatal care pathways and the identification of deafness. (2012)**						X		X					X		
24	Watkin P.M., Baldwin M. **Identifying deafness in early childhood: Requirements after the newborn hearing screen. (2011)**						X		X					X		
25	Winter A.M., Teare J. **Workforce planning and community children's nurses: it's all in the advertisements. (2002)**														X	
26	Wolff A., Griffin H., Flanigan M, Everest S., Thomas D., Whitehouse W. **Development and evaluation of a community respiratory physiotherapy service for children with severe neurodisability. (2015)**				X									X	X	

3.2 Call for evidence

The call resulted in 29 practice example submissions, with 30 further examples received in survey responses. After evaluation by two steering group members against the agreed criteria (Appendix 4), 21 were considered appropriate, plus 25 of those submitted with the survey. A number of these did not provide complete information or give permission to publish their example. Currently 26 examples are included in the good practice section, but this will continue to be reviewed and updated on the website. Whilst only a few had run long enough to provide measurable improvement in outcomes, a large number demonstrated positive practice that was supported by peers and improved the experience and or efficiency of services for patients, families and staff. All submissions were categorised into different areas of CCH work by members of the working group and the results are shown in Table 2. These practice examples have been cited throughout this document and are available via the CCH webpage. www.rcpch.ac.uk/cch.

Table 2: Good practice examples

Good practice examples	Safeguarding	LAC / adoption & fostering	ADHD/ASD	Neurodisability/complex needs	Behaviour/mental health/CAMHS	Audiology/Vision impairment	Long term conditions	Child public health	Child Death pathway	Palliative care	Teaching/training	Research	Service/pathway design	Skill mix	Transition to adult services	Managing performance
Cross Sussex paediatric Sexual Abuse Referral Centre (SARC)	×												×			
Plymouth citywide school age ASD assessment pathway			×		×								×			
Performance dashboard to monitor performance in Wirral																×
'Listening into Action' project to reduce DNAs in Wirral																×
Skill mix in ADHD assessments in Wirral			×											×		
Recording activity on electronic records in Wirral																×
Rapid response to child death in Nottinghamshire									×				×	×		
Referral guidelines for paediatric outpatients from primary care in Nottinghamshire													×			
Pharmacist review of ADHD patients in Leicester			×											×		
CAMHS and commissioner appointed ADHD nurse in South Devon and Torbay			×											×		
Designated doctor in the Clinical commissioning group (CCG) in South Devon and Torbay		×											×			

Good practice examples	Safeguarding	LAC / adoption & fostering	ADHD/ASD	Neurodisability/complex needs	Behaviour/mental health/CAMHS	Audiology/Vision impairment	Long term conditions	Child public health	Child Death pathway	Palliative care	Teaching/training	Research	Service/pathway design	Skill mix	Transition to adult services	Managing performance
ASD service, co-triaging referrals with CAMHS in Lothian			x		x								x			
Child protection service, working with child protection advisors in Lothian	x												x	x		
CYP weight management clinic in Sussex	x	x		x									x			
ADHD team skill mix in South London			x											x		
Experienced nurses undertaking LAC initial health assessments in Sussex		x												x		
Jointly run child behaviour assessment clinic in Dorset					x								x			
Advanced nurse practitioner role within the paediatric medical service – in Southampton, West Hampshire and Test Valley														x		
An integrated ADHD pathway in Hertfordshire			x										x	x	x	
Standard operating procedure for Education, health and care plan (EHCP) in Wirral				x									x			
Sexual assault referral centre at Sheffield children's hospital	x												x			

Good practice examples	Safeguarding	LAC / adoption & fostering	ADHD/ASD	Neurodisability/complex needs	Behaviour/mental health/CAMHS	Audiology/Vision impairment	Long term conditions	Child public health	Child Death pathway	Palliative care	Teaching/training	Research	Service/pathway design	Skill mix	Transition to adult services	Managing performance
Transition clinic for CYP with physical disability and Profound and multiple learning disabilities (PMLD) in Harrow				×									×		×	
Child behaviour assessment clinic in Weymouth					×								×			
Weekly joint triage meeting between community paediatrics and CAMHS in Bury			×		×								×			
Paediatric triage and partial booking for acute and community paediatrics reduces DNA rate in North of Northern Ireland													×			×
Conner's assessment via online forms in West Lancashire			×		×								×			

3.3 UK survey of community child health services

3.3.1 Response rate

187 community clinical leads in the UK were contacted and 103 responses were received, a rate of 55.1%. Many leads were unable to supply the data we asked for, making comments such as:

"We do not currently have systems to easily access information regarding referral patterns or waiting times"

"We have huge problems about the numbers as our Trust does not routinely collect them for any department"

Responses were received from across the UK with varying levels of completion across the regions (see Table 3). At least three responses were received from each BACCH region.

Table 3: Response rates by BACCH region

BACCH regions	Number	%
Northern Ireland	4	80
West Midlands	9	78
South West	8	75
Mersey & Cheshire	4	67
Scotland	8	67
Trent	7	67
North West	12	61
Thames North East	6	60
Wessex	5	57
Thames South East	7	53
Thames North West	6	46
East Anglia	7	44
Oxford	3	43
Thames South West	5	43
Wales	4	42
Northern	3	40
Yorkshire	5	33

3.3.2 Organisational structure, funding arrangements and staffing

- In Scotland, Wales and Northern Ireland, CCH services are provided by the appropriate health board or health and social care trust which are also responsible for general paediatrics. In England the providers of CCH services are more diverse – 65 are in trusts providing both acute and community services, 10 in separate community trusts, 14 in acute trusts, 10 in mental health and community trusts, 11 in specialist trusts and five in independent providers and social enterprises[2].

- Almost 60% (42/71) of responding services stated that they are funded on a block contract basis, 28.2% (20/71) with a capped block. A further nine 12.7% (9/71) services have introduced an element of payment by results (PBR) but no service was paid fully by tariff.
- On average (mean), a CCH service covers a 0-19 years population of 89,527 (range 31,520 – 250,360).
- There are on average 2.0 career grade paediatricians for every 100,000 of total population (1.2 consultants and 0.8 SAS doctors). For every 100,000 children aged 0-19, there are 8.3 career grade paediatricians (5 consultants and 3.3 SAS doctors)[2, 8].

3.3.3 Clinical leadership

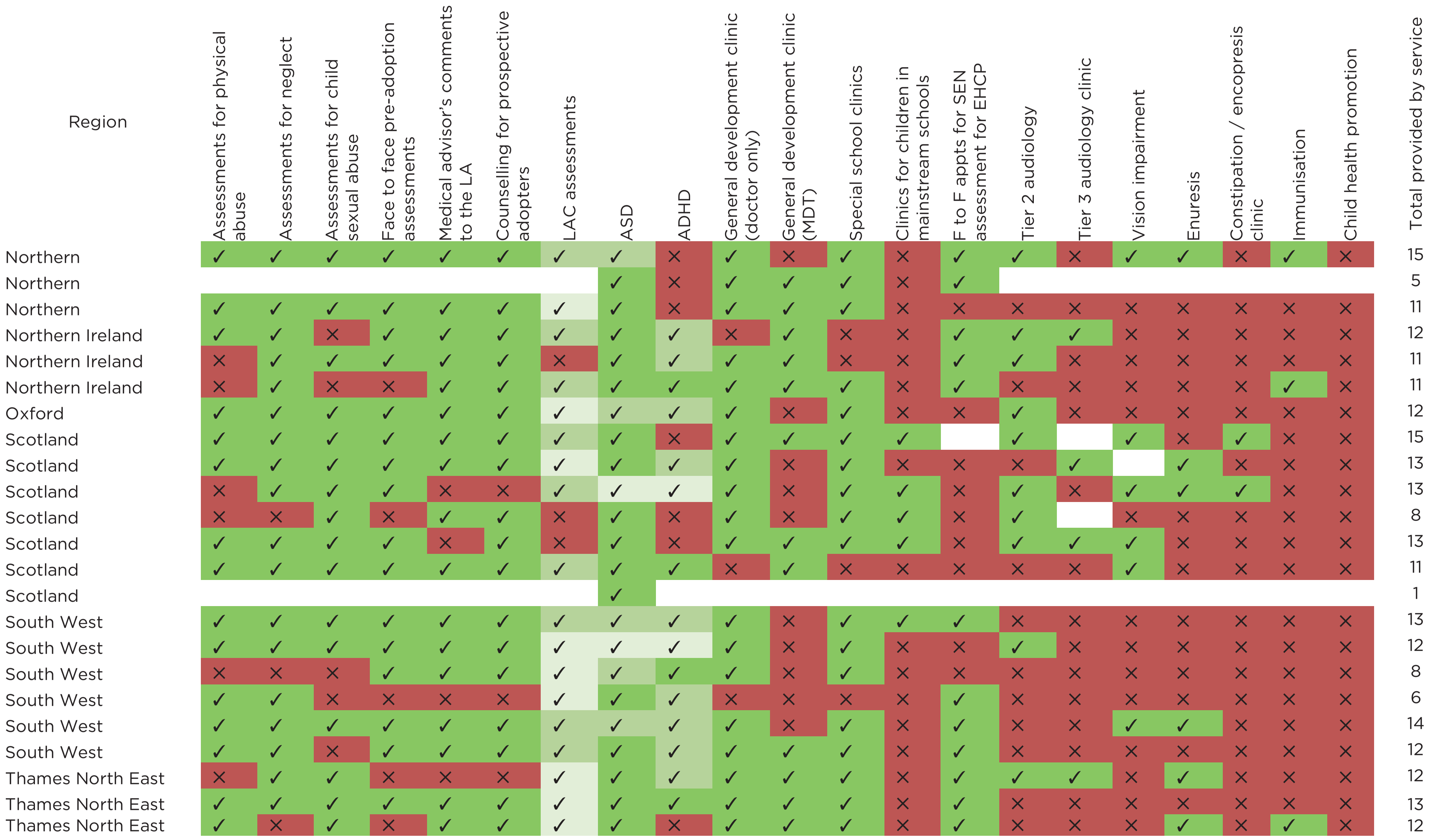
- 81% of services had a community paediatrician as the clinical lead for CCH, 15% had a non-CCH paediatrician and in 4% the lead was not a paediatrician.
- Almost half (40/83) of clinical leads have 1 Programmed Activity (PA) allocated in their job plan for the lead role, 29 have less than 1PA and 14 more than 1PA giving a mean of 0.99 PAs.
- In practice, 16 spend less than 1PA carrying out their leadership role, 16 spend 1PA, and 61% (50/82) spend more than 1PA, giving a mean of 1.8 PAs.

3.3.4 Range of services provided

- The survey asked whether a range of 21 clinics and services was provided. Table 4 shows for each of the 85 responding organisations which of the 21 services were provided. Each row in the table represents a service identified by its region. Where a particular clinic or service (listed in the top row) is provided, that is identified by a tick and green shading. Non-provision is indicated with a cross and red shading. For a small number of clinics, light and dark green shading is used to indicate specific variations in provision as indicated in the coding notes at the foot of the table. The three rows underneath the clinic/service show the numbers and percentage of organisations providing each service and the total number of services responding to that particular question. The far right hand column indicates the total number of clinics/services provided in each organisation.
- CCH services are wide ranging. Some are core; for example, 99% (85/86) of CCH services provide an ASD assessment clinic and over 90% (78/84) provide special school clinics and undertake looked after children assessments. However others are less common: only three services (4%) reported undertaking child health promotion clinics and eight (11%) clinics for constipation/encopresis. A small number also undertake general paediatrics clinics in community settings.
- Each CCH service provides an average (mean) of 11 different types of clinics and services (interquartile range 9-14, median 12).

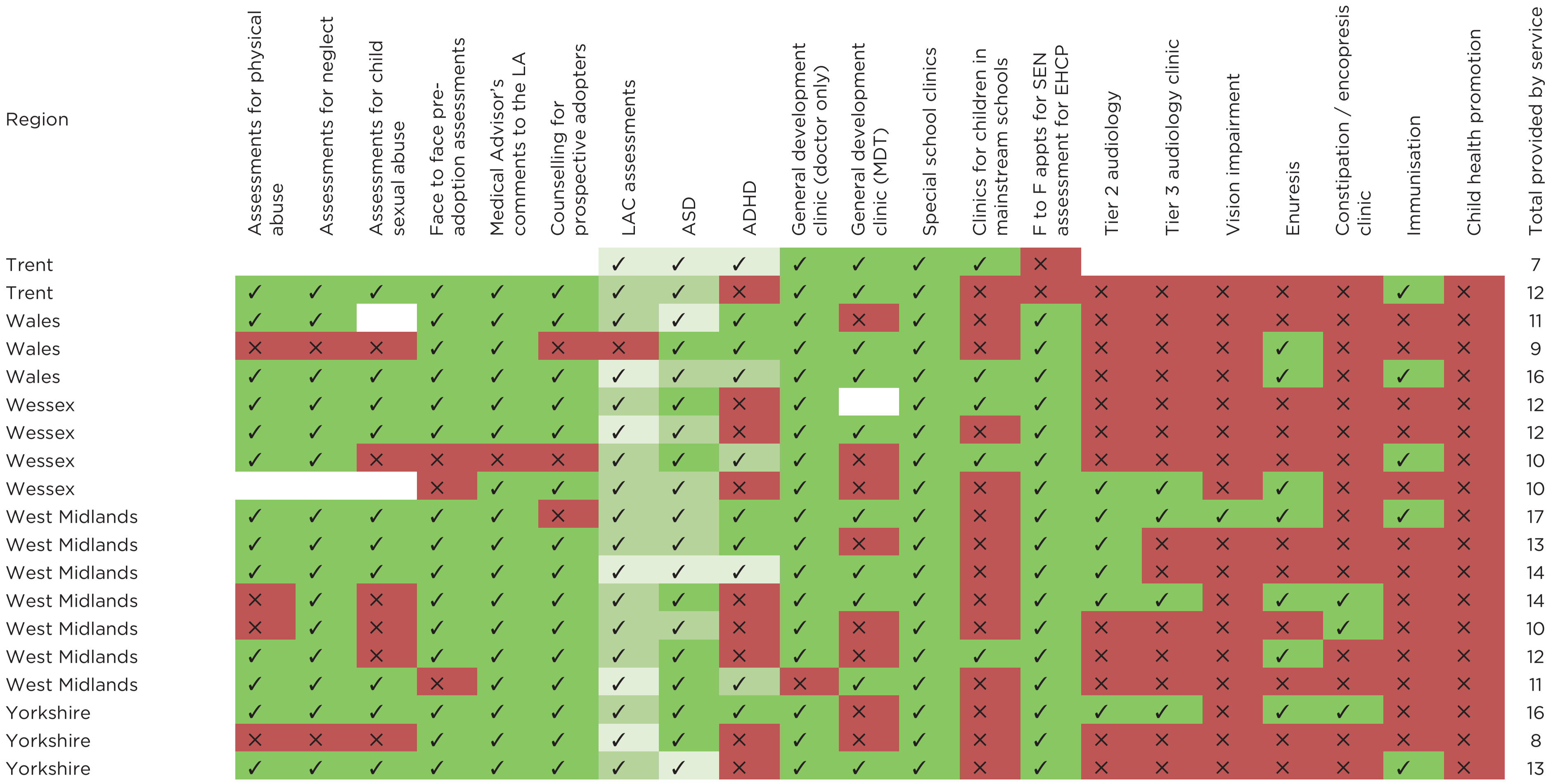
Table 4: Clinics and services provided

Region	Assessments for physical abuse	Assessments for neglect	Assessments for child sexual abuse	Face to face (F to F) pre-adoption assessments	Medical advisor's comments to the LA	Counselling for prospective adopters	LAC assessments	ASD	ADHD	General development clinic (doctor only)	General development clinic (MDT)	Special school clinics	Clinics for children in mainstream schools	F to F appts for SEN assessment for EHCP	Tier 2 audiology	Tier 3 audiology clinic	Vision impairment	Enuresis	Constipation / encopresis clinic	Immunisation	Child Health Promotion	Total provided by service
Provide service	58	62	43	57	62	59	74	85	53	76	45	78	19	66	26	17	13	23	8	20	3	
% providing service	76%	82%	57%	79%	84%	82%	93%	99%	63%	89%	54%	93%	23%	80%	34%	23%	17%	30%	11%	26%	4%	
Total responded	76	76	75	72	74	72	80	86	84	85	83	84	82	82	77	75	76	76	76	78	78	
East Anglia	✓	✓	✗	✓		✓	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	10
East Anglia	✓	✓	✗	✓	✗	✗	✓	✓	✓	✓	✗	✓	✓	✓	✗	✗	✗	✓	✓	✗	✗	12
East Anglia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓	✗	✓	✗	✓	✗	✗	✗	✗	✗	12
East Anglia	✓	✗	✗	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓	✗	✓	✓	✗	✗	✗	✗	12
East Anglia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗	✗	✗	✗	✗	15
East Anglia	✓	✓	✗	✓	✗	✓	✓	✓	✗	✓	✗	✓	✗	✓	✓	✗	✓	✓	✗	✗	✗	12
Mersey & Cheshire	✓	✗	✗				✓			✓				✓			✗			✓	✗	5
Mersey & Cheshire	✓	✓	✗	✗	✓	✓	✓	✓	✓	✓	✗	✓	✗	✓	✗	✗	✓	✗	✗	✗	✗	11
Mersey & Cheshire	✓	✓	✗	✓	✓		✓	✓	✓	✗	✗	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	9
Mersey & Cheshire	✓	✓	✗	✓	✗	✗	✓	✓	✓	✓	✗	✗	✓	✓	✗	✗	✗	✓	✓	✗	✗	11
North West	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗	✗	✓	15
North West	✗	✗	✗	✓	✗	✗	✓	✓	✓	✓	✗	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗	8
North West	✓	✓	✗		✓	✗	✓	✓	✓	✓	✗	✓	✗	✗	✓	✓	✗	✓	✓	✗	✗	12
North West	✗	✗	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	10
North West	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✓	✗	✗	✗	✗	13
North West							✓	✓	✗	✓	✗	✓	✗	✓								5
North West	✓	✓	✓	✓	✓	✗	✓	✓	✗	✗	✓	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	10
North West	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	11
North West	✗	✓	✗	✓	✓	✓	✓	✗	✗	✓	✓	✓	✗	✓	✓	✗	✗	✗	✗	✗	✗	10
North West	✗	✗	✗	✓	✓	✗	✓	✓	✓	✓	✗	✓	✗	✓	✓	✗	✗	✗	✗	✓	✗	10
North West								✓	✗	✓	✗	✓										3



Region	Assessments for physical abuse	Assessments for neglect	Assessments for child sexual abuse	Face to face pre-adoption assessments	Medical advisor's comments to the LA	Counselling for prospective adopters	LAC assessments	ASD	ADHD	General development clinic (doctor only)	General development clinic (MDT)	Special school clinics	Clinics for children in mainstream schools	F to F appts for SEN assessment for EHCP	Tier 2 audiology	Tier 3 audiology clinic	Vision impairment	Enuresis	Constipation / encopresis clinic	Immunisation	Child health promotion	Total provided by service
Northern	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✓	✗	✓	✓	✗	✓	✓	✗	✓	✗	15
Northern								✓	✗	✓	✓	✓	✗	✓								5
Northern	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	11
Northern Ireland	✓	✓	✗	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✓	✓	✓	✗	✗	✗	✗	✗	12
Northern Ireland	✗	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✗	✗	✓	✓	✗	✗	✗	✗	✗	✗	11
Northern Ireland	✗	✓	✗	✗	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗	✗	✗	✓	✗	11
Oxford	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✓	✗	✗	✗	✗	✗	✗	12
Scotland	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓		✓		✓	✗	✓	✗	✗	15
Scotland	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗	✓		✓	✗	✗	✗	13
Scotland	✗	✓	✓	✓	✗	✗	✓	✓	✓	✓	✗	✓	✓	✗	✓	✗	✓	✓	✓	✗	✗	13
Scotland	✗	✗	✓	✗	✓	✓	✗	✓	✗	✓	✗	✓	✓	✗	✓		✗	✗	✗	✗	✗	8
Scotland	✓	✓	✓	✓	✗	✓	✗	✓	✗	✓	✓	✓	✓	✗	✓	✓	✓	✗	✗	✗	✗	13
Scotland	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	11
Scotland								✓														1
South West	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗	13
South West	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✓	✗	✗	✗	✗	✗	✗	12
South West	✗	✗	✗	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	8
South West	✓	✓	✗	✗	✗	✗	✓	✓	✓	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗	6
South West	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✓	✗	✗	✓	✓	✗	✗	✗	14
South West	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	12
Thames North East	✗	✓	✓	✗	✗	✗	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗	✓	✗	✗	✗	12
Thames North East	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	13
Thames North East	✓	✗	✓	✗	✓	✓	✓	✓	✗	✓	✓	✓	✗	✓	✗	✗	✗	✓	✗	✓	✗	12

Region	Assessments for physical abuse	Assessments for neglect	Assessments for child sexual abuse	Face to face pre-adoption assessments	Medical advisor's comments to the LA	Counselling for prospective adopters	LAC assessments	ASD	ADHD	General development clinic (doctor only)	General development clinic (MDT)	Special school clinics	Clinics for children in mainstream schools	F to F appts for SEN assessment for EHCP	Tier 2 audiology	Tier 3 audiology clinic	Vision impairment	Enuresis	Constipation / encopresis clinic	Immunisation	Child health promotion	Total provided by service
Thames North East							✓	✓	✗	✓	✓	✓	✓	✓								7
Thames North East								✓	✗	✓	✓	✓	✗									4
Thames North East	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✓	✓	18
Thames North West	✓	✓	✓	✗	✗	✗	✗	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	9
Thames North West	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗	✗	✗	✓	✗	14
Thames North West	✗	✗	✗	✗	✓	✓	✓	✓	✗	✓	✗	✓	✗	✓	✗	✗	✗	✗	✗	✓	✗	8
Thames North West	✗	✗	✗	✓	✗	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗	✓	✗	✓	✗	11
Thames North West	✗	✗	✗	✗	✓	✓	✗	✓	✗	✓	✗	✓	✗	✓	✓	✓	✗	✗	✗	✗	✗	8
Thames North West	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗	✓	12
Thames South East								✓	✓	✓	✓	✓		✓	✗	✓	✗			✓	✗	8
Thames South East	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗	✓	✗	✗	✓	✗	✗	✓	✗	14
Thames South East	✗	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗	12
Thames South East								✓	✗	✓	✓	✓	✓	✓								6
Thames South East	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗	✓	✗	✓	✗	15
Thames South East								✓														1
Thames South West	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗	✓	✓	✗	✗	✓	✗	✓	✗	15
Thames South West	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓	✗	✓	✗	✗		✗	✗	✓	✗	12
Thames South West	✓	✓	✓	✗	✗	✓	✓	✓	✓	✓	✗	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	10
Thames South West	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✓	✗	✓	✗	✗	✗	✓	✗	✓	✗	13
Thames South West	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✗	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	11
Trent	✓	✓	✗				✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✗	✓	✗	✗	✗	12
Trent	✓	✓	✓		✓		✓	✓	✓	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	8
Trent	✓	✓	✗	✓	✓	✓	✓	✓	✓	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	9
Trent	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✗	✓	✗	✗	✗	✗	14



Region	Assessments for physical abuse	Assessments for neglect	Assessments for child sexual abuse	Face to face pre-adoption assessments	Medical Advisor's comments to the LA	Counselling for prospective adopters	LAC assessments	ASD	ADHD	General development clinic (doctor only)	General development clinic (MDT)	Special school clinics	Clinics for children in mainstream schools	F to F appts for SEN assessment for EHCP	Tier 2 audiology	Tier 3 audiology clinic	Vision impairment	Enuresis	Constipation / encopresis clinic	Immunisation	Child health promotion	Total provided by service
Trent							✓	✓	✓	✓	✓	✓	✓	×								7
Trent	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	×	×	×	×	×	×	×	✓	×	12
Wales	✓	✓		✓	✓	✓	✓	✓	✓	✓	×	✓	×	✓	×	×	×	×	×	×	×	11
Wales	×	×	×	✓	✓	×	×	✓	✓	✓	✓	✓	×	✓	×	×	×	✓	×	×	×	9
Wales	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	×	×	✓	×	✓	×	16
Wessex	✓	✓	✓	✓	✓	✓	✓	✓	×	✓		✓	✓	✓	×	×	×	×	×	×	×	12
Wessex	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	×	✓	×	×	×	×	×	×	×	12
Wessex	✓	✓	×	×	×	×	✓	✓	✓	✓	×	✓	✓	✓	×	×	×	×	×	✓	×	10
Wessex				×	✓	✓	✓	✓	×	✓	×	✓	×	✓	✓	✓	×	✓	×	×	×	10
West Midlands	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	×	✓	×	17
West Midlands	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	×	✓	✓	×	×	×	×	×	×	13
West Midlands	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	×	×	×	×	×	×	14
West Midlands	×	✓	×	✓	✓	✓	✓	✓	×	✓	✓	✓	×	✓	✓	✓	×	✓	✓	×	×	14
West Midlands	×	✓	×	✓	✓	✓	✓	✓	×	✓	×	✓	×	✓	×	×	×	×	✓	×	×	10
West Midlands	✓	✓	×	✓	✓	✓	✓	✓	×	✓	×	✓	✓	✓	×	×	×	✓	×	×	×	12
West Midlands	✓	✓	✓	×	✓	✓	✓	✓	✓	×	✓	✓	×	✓	×	×	×	×	×	×	×	11
Yorkshire	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	×	✓	✓	✓	×	✓	✓	×	×	16
Yorkshire	×	×	×	✓	✓	✓	✓	✓	×	✓	×	✓	×	✓	×	×	×	×	×	×	×	8
Yorkshire	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	×	✓	×	×	×	×	×	✓	×	13

Additional coding notes
For ASD and ADHD
✓ ASD (or ADHD) included in general clinic (doctor only)
✓ ASD (or ADHD) included in general clinic (multidisciplinary team)

Blank cell- No answer provided
For LAC
✓ Yes, initial health assessments AND review health assessments
✓ Yes, initial health assessments only

3.3.5 Activity and performance

- The average (mean) number of referrals reported by services is 1674 with means of 1413 new appointments and 3060 follow up appointments.
- There are an estimated 1940 referrals per 100,000 children aged 0-19 (509 referrals per 100,000 total population).
- The average waiting time for first appointment is 14.6 weeks (range 6-33 weeks). “Was not brought/did not attend” (WNB/DNA) rates are 10.8% for new appointments and 12.8% for follow up appointments respectively.

Neurodevelopmental

- For 33.4% of ASD services, the time from referral to first appointment is between 12-18 weeks. 42.5% of services have a waiting time exceeding the 18 week referral to treatment rule (RTT). Only 24.3% of services have a waiting time less than 12 weeks.
- The average waiting time from being put on the waiting list for specific ASD diagnostic assessment to the conclusion of the assessment pathway is 35.5 weeks. This average is based on responses from 44 services and breaches the 18 week RTT.
- Pressure on ASD services is further highlighted by the data showing that only 13.7% (7/51) of services can always see patients when follow up is due and 62.8% can do so no more than half the time.
- Waits for ADHD are shorter than for ASD with the most common length of waiting being 6-12 weeks. 25.9% of services have waits greater than 18 weeks compared to 42.5% of ASD services.
- Nevertheless, the average waiting time from referral to diagnosis of ADHD is 29.9 weeks which breaches the 18 week referral to treatment rules.
- Pressure on ADHD follow up services is similar to ASD; only 11.4% of services can always see patients when follow up is due and 60% can do so no more than half the time.

Schools and Special educational needs (SEN)

- 93% of services provide clinics in special schools. 67 services were able to provide data on the number of special schools where they provided clinics on site, with a mean of 5.3 special schools per service.

- 23% (19/82) services provide clinics for children in mainstream schools. Few of these services were able to provide activity data for these clinics.
- 25 services were able to provide the total number of new EHCP requests received from 1 April 2015 - 31 March 2016 and the average of these was 195.2.

Vulnerable children

- The median numbers of new referrals and new appointments for looked after children assessments per annum is between 151 and 200 per service (respondents were given grouped options).
- Assessment for neglect is provided by 82% (62/76) of services, for physical abuse by 76% (58/76), and for sexual abuse 57% (43/75).
- 74/80 (93%) of the responding services provide health assessments for looked after children; 37 (46%) provide initial and review health assessments and 37 (46%) provide initial health assessments only.
- The time slot allocated for looked after children initial health assessment appointments in 64% of services is between 46-60 minutes with a further 21% between 31-45 minutes.
- The statutory requirement is for all patients to be seen within four weeks of being taken into care. Fewer than half (43%) of services achieve 90% of patients seen within the statutory four weeks of referral request. The average waiting time from referral to first appointment is less than 6 weeks in 83% of services (20/24) but one service has a waiting time above 18 weeks.

Audiology

- In 34% (26/77) of services community paediatricians provide a tier 2 audiology clinic and a tier 3 audiology clinic in 23% (17/75) of services.

Vision

- The composition of the core team for vision impairment provided by those who responded to this question is very consistent in that in a community paediatrician, orthoptist and vision support teacher is present in 12 out of 13 teams.

Child public health

- The 2015 Census showed just 31.5% of services had a lead doctor for immunisation - a decrease from the 51.7% recorded in the RCPCH 2013 Workforce Census, and the 2016 survey showed just 25.6% of services provide a specialist immunisation advice service. These reductions may reflect the transferring of public health services to local authorities in England.

- The proportion of CCH services providing a leadership role for the Healthy Child Programme fell from 19% to 16.3% between 2013 and 2015.
- Only 3.8% (3/75) services provide routine healthy child clinics under the Healthy Child Programme.

Administrative and IT arrangements

- In organisations where clinicians are allocated less than 1PA for clinical administration per PA of clinic time, 75% (27/36) of clinical leads reported this to be insufficient time for administration, phone advice, referral and report writing after clinics.
- In 37.8% (28/74) of services, health care professionals do not have access to the IT system to contemporaneously enter information whilst seeing a patient, 28.4% (21/74) have access sometimes and 33.8% (25/74) do have access.
- The use of telephone or text reminders for new patients varies across services; 28 (38.4%) of services say they do this and 28 do not. A further 23 say they use such reminders sometimes. The average WNB/DNA rate for new and follow up appointments is lower when text or telephone reminders are used, 8.3% compared to 9.5% for new and 9.3% compared to 12.9% for follow-up appointments, although it is highest in services when they are sometimes used.
- 53.4% of services (39/73) report that doctors are undertaking inappropriate administration tasks (such as filing, photocopying, and meeting arrangements).

The detailed findings and tables can be found at http://www.rcpch.ac.uk/cch

3.4 RCPCH Workforce Census

3.4.1 CCH workforce

10.5% (419 of 3986) of paediatric consultants in the UK are 100% community paediatricians, and another 6.8% (271 of 3986) are community paediatricians with a special interest. A further 4.4% (177 of 4986) are in mixed general paediatric and CCH roles, a decline from 239 in 2013. This gives a total of 867 consultants working in CCH. There has been no change in the proportion of the consultant workforce working in CCH since 2013.

The majority of SAS doctors are working as 100% community paediatricians (49.5%, 400 of 808 SAS paediatricians), with a further 9.7% (78 of 808) working as community paediatricians with a special interest.

The most commonly stated special interests among CCH paediatricians (consultants and SAS doctors) relate to vulnerable children/safeguarding (187), neurodevelopmental (146), neurodisability (94) and neurology (20).

3.4.2 National variation

The proportion of doctors (consultant, SAS doctor and other non-training grades) working in CCH varies between UK nations. In Wales, the proportion is 35.5% (87 of 245); in Scotland, 29.8% (131 of 440), in Northern Ireland, 29.8% (56 of 188) and in England it is 24.9% (983 of 3952).

3.4.3 Vacancies

Across the whole paediatric career grade workforce, we estimate vacancy rates of 5.4%; for consultants, this is 3.8%, for SAS doctors 7.5%, and other non-training grade doctors, 34.5%. The highest consultant vacancy rates are for community posts (8.5%) and 50% general/50% community posts (11.0%). SAS doctor CCH post vacancies are estimated to be 4.1%, less than for the workforce as a whole.

3.4.3 Community child health services

70.8% (138 of 195) of child health organisations include CCH services, including all those in Scotland, Northern Ireland and Wales. Because some organisations cover a wide geographic area, they may contain more than one separate CCH service. This means that there are a total of 169 distinctly managed CCH services in the UK.

3.4.4 Lead and statutory roles

Since the 2013 census, there have been changes to NHS management arrangements, particularly in England with the implementation of clinical commissioning groups. This has affected the way lead roles are fulfilled within paediatrics, and makes comparisons with previous census data difficult. The fill rate for all roles remains high; across all lead roles, presumably because of their statutory nature. 97.1% (825 of 964) of posts are filled.

There has been a small increase in the proportion of lead roles occupied by consultants from 75.2% in 2013 to 77.2% in 2015. This accompanies a decline over the same period of roles filled by SAS doctors from 16.5% to 12.5%. The proportion of Designated Medical Officers for Special Educational Needs and Disability (SEND) who are SAS doctors, for example, has decreased from 21.8% to 11.9% between 2013 and 2015.

The average number of PAs allocated for lead roles remained similar to 2013 figures. For the designated doctor for safeguarding (2.8 PAs) and named doctor for safeguarding (1.9 PAs) there was no change. The healthy child programme coordinator fell from 1.5 to 0.4 and immunisation coordinator from 0.9 to 0.5. This echoes the reduction in paediatric involvement in public health activity noted above. The changes arising from the Wood report[9] are beginning to be implemented in respect of child death overview panels and their composition.

For 41.6% of lead roles, the employer for the lead role part of the contract was the acute trust/health board, for 19.3% an integrated acute and community trust/health board, and for 14.4% it was a CCG.

3.4.5 Safeguarding services

94.6% (141 of 149) of responding organisations stated that a physical abuse assessment service exists within their area. 76.2% (112 of 147) stated that a sexual abuse assessment service exists within their area. All responding organisations in Scotland, Northern Ireland and Wales had both services within their organisation. 76% (111 of 146) of organisations stated that a Sudden Unexpected Death in Infancy (SUDI) service exists within their area or that they follow the Procedural Response to Death in Infancy (PRUDIC).

RCPCH will commence its next census data collection in September 2017. The full report of the 2015 census and all previous RCPCH censuses can be found at www.rcpch.ac.uk/workforce.

3.5 Evidence from invited reviews

Since 2012, twenty-two RCPCH invited reviews have included community paediatric services in England; none have been conducted in the other UK countries. Nine services have been part of acute hospital trusts, seven in former mental health trusts and six in standalone community trusts. Nationally, 77% of CCH services are provided by acute trusts where there is a larger group of paediatricians within the trust. In smaller organisations with fewer doctors / paediatricians, the strengths and needs of small community paediatric teams and the services and skills they offer may be less well recognised and their contributions to the wider trust may not always be sought. The demand for external advice from these organisations appears to be higher.

In Scotland, Wales and Northern Ireland where there is no commissioner/provider procurement, the speciality has had a historically low profile compared with hospital services[10].

The reviews identify a historic underinvestment in data collection and outcomes recording; 'block contract' funding offers little motivation for investment in services which do not generate activity-based income. Increasing demand (from rising ADHD and ASD referrals, for example) has therefore in many of the areas reviewed failed to be met by matched increase in resources or modernisation, as they would be by activity-based funding. This leaves services overburdened with long waiting lists and clinical staff feeling unable to engage with service development.

Despite high profile 'joint commissioning' and 'service integration' initiatives, the fragmentation of services and reorganisation of staff in post has resulted in continuing challenges to service provision across providers. As a result we have seen:

- Separation of commissioning of child public health including health visiting and school nursing from the commissioning of community paediatrics leading to fragmentation of clinical pathways.
- Multiple IT systems across (and sometimes within) organisations with little or no interoperability, inhibiting the delivery of multidisciplinary working and proving a potential safeguarding concern.
- Variable implementation of electronic clinical records.
- Inconsistent data collection.
- Inconsistent management of clinical pathways, which can be confusing for families and cause delay in care.
- Lack of identified accountability when signing off EHCPs[11] on behalf of CCGs, particularly if care is to be delivered by another trust.
- Gaps in services for certain groups, for example follow up of children diagnosed with ASD, lack of clarity about which service sees children with behaviour problems.
- Loss of liaison health visitors and other key individuals who `join the dots` for safeguarding.

- Challenges when re-tendering – sometimes specifications and new contracts have omitted services or failed to recognise interdependencies due to having been developed without consulting the clinicians.

It is important to note that reviews are only invited by clients with concerns about a service, and there are undoubtedly some excellent, well-resourced services in the UK. However presenting the above findings to colleagues at the BACCH annual scientific meeting in 2015 and 2016, there was a high level of identification with the problems and a strong desire to support colleagues to overcome them. The absence of national standards/guidelines/benchmarks has also proved challenging for organisations attempting to address these issues and this is one of the prime motivators for producing this guidance.

3.6 Stakeholder engagement

A total of 17 stakeholders attended sessions in January 2016 and 24 attended in June 2016. Overall the groups supported and refined the proposed outputs and contributed to development of the service component section, innovative practice examples and the calculator. They requested particular tools such as a data recording template to ensure they had appropriate information to plan and develop their service and members of the stakeholder group have piloted and checked the various outputs from the projects before publication.

4 Service planning framework

These pointers have been developed by the steering group and validated through consultation. Based upon evidence from published papers, survey and census data, they provide a framework for design and planning of a community paediatric service. The RCPCH can provide examples and evidence on request to support sharing of practice and service development.

4.1 What community paediatricians do

- Community paediatricians have expertise working with vulnerable groups of children and their carers. This includes children with developmental disorders and disabilities, those with complex health needs, special educational needs, behavioural presentations of neurodevelopmental disorders or neurodisability and those for whom there are concerns about abuse, who are looked after or are in the process of being adopted. Community paediatricians deal with prevention, identification, assessment and diagnosis and coordinate the ongoing case management of all the issues around a child and their family, practising medicine in a biopsychosocial[12] model.
- Community paediatricians have a holistic approach to child health; a role in health promotion and protection services for those who are well, supporting those who may not be accessing the care they need, and those who are referred in by other professionals, seeking specialist care.

4.2 Service planning

- CCH services should be commissioned or planned as part of an integrated evidence based pathway from prevention and identification through to assessment and management and where appropriate contribute to ongoing care including transition to adult services using a ‘Family Friendly’ approach[5]. This requires service planners, commissioners, providers and regulators to work together.
- The paediatricians should provide leadership within a multidisciplinary team to enable the delivery of holistic, specialist care that may include the general practitioner (GP), health visiting, school nursing, AHPs, CAMHS, community children`s nursing, general paediatrics and paediatric subspecialties including end of life care, as required.
- Community child health services can be delivered across a range of locations which may include clinics, homes, nurseries, schools and social care settings. It has been shown that child development teams which are co-located are more likely to work effectively together[13].

- Community paediatricians must work across agencies, and often have a statutory duty to do so. This includes local authority services, particularly education and social care, and third sector/voluntary organisations.
- Children, young people and families should be actively involved both in the planning and decision making around their care and in the planning and design (co-production) of services as a whole[14].
- There should be clear, agreed thresholds for access to and discharge from the care of a community paediatrician, underpinned by specifications and service level agreements[ii].

4.3 Organisational arrangements

- CCH teams should have a clinical lead who understands fully the detail of day to day work, strategic issues, population needs and workforce requirements and who can lead and represent the service effectively. This will usually be a community paediatrician.
- Community paediatricians should be supported to make best use of their skills and expertise, focussing their time on what only the community paediatrician can do; there must be clarity on roles and responsibilities within the team and with professionals from other health services and agencies.
- Clinical settings should be accessible and equipped and staffed appropriately with nursing, play and administrative support. This is of particular importance as many of the children seen will have physical disabilities and/or challenging behaviour. Relevant standards are set out in You're Welcome[15] and the Paediatricians' Handbook[16].
- Community paediatricians should have secure rapid real time access to full clinical records and corporate systems which facilitate appropriate information sharing between disciplines and across organisations. Record handling should comply with the organisation's information management policies. Wherever possible full data access and secure communication should be available at all clinic locations.

4.4 Team and individual job planning

- The time allocated in job plans should reflect the complex nature of the reports and assessments required and allow time for ongoing caseload management, consideration of travel time to off-site clinic settings, flexibility to facilitate multi-agency working and adequate availability for meetings with families and professionals. These elements are

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[ii] The RCPCH can provide examples

included in the calculator tool provided and further guidance is provided in the Paediatricians' Handbook[16] and BMA/BACCH guidance[17].

- The service needs to be sufficiently resourced to adhere to statutory timeframes without consequent adverse impact on other, non-statutory referrals where there may be higher clinical need, or on timely follow up when longer waits may delay diagnosis and have an impact on family or educational support.

4.5 Performance monitoring and quality improvement

- The primary intention is to continually improve safety, experience and outcomes thereby improving the value of the service to local children and families. Contract monitoring is a secondary function. Clinical leadership in this area is essential to ensure that the data collected is meaningful and used to best effect.
- Data collection systems should be strengthened to become equivalent to those for tariffed services, in order to allow easy recording of pertinent and statutory statistics, monitoring of demand and activity, clinical and financial performance, and to enable benchmarking[18] against other community paediatric services. This will facilitate a continuous cycle of quality assurance and improvement as well as collection of diagnostic/condition coding. These should become easier through the recently mandated community services data set for England[19].
- Community paediatricians should work to the usual NHS standards. However they also have statutory requirements to meet other standards e.g. local authority standards for safeguarding, SEND and LAC that are not currently monitored through the NHS.

5 Components of a CCH service

This chapter sets out 22 components of a CCH service, which generally form the basis of commissioning contract(s) in England and service planning in Scotland, Wales and Northern Ireland. Each section defines a condition/service, links to guidance and standards, and findings from the RCPCH census and community survey relating to current provision.

Each CCH service will be planned and delivered based on local needs and arrangements; some services (such as those for ASD and ADHD) may be provided by others, such as CAMHS, for different age groups or may be provided on an area or regional basis. These tables are designed to be a basis for discussion during contract negotiations and provide a condensed summary of all the relevant standards together with examples of innovative practice and points to consider in the longer term.

Paediatricians are working with particularly challenging families and those in great need, especially parents with mental health problems, substance misuse, learning difficulties and possible domestic abuse where the development of the child could be considered suboptimal for reasons of parental capacity. For some of these families the assessment does not lead to a diagnosable condition so the time spent can go unrecognised in contractual planning. Collection of data for referrals received, those accepted and those offered an appointment may be helpful to identify this demand. For further information see the BACCH Prospectus 2012[20] or www.rcpch.ac.uk/cch.

A note about references: Unless otherwise indicated the statistical data has been taken from the 2015 RCPCH Workforce census or the survey conducted in 2016 as part of this project.

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)	53
H: Statutory role – Designated LAC doctor	55
I: Statutory Role – Named LAC doctor	56

Children with neurodevelopmental conditions

J: Autism Spectrum Disorders	57
K: Attention deficit hyperactivity disorder (ADHD)	59
L: Other developmental conditions (excluding ASD and ADHD)	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: Vision 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

Vulnerable children and families

A: Safeguarding medical assessments (physical abuse, neglect)

Definition

Provision of an urgent medical assessment to determine and document harm following suspicion of child maltreatment.

Data on the national incidence or prevalence of the condition

- In the year to 31 March 2016[21], 33.7/1000 children in England were classified as a 'Child in need', a relatively stable rate since 2010 but with significant local variation – from 15 per 1000 to 70 per 1000.
- Comparative rates per 1000 were 30.6 in Wales, 55.8 in Northern Ireland, 15 in Scotland.
- The rate of referral to social care in the year to 31 March 2016 was 53.2/1000 – relatively stable since 2010, mostly by police (27%) but 14% by health services.
- The Section 47 investigation initiation rate was 14.8/1000, doubling since 2010.
- The number of initial child protection conferences was 6.2/1000, up 50% since 2010.
- In England the rate of children with a child protection plan was 4.3/1000, an almost 50% increase since 2010. For Wales the figure was 4.8/1000, 4.9/1000 in Northern Ireland and 2.7/1000 in Scotland.

Clinical and service planning guidance for this condition or service

England
- Working Together to Safeguard Children[22]
- Section 47 of the Children Act 1989[23]
- NICE Guidance: Child maltreatment: when to suspect maltreatment in under 18s[24]

Scotland
- National Guidance for Child Protection in Scotland[25].

Wales
- Children and young people: rights to action safeguarding children: working together under the Children Act 2004[26].

Northern Ireland
- Co-operating to safeguard children[27].

UK-wide
- Details of the procedures to be followed are set out in the RCPCH Child Protection Companion[28].
- Intercollegiate guidance sets out professional roles, responsibilities and training requirements for designated and named roles[29].

Workforce implications of the standards or guidance

A response within 24 hours is required where possible to a request for medical assessment from a social worker in suspected physical abuse[28]. A longer times scale (up to 10 working days) is permissible for neglect, depending on clinical need.

An experienced SAS or consultant paediatrician should be available on call with no other fixed commitments during the service operating time. For community paediatrics this is usually office hours with out of hours usually being covered by the acute general paediatric rota. Less experienced doctors whether SAS or trainees may participate in the rota but consultant supervision should be available. This was available to all separate rotas which included trainees in 2015. The doctor on call will discuss the request with the social worker but other administrative staff should be available to set up the clinic and assemble relevant clinical records.

Other children in the family should be considered in relation to their need for assessment. Assessments should be undertaken with a chaperone present.[28]

The average time taken to complete the end to end process of the medical assessment and report depends on many factors; modal time for physical abuse and neglect examinations is 45-60 minutes but time is also required for report writing, consideration at peer review, participation in child protection conferences and strategy discussions before and after the assessment, providing statements for the police and possibly participation in court proceedings. A suggested starting point for service planning may be 3 hours per child (from consensus).

How the condition is dealt with / service currently delivered

- The percentage of UK CCH services providing assessment for neglect is 82% and physical abuse is 76%.
- Between 2015 and 2016, 73% of CCH services offered over 50 appointments specifically for physical abuse; 14% offered over 200 appointments for the year.
- The numbers were much lower for neglect, with only 12.9% of CCH services needing to offer over 50 appointments for the year.

Options for future treatment of condition/delivery of service?

This is a statutory function that is likely to continue. The growth of multi-agency hubs for safeguarding is helping to improve information sharing. Background information can be particularly valuable when neglect is suspected, or to inform child protection investigations and such information can be gathered through the Multi Agency Safeguarding Hub (MASH) with a health review by a public health nurse, followed by referral to the paediatric service if a medical opinion is needed about a specific issue.

B: Child sexual abuse (forensic and historic)

Definition

Forensic, acute or historic examination of under-18s following alleged sexual assault.

Data on the national incidence or prevalence of the condition

The total number of recorded sexual offences against under-16s rose sharply by 38% from 22,294 in 2013/14 to 30,698 offences in 2014/15 and by 85% over five years from 16,627 in 2010/11. The rate of offences per 1,000 has ranged from a low of 1.4 in 2007-09 to a high of 3 per 1,000 children in 2014/15[30].

Clinical and service planning guidance for this condition or service

In addition to guidance listed in A above:

- Service specification for the clinical evaluation of children who may have been sexually abused (England)[31]
- Physical Signs of Child Sexual Abuse[32]
- Guidance from the Faculty of Forensic and Legal Medicine (FFLM) about examination[33] and competencies[34] of those conducting examinations.
- Child sexual abuse (CSA) forensic medical examinations: Interim Guidance regarding numbers of examinations and the maintenance of competence Jan 2017[35]
- New guidance on DNA anti-contamination: forensic medical examination in sexual assault referral centres (SARC)s and custodial facilities[36].

Workforce implications of the standards or guidance

Acute CSA examinations should be carried out as soon as possible to preserve forensic evidence but other considerations may also need to be taken into account e.g. availability of staff, if the CYP is under the influence of alcohol or drugs, or if a young child they are best seen in daytime rather than late at night. RCPCH provide guidance links[28]on how such decisions should be made.

Historic cases should be seen within 10 working days[28]. Provision should be made for historic abuse referrals and access to colposcopy for children with genital conditions or behavioural concerns where there is no allegation, but which require consideration of sexual abuse[24,32].

Acute CSA assessments are conducted in various settings including hospitals and SARCs in England and Wales. For SARCs a separate contract may exist[37 38] depending on the setting. Assessments may be conducted jointly with a paediatrician and a forensic physician or by a single doctor with all the relevant competencies[33] and require a child-friendly setting, forensically clean room, and appropriate colposcope and secure recording. New guidance on DNA contamination requires stringent measures to reduce cross contamination[28].

FFLM standards identify that the minimum standard to conduct forensic CSA examinations unsupervised is MRCPCH and Licentiate of the Faculty of Forensic & Legal Medicine (LFFLM). LFFLM is a considerable and expensive undertaking and very few paediatricians have the dual qualification.

Community paediatricians participating in acute CSA examinations must be suitably skilled and qualified as set out in guidance and be commissioned/job planned to provide for this work within their duties[34,35]. Peer review of all cases must take place and it is recommended that non-consultants should be supervised unless they are very experienced. Joint RCPCH/FFLM guidance[33] suggests 20 forensic examinations per year for a doctor to maintain competence; this is further explained in subsequent interim guidance[35].

The average time taken to complete the end to end process of medical assessment and report depends on many factors; the median appointment length is 76-90 minutes (survey respondents were given grouped answer options) but time is also required for report writing, consideration at peer review, participation in child protection conferences and strategy discussions before and after the assessment, providing statements for the police and possibly participation in court proceedings. A suggested starting point for planning may be 4 hours per child (consensus).

How the condition is dealt with / service currently delivered

- 57% of UK CCH services provide assessment for sexual abuse. 30% of services providing data offered over 50 appointments for sexual abuse in the year ending 31 March 2016, but 48% offered fewer than 25 appointments.

Options for future treatment of condition/delivery of service

Provision would benefit from increased multiagency working with shared processes and standards between providers and professional groups.

In some areas these assessments are being consolidated into Sexual Assault Referral Centres (SARCs). In England the health functions of these are commissioned directly by NHS England[37].

C: Statutory role - Designated doctor for safeguarding / Lead paediatrician for child protection

Definition

In England, designated doctors are appointed by CCGs, and in Northern Ireland by the Safeguarding Board. They are responsible for ensuring that the health service response is effective and named doctors are supported to work effectively in provider trusts. They also contribute strategic medical advice to the Local Safeguarding Children Board and wider overall health / education / children`s services provision. They work closely with the designated nurse for safeguarding. In England, the role is sometimes combined across more than one commissioner. Designated professionals, as clinical experts and strategic leaders, are a vital source of advice to the CCG, NHS England, the local authority and the Local Safeguarding Children Board (LSCB), and of advice and support to other health professionals.

In Scotland the lead paediatrician in child protection carries out a similar function for the health board, liaising with the paediatrician with “special interest in child protection” and lead nurse for child protection.

In Wales there is a National Safeguarding Team with designated doctors and nurses which is part of Public Health Wales. The team provides professional and strategic leadership to the NHS in Wales in safeguarding people. They work closely with Welsh Government, other national organisations and the Regional Safeguarding Boards.

Clinical and service planning guidance for this condition or service

In addition to relevant guidance listed in A.

- The NHS accountability and assurance framework[39] sets out lines of accountability for designated professionals in England, especially those such as paediatricians not directly employed by CCGs. In some areas there will be more than one CCG per local authority area, and CCGs may consider ‘lead’ or ‘hosting’ arrangements for their designated professional team, or a clinical network arrangement.

Workforce implications of the standards or guidance

Model job description, competency framework and criteria for assessment for the Designated Doctor[40] and Lead Paediatrician[41] roles are available which suggest 4.5-5 PAs would be the appropriate resource required for an average local authority or CCG area.

How the service is currently delivered?

- In 2015 in England, Wales and Northern Ireland 64% of services provide the designated role with 93.5% filled and on average 2.9 PAs allocated to the role.
- In Scotland 91% of services have a lead paediatrician for child protection and all posts are filled with an average of 2.3 PAs.

Options for future treatment of condition/delivery of service?

This is a statutory role that is usually delivered by a consultant paediatrician (in 94.3% of Trusts in England and 80% in Scotland[2]). Other suitably competent professionals could carry it out e.g. SAS paediatricians but the individual would be expected to be trained to level 5 safeguarding competencies[29].

D: Statutory role - Named doctor for safeguarding / Paediatrician with special interest in child protection

Definition

A statutory role to oversee provision of child protection service within a provider trust or health board, including reporting internally and externally, and ensuring medical staff are suitably trained and undergo peer review. There should be an identified role in every trust or health board.

Clinical and service planning guidance for this condition or service

- The role is set out for England in Working Together[22] and intercollegiate guidance[29].
- The named doctor in an organisation with child health services will nearly always be a paediatrician but suitably trained doctors from other backgrounds in other organisations e.g. GP in a CCG, psychiatrist in a mental health trust.
- Where community paediatricians are employed by a mental health or other trust, it is recommended that the named role for paediatricians is preserved and provided alongside any other named doctor provision for the mental health component[29].

Workforce implications of the standards or guidance

A model job description, competency framework and criteria for assessment for these roles is available from the RCPCH[42,43]. Each document sets out the PAs that would usually be required for an average district, suggesting 2-2.5 PAs, and the variables that would influence this allocation.

How the service is currently delivered?

- 95.8% of responding services provide the role with 98.1% filled by a paediatrician (consultant 91.7%; SAS 7%) and average 1.9 PAs allocated to the role.

Options for future treatment of condition/delivery of service?

The role is likely to continue to be a statutory requirement. It is not clear how the function is provided within non-NHS provider organisations in England though this is a requirement for all NHS-funded services including private and social enterprise and a medical role within ambulance trusts.

E: Statutory role – Child death service

Definition

A statutory process and roles relating to all child deaths including sudden unexpected death in infancy and childhood (SUDIC). Includes the (England) statutory role of Designated Paediatrician for Unexpected Deaths in Childhood and link with the Child Death Overview Panel (CDOP) representative. In Wales the function is Procedural Response to Unexpected Deaths in Childhood (PRUDIC) and Child Death Review Programme but these are not statutory. In Scotland a SUDI paediatrician is required.

Clinical and service planning guidance for this condition or service

UK wide
- Sudden unexpected death in infancy and childhood[44].

England
- The designated paediatrician is a statutory, advisory appointment by the CCG in England who is responsible for coordinating responses to all childhood deaths. Responsibilities are set out in Working Together chapter 5[22]. The role includes oversight to the Child Death Review process, rapid response to notification of death, liaison with relevant professionals, contribution to medical advice to notifications and possibly chairing subsequent case discussions. Usually the same individual attends the CDOP to facilitate discussion about the medical aspects of deaths. A lead health professional is appointed to co-ordinate the health response to that specific death. This may be the designated paediatrician or may be the attending doctor if there is no out of hours cover for the activity.

Wales
- The process is covered by guidance[45] to ensure the response is safe, consistent and sensitive to those concerned.

Scotland
- There is a defined process and approach set out by the Scottish Government[46].which includes appointment of a SUDI paediatrician

Northern Ireland
- The Safeguarding Board for Northern Ireland has established a Child Death Overview panel that works across five safeguarding panels.

See also
- Protecting vulnerable people in the NHS re oversight and accountability to CCGs in England[39]
- NQB National guidance – learning from deaths[47].

Workforce implications of the standards or guidance

The RCPCH estimates[44] that for a total population of 500,000, approximately one day a week of paediatrician time (2PA) would be required to cover both the paediatric roles within the rapid response team and the Child Death Overview Panel. This assumes that the paediatrician undertakes the majority of the health roles themselves rather than using a delegated model using other health professionals for some of the roles required.

How the service is currently delivered?

- 33 CCH services (48% of responders) report that a community paediatrician is not required to attend the CDOP panel. Yet 19 (79%) of the remaining services report that if a community paediatrician in their service cannot attend the CDOP panel then a community paediatrician from another service attends – panel catchments often cover more than one organisation/districts which makes efficient use of expertise.

- In England, Scotland and NI, 60.6% of services responding provide a CDOP panel child health representative and 98.9% of posts are filled. In Wales 80% of services responding follow the PRUDiC process and identified a practitioner, who would usually be the Named Nurse (Head of Safeguarding) or another specialist nurse, and all posts are filled.
- Designated Paediatrician for Child Death roles exist in 52.9% of responding services and the post is filled in 98.6% of cases. On average 1.1 PA is allocated for this role,
- 0.7 PAs are allocated for the CDOP panel representative and 1.0 for PRUDiC practitioner.

Options for future treatment of condition/delivery of service?

New statutory guidance is expected in 2017 following the Wood report[9] and the National Child Mortality Review. Trusts will need to establish systems to review all deaths.

F: Statutory Role – Medical Adviser for Fostering and Adoption

Definition

A statutory role for adoption agencies in England, Wales, and NI covering health and emotional assessment of children being proposed for adoption or long term fostering. This would usually include health assessment of children, collation of an adoption report including health history and identifying the child's current and future needs, advice on health of adopters/carers and may include an interview with prospective adoptive family and counselling of them about the child's needs. Includes attendance to provide medical advice at fostering (non-statutory) and adoption (statutory) panels.

In Scotland there is a statutory role for adoption agencies to appoint a registered medical practitioner to provide advice.

Data on the national incidence or prevalence of the condition

5,030 children were adopted from care in England and Wales during the year ending 31st March 2016, compared to 5,713 in 2015[48]. There are no data on the number of adult health reports completed.

Clinical and service planning guidance for this service

- Statutory guidance from Government for England Wales and Northern Ireland require an adoption agency to appoint a medical adviser.

England
- CCG responsibilities are set out in England in Promoting the Health and Well-being of Looked-After Children[49].
- HM Government. Statutory guidance on adoption. 2013[50].

Wales
- The Adoption Agencies (Wales) regulations 2005[51].

Northern Ireland
- The Adoption Agencies regulations (Northern Ireland) 1989[52].

Scotland
- In Scotland[53] the requirement is for a registered medical practitioner to be appointed to provide advice.

UK-wide
- Guidance and details of the competencies required for the role are set out in the intercollegiate guidance[54].
- The Local Government Association has also published guidance on responsibilities[55].

Workforce implications of the standards or guidance

The individual should be a senior paediatrician with higher professional training or equivalent with the competences to carry out this role. A breakdown of duties can be found in the guidance from the British Association for Adoption and Fostering (BAAF)[56].

A minimum of 2 sessions/PAs (8 hours or 0.2 whole time equivalents) for approximately 400 looked after children per year. This would include preparation of the adoption medical report, which may involve assessing the child and attending fostering /adoption panel but does not include doing initial health assessments (IHA) for children coming into care or time for preparing adult adopter / fostering medical reports.

How the service is currently delivered?
• 67.1% of services provide this role with 97.3% of posts filled and with an average 2 PAs allocated. • A pre-adoption face to face assessment (separate from IHA) is offered by 79% of CCH services. • 84% of community paediatric services provide medical advisor's comments to the local authority on 'Adult Health Forms' (AH Forms) from applicants as foster carer, special guardian or prospective adopter. • 82% of community paediatric services provide counselling for prospective adopters, on the health and development of children being considered for adoption.
Options for future treatment of condition/delivery of service?
While this is a local authority requirement / statutory role which may be procured separately, most local authorities use an advisor employed by the NHS. Some agencies outside local authorities such as charitable organisations may use sessional medical advisors. There is potential for joined up work between LAC IHAs and adoption to prevent repetition and overlap. The adult assessment may be conducted by suitably trained GPs under the oversight of the LAC team with suitable peer support and review to meet Intercollegiate and BAAF competencies.

G: Looked After Children (LAC)

Definition

Provision of Initial Health Assessments (IHA) for physical and mental health wellbeing of children and young people, plus advice and counselling on a healthy lifestyle, as they become looked after. This is a statutory requirement in each local authority area.

Data on the national incidence or prevalence of the condition

In England in 2015, 6 per 1,000 under 18 population are being ‘looked-after’[48]. This figure varies significantly at local authority level from a low of 2.2 (Wokingham) to a high of 16.4 (Blackpool), with an average of 1.8 children per 1,000 entering the care system per year. In Wales in 2015, 9 per 1,000 of the under 18 population were being ‘looked after’.

Clinical and service planning guidance for this condition or service

UK-wide
- Promoting the health of children in public care[57]

England
- The Care Planning, Placement and Case Review (England) Regulations 2010[58]
- Promoting the Health and Wellbeing of Looked After Children[49]
- NICE guidance Looked After Children and Young People[59]
- NICE Quality Standard[60]

Wales
- The Care Planning, Placement and Case Review (Wales) Regulations 2015[61]

Scotland
- Looked after Children (Scotland) Regulations 2009[62]

Northern Ireland
- Arrangements for Placement of Children (General) Regulations (Northern Ireland) 1996[63]

Workforce implications of the standards or guidance

In England IHAs must be conducted by a medical practitioner, with competencies set out in the intercollegiate guidance[54]. This is usually a paediatrician but may be a suitably trained GP with level 3 and some level 4 competences. Routine reviews are usually done by specialist LAC nurses, GPs, school nurses or health visitors although paediatricians may review complex cases occasionally.

In Wales and Scotland, initial and review health assessments may be carried out by doctors or nurses.[61,62]

In England the IHA must be reported back to the Local Authority by their first statutory LAC review by social care, i.e. within 20 working days of the child becoming looked after. The regulations in the other countries are similar although not the same.

The number of clinics required per week should be planned according to the number of requests for initial health assessment. In order to meet the statutory timescale requirements, appointments should be offered within 2 weeks of request, with report finalised within one week of the assessment. In England reports written by examining doctors should be quality assured by a Named or Specialist Doctor for LAC (see Template I below).

In England responsibility for payments to providers is set out in the NHS England ‘Who

Pays?' guidance[64]. A national tariff – as yet the only tariff for community paediatrics - has been agreed for IHAs and reviews for out of area assessments i.e. when the child is placed outside the home borough. Non-mandatory tariffs have also been developed for in-area initial and review health assessments.

How the condition is dealt with / the service currently delivered

- 46% of services provide IHAs only, 46% provide IHAs and review health assessments, and 7.5% provide no service.
- 64% of CCH services report their time slot allocated for LAC IHA appointments is between 46 – 60 minutes plus administrative time. Guidance suggests 1PA of administration time per clinic would be appropriate[54].
- There is a wide range of demand for medicals – from 50 or fewer to over 500 per service.

Options for future treatment of condition/delivery of service

The development of tariffs in England should improve funding and service provision once they are embedded. In at least one area specialist nurses have been trained to provide IHA under medical supervision (see innovative practice examples), however this is out with current statutory guidance in England. If skill mix is introduced, there needs to be robust oversight to quality assure training and reports.

The Children and Social Work Act 2017[65] may have some effect on function.

H: Statutory role – Designated LAC doctor

Definition
Provision of strategic advice on the health of local looked after children. In England the designated doctor and nurse for LAC are statutory (CCG) roles. In Wales, professionals for Safeguarding (and LAC) are employed by Public Health Wales. Named doctors for LAC provide a health board strategic function as well as an operational role. In Scotland specialist doctors deliver the strategic overview plus local services to their health board. These roles have responsibility for strategic service planning and advice regarding policies, adverse events, training and supervision and are separate from any responsibilities for individual children or young people who are looked after. In England the role includes provision of advice to commissioners and preparation of the annual health report (with designated nurse).
Clinical and service planning guidance for this condition or service
• Promoting the Health and Wellbeing of Looked After Children[49]. • Looked After Children; Knowledge skills and competencies of healthcare staff[54]. • NICE guidance PH28 Looked After Children and Young People[59].
Workforce implications of the standards or guidance
Model job description and competency framework is available - a minimum of 2 PAs per week (8 hours or 0.2WTE) per 400 LAC population (excluding any operational activity such as health assessments)[54] is recommended. The Designated Doctor should be a senior paediatrician with additional competence in Looked After Children to Level 5.
How the service is currently delivered
• The Designated Doctor is usually a consultant paediatrician (76.4%) or SAS paediatrician (21.3%) • Although the function in England may be commissioned by the CCG separately from the CCH service, the post holder is required to be clinically active in community paediatrics in at least part of the geographical location covered by the post. • Designated Doctor for LAC is allocated an average (mean) 1.9 PAs. This was not measured against LAC population for the area covered.
Options for future treatment of condition/delivery of service
No change anticipated.

I: Statutory Role – Named LAC doctor

Definition

Provision of operational advice on the health of local looked after children. This is a statutory role in England[49]

In Wales named doctors for LAC provide a health board strategic function as well as an operational role.

In Scotland specialist paediatricians, GPs and nurses deliver local services for LAC and lead paediatricians for each area provide strategic advice to their health board. NHS boards also have a nominated board director with corporate responsibility for LAC.

In NI, there are lead clinicians and specialist nurse leads for looked after children.

These roles are responsible for promoting good professional practice within their organisation, providing supervision, advice and expertise for fellow professionals, quality assurance of health assessments, and ensuring that awareness training is in place.

Clinical and service planning guidance for this service

- Promoting the Health and Wellbeing of Looked After Children[49].
- Looked After Children knowledge skills and competencies of healthcare staff[54].
- NICE guidance PH28 Looked After Children and Young People [59].

Workforce implications of the standards or guidance

Model job description and competency framework is available. The named doctor role requires a minimum of 1PA, equivalent to 0.1 Whole Time Equivalent (WTE) or 4 hours per week per 400 looked after children[54].

How the service is currently delivered

- 39.5% of services provide the role with 96.7% of posts filled and an average of 1.5 PAs allocated per service.
- There is a consultant paediatrician in 69% of posts and SAS paediatrician in 25.9%,

Options for future delivery of service

No change anticipated
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Children with neurodevelopmental conditions

J: Autism Spectrum Disorders

Definition

ASD is a lifelong disorder which significantly limits or impairs the activities of daily living characterised by difficulties interacting and communicating with other people and restricted, repetitive patterns of behaviours, interests or activities.

Data on the national incidence or prevalence of the condition

It is estimated that 1.1% of the UK population has ASD[66,67]. Males are affected four times more than females. There is an increased risk of ASD in certain children or young people e.g. sibling of a child with ASD; certain chromosomal and other developmental disorders and premature birth. Approximately 70% of individuals with ASD will have at least one other disorder (often unrecognised) including learning difficulties, anxiety, ADHD, oppositional defiant disorder and challenging behaviour which impairs their psychosocial functioning further. Research shows considerable co-morbidity of ASD and ADHD[68,69] and considerable dissatisfaction with the diagnosis process as a whole[70].

Clinical and service planning guidance for this condition

England

- NICE Guideline Autism spectrum disorder in under 19s: support and management:CG170[71]
- NICE Guideline Autism spectrum disorder in under 19s: recognition referral and diagnosis CG128[72]

Scotland

- SIGN Guidance Assessment, diagnosis and interventions for autism spectrum disorders SIGN 145[73]

Wales

- The All Wales neurodevelopment diagnostic assessment pathway[74]

All set out the pathways of care including:

- A multidisciplinary pathway approach. An individualised diagnostic assessment based on International classification of disease (ICD) and/or diagnostic and statistical manual of mental health disorders (DSM) criteria which may include the use of standardised tools, although none are specifically recommended.
- Where there is diagnostic uncertainty further assessments may be organised using tools such as Autism Diagnostic Interview (ADI), Developmental, Dimensional and Diagnostic Interview (3Di), Autism Diagnostic Observation Schedule (ADOS), Diagnostic Interview for Social and Communication disorders (DISCO) and cognitive assessment.
- A needs based management plan should be shared with parents, with appropriate referrals for early interventions by multidisciplinary and multiagency teams.

NICE further recommends that the pathway is overseen by a multiagency autism strategy group with an identified lead professional for pathway development and training of teams. SIGN recommends using the Getting it right for every child (GIRFEC) structure.

All guidelines recommend that each assessment includes:

- a developmental history, focusing on developmental and behavioural features consistent with DSM-IV criteria

- assessment (through interaction with and observation of the child or young person) of social and communication skills and behaviours
- a clinical history and examination including consideration of the differential diagnosis
- systematic assessment for conditions that may coexist with autism
- development of a profile of the child's or young person's strengths, skills, impairments and needs that can be used to create a needs-based management plan, taking into account family and educational context
- communication of assessment findings
- information about autism and its management and the support available on an ongoing basis
- supporting children and young people with autism and their family and carers during times of increased need, particularly transitions
- specific carer support
- NICE and SIGN recommend a follow up appointment soon after assessment (NICE recommends after 6 weeks) for further discussion of the diagnosis and its implication and each individual diagnosed has a case manager or key worker

Workforce implications of the standards or guidance

NICE was unable to produce detailed implementation cost information due to the variation of provision across services. As a guide, however, they estimate that it would take two to three senior professionals about three hours each to produce an individual profile on each child. Increasing the multidisciplinary and multiagency approach to ASD could increase costs and/or produce savings depending on the current model.

Due to the complexity and comorbidity linked with ASD, access to a wide multidisciplinary and multiagency team is essential. NICE recommends that the local team includes or has access to core staff:

- Paediatrician or paediatric neurologist and/or child and adolescent psychiatrist
- Speech and language therapist
- Clinical and/or educational psychologist
- Occupational therapist
- Social worker
- Support staff

Possibly a specialist health visitor or nurse and a specialist teacher.

How the condition is dealt with / service currently delivered

- 99% of CCH services provided ASD assessments, an increase since the 2013 census. Across the UK there is a range of approaches, for example: 55% of services provide a specific ASD assessment clinic for new cases/follow up post diagnosis whereas others provide ASD assessments within general clinics.
- In dedicated services, the average number of referrals per service was 332, approximately 4 per 1000 children aged 0-19 with an average 281 new and 577 follow up appointments offered. 46% of services have more than 1 hour allocated for new ASD appointments; 39% have 46-60 minutes, with 15% offering appointments of less than 45 minutes.

Options for future treatment of condition/delivery of service?

Guidance recommends the establishment of ASD teams/services to streamline assessment and diagnosis of ASD (NICE suggest local groups for England; Scotland and Wales have established national frameworks).

Some innovative practice examples are exploring increased cooperation with CAMHS to improve access and introducing skill mix to meet demand.

K: Attention deficit hyperactivity disorder (ADHD)

Definition

ADHD presents with high levels of hyperactivity, impulsivity and inattention that result in significant psychological, social and/or educational or functional impairment that occurs across multiple domains and settings and persists over time.

Data on the national incidence or prevalence of the condition

In the UK, a survey of children between the ages of 5 and 15 years found that 3.6% of boys and 0.9% of girls had ADHD[75]. The rate of diagnosis and prescription for ADHD rose steeply up to 2008 but has since plateaued at 0.51% of children[76]. There is concern about under recognition and under treatment compared with other European countries and the US[76, 77]

Clinical and service planning guidance for this condition or service

England & Wales

- NICE guidance (covering England & Wales) ADHD: diagnosis and management CG72[78]

Scotland

- SIGN guidance Management of ADHD in children and young people SIGN 112[79]

Northern Ireland
- A consensus statement from practitioners in Northern Ireland[80] (based on NICE guidance).

Key points include:
- A watchful waiting period (NICE suggests 10 weeks) and offering parent training for moderate symptoms.
- Diagnosis should only be made by a specialist psychiatrist, paediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD. Diagnosis includes a full clinical and psychosocial assessment of the person:
- A full developmental and psychiatric history.
- Observer reports from more than one setting.
- Assessment of the person's mental state.
- Diagnosis should not be solely on the basis of rating scale or observational data.
- Drug treatment is not recommended for pre-school children. However before discharge, consider other comorbidities and the possible impact of school entry.
- School aged children with severe or moderate symptoms, who have not responded to parent education, should be offered medication.
- Medication should be used only as part of a comprehensive treatment plan that includes psychological, behavioural and educational advice and interventions.
- During initial titration, progress should be monitored (NICE suggests weekly telephone contact and standardised rating scales are used).
- Primary care practitioners should not initiate treatment but primary care practitioners can participate in ongoing prescribing and monitoring under shared care agreements.
- Children and young people who are treated with medication will require long term follow up to monitor the effects of medication. NICE recommends 6-monthly monitoring of height and weight, plotted on a centile chart, with an initial weight measurement 3 months after starting medication. Heart rate and blood pressure should be monitored every 3 months.
- Treatment may be required for the whole of the childhood years and may need transition into adult services if symptoms persist.

Workforce implications of the standards or guidance

While originally the remit of CAMHS, community paediatricians have played an increasingly important role (63% of services in 2016 compared to only 15% of services in 2006[81]). The demand for assessment and ongoing follow up has had a significant impact on many community paediatric services as access to CAMHS has deteriorated.

Service provision is co-dependent on other disciplines, including nurses, occupational therapists, clinical and educational psychology and CAMHS. Availability of these other services impacts on the workforce requirement for CCH services.

How the condition is dealt with / service currently delivered?

- Nearly two thirds of UK CCH services provided an ADHD service.
- 25% provided a specific ADHD clinic for new cases/follow up and medication review post diagnosis
- 38.1% included ADHD in general clinics.

Options for future treatment of condition/delivery of service?

People with ADHD would benefit from improved organisation of care and better integration of paediatric, child and adolescent mental health services (CAMHS) and adult mental health services[78].

Poor access to parent training and therapy input, usually provided through CAMHS, may increase reliance on medication.

The examples of innovation described the introduction of skill mix to ADHD assessment and monitoring, including nurses, pharmacists and CAMHS.

L: Other developmental conditions (excluding ASD and ADHD)

Definition

This is a diverse group of conditions, which include:

- physical disability including motor disorders such as cerebral palsy
- intellectual disability – general and specific learning disability
- impairment of special senses (see separate sections on hearing and visual impairment)
- acquired brain injury, neurodegenerative and neuromuscular disorder and other acquired disabling conditions
- less complex developmental difficulties including speech and language, motor delay and developmental coordination disorders
- progressive conditions
- inherited/genetic disorders,
- consequent comorbidities such as epilepsy management – a common problem in all CYP with above conditions[20].

Data on the national incidence or prevalence of the condition

UK Government estimated that in 2011-12, 6% of children had disabilities[82].

In addition, children with less complex difficulties may be identified during the routine reviews that form part of the healthy child programmes and referred from health visitors, primary care and education services.

Clinical and service planning guidance for this condition or service

Key aims of the service are:

- early diagnosis and intervention
- effective multidisciplinary and interagency interventions
- proactive management of known disabilities to prevent unnecessary exacerbation of symptoms and deterioration of condition
- reduce impact of disability on individual and family members
- reassurance and/or monitoring of progress where appropriate
- preparing medical advice for schools, including statutory processes for EHCP and adoption

Quality standards are available from the British Academy for Childhood Disability (BACD)[83,84].

Workforce implications of the standards or guidance

Service provision is co-dependent on other disciplines, including physiotherapy, occupational therapy, speech and language therapy, nurses, clinical psychology, early years and education services, as well as CAMHS. Availability of these other services impacts on the workforce requirement for CCH services.

How the condition is dealt with / service currently delivered?

In most services, the service is provided by paediatricians of varying levels including trainees, specialty doctors and consultants. Many areas have paediatricians who have had additional specialist training in paediatric neurodisability. They work as part of a multi-disciplinary team, ideally co-located in a child development centre[13] although current funding difficulties are hampering the ability to work together[85].

- 54% of services provided clinics for detailed assessment of complex difficulties with a multi-disciplinary team. The most common length of appointments (41.2% of services) was 46-60 minutes, although 24% offered appointments of more than 90 minutes. The median waiting time was 6-12 weeks (grouped answer options provided in the survey). Follow up appointments were usually shorter; 46.7% were for 30 minutes or less and most responders were able to see patients for follow up when they were due.

- 89% of responders provided doctor only clinics; 42% included both detailed assessment and triage, 41% provided only complex assessment and 7% provided triage only in these clinics. The median time slot was 46-60 mins although 26% offered slots more than 60 minutes. Time slots for triage only/less complex clinics were shorter: 20% 30 mins or less, 34% 31-45 mins and 37% 46-60 mins.
- Approximately 40% of services mentioned additional specialist clinics. The most common are for botulinum toxin, developmental coordination disorder and epilepsy.

Options for future treatment of condition/delivery of service?

There is increased emphasis on the need for collaboration between education, health and social care services to provide support for children and young people with SEND. Thus integrated models of service and skill-mix in service provision are likely to increase in future although many areas already have such arrangements in place.

M: Special educational needs and disability (SEND) service

Definition

Provision of medical assessment and report for children and young people who are subjects of statutory special educational needs (SEN) assessment. This is a provision under the Children and Families Act in England[86], The Education (Additional Support for Learning) Act 2004 in Scotland[87], and The Special Educational Needs and Disability Order in Northern Ireland[88]. In Wales, the current legislative framework for SEN is provided by The Education Act[89] but it is anticipated that new legislation will be implemented in the near future.

Health professionals are required to notify to local authorities when they have identified individual children who have or may have SEN. They must provide advice on SEN when requested and within certain timescales.

Data on the national incidence or prevalence of the condition

- There was a total of 287,290 CYP with SEN Statements or EHC Plans in England as at January 2017, an increase of 30,975 (12.1%) from 256,315 in January 2016[90].
- In the year 2016, 36,094 new EHC Plans and SEN Statements were issued in England[90].
- In 2016, over 170,000 Scottish children were identified as having additional support needs and 2385 had a coordinated support plan[91]
- Statistics for Wales and NI are also available[92,93]

The five commonest conditions leading to EHC Plans or SEN statements in England are:

- autism spectrum disorder
- speech, language and communication needs
- social emotional and mental health needs
- severe learning difficulty
- moderate learning difficulty[94].

Clinical and service planning guidance for this condition or service

UK-wide

- BACCH and BACD jointly published a package of materials including job description and examples of medical advice reports[95].

England

- Detailed advice and guidance is available in the Department for Education (DFE)/Department of Health (DH) Code of Practice[14].

Scotland

- The Education (Additional Support for Learning) Act 2004 in Scotland[87]
- The Education (Scotland) Act 2016[96].modified some of the 2004 legislation

Wales

The Additional Learning Needs and Educational Tribunal (Wales) Bill is currently going through the Welsh Assembly[97].

Workforce implications of the standards or guidance

Medical assessments need to be undertaken by doctors with experience in child development and neurodisability, and under the supervision of suitably experienced consultants in order to provide a holistic and comprehensive assessment of the child's needs. There is a statutory requirement for assessments to be completed within 42 days of the request.

How the condition is dealt with / service currently delivered?
• 80.5% of services offer face to face assessment for SEN assessments for EHC plans. • 80.4% of the appointments are between 30 to 60 minutes. • For those already known, reports may be available to the local authority, or can be compiled from available information without the need to see the children. • Only 48.6% of services in the survey were able to submit 90% or more of reports to educational authorities within the required 42 days. • Approximately 20% of CCH services said they did not offer SEN medical assessments.
Options for future treatment of condition/delivery of service?
No change anticipated.

N: Designated medical officer for SEND - England only

Definition

Appointment of a designated medical officer (DMO) for SEND by CCGs is recommended by the Code of Practice for SEND[14]. DMO's main duties are:

- To work closely with the paediatric multi-disciplinary team in supporting all activities necessary to ensure that the health provider services and CCG meet their responsibilities for children with SEND.
- To provide overall strategic direction for the local health service in meeting statutory requirements for SEND, identifying priorities for development and facilitating improvement in implementation.
- This is a non-statutory role which would usually be carried out by a paediatrician, but there is local flexibility for the role to be undertaken by a suitably competent qualified and experienced nurse or other health professional (in which case the role would be the Designated Clinical Officer). The person in this role should have appropriate expertise and links with other professionals to enable them to exercise it in relation to children and young adults with EHC plans from the age of 0 to 25 in a wide range of educational institutions. Each local area needs to decide whether to appoint a DMO, a DCO or both, and work out how the different roles will align most effectively
- The DMO is not expected to provide all the medical reports for individual children, which are provided by their regular paediatrician.

This role does not exist in Scotland, Wales or Northern Ireland.

Clinical and service planning guidance for this condition or service

DFE/DH: SEND Code of Practice[14]

A practical handbook is available from the Council for Disabled Children[98] which includes advice on preparing good quality health input to EHC plans.

There is a model job description for the DMO jointly written by BACCH and BACD[95].

Workforce implications of the standards or guidance

The DMO should be a consultant in a trust hosting children's services with higher professional training in a relevant paediatric subspecialty, or demonstrate level 3 competences in neurodisability, and are able to manage children with complex health needs.

The model job description states that this role requires 2 PAs per week per CCG or local authority, with child population of up to 70,000.

How the service is currently delivered?

- The DMO role exists in 47% of services that responded with 99% of the existing roles filled.
- On average 1.1 PAs were allocated for this role.
- A paediatrician attends the SEND decision-making panel in only 35% of services.
- In 23%, the panel requested paediatric representation that could not be fulfilled.
- In 41% of cases there are no health professionals on SEND panels, while in others health was represented by a variety of other professionals including non-clinicians.

Options for future treatment of condition/delivery of service?

Given the importance and statutory requirements for multidisciplinary and multiagency working in this area, the lack of paediatric representation at the point of decision making about their support needs is of concern.

Other conditions and services

O: Paediatric audiology/audiovestibular medicine

Definition

Audiovestibular conditions include the detection, assessment and management of children who are suspected of having a hearing impairment, or where a hearing impairment needs to be excluded e.g. as part of a more general developmental assessment, or assessment for special educational needs. This includes:

- congenital permanent hearing impairment, either in isolation or as part of a more complex neurological condition
- progressive and acquired hearing impairment
- aetiological investigation (looking for the cause) of hearing impairment including genetics
- auditory neuropathy spectrum disorders
- auditory processing disorders
- glue ear
- balance disorders
- tinnitus and hyperacusis
- non-organic hearing loss
- mental health problems in deaf children
- educational advice
- management of screening programmes

Data on the national incidence or prevalence of the condition

- One in 1000 children[99,100] are born with significant permanent hearing impairment, and a similar number develop a hearing loss during childhood (overall prevalence two per 1000 in childhood).
- Early intervention with hearing aids and habilitation improves long term outcomes for speech and learning[101].
- About 40% of children with permanent hearing impairment have additional medical and/or developmental problems, with one in five having two or more.
- The cause of permanent hearing impairment needs to be investigated: about half will have a genetic cause and there may be associated syndromes and systemic conditions.
- The recognition of congenital CMV infection, where timely treatment has been shown to reduce the risk of hearing loss, means that prevention of permanent hearing loss is becoming a reality.
- In the pre-school years up to 80% of children have an episode of otitis media with effusion (glue ear)[100].
- Epidemiological information on balance disorders is sparse but these are increasingly recognised in children and young people[100].

Clinical and service planning guidance for this condition or service

UK-wide

- Hearing and balance disorders. Achieving excellence in diagnosis and management[100]
- Quality Standards in Paediatric Audiology: Guidelines for the early identification and audiological management of children with hearing loss[102]
- British Association of Audio Vestibular Physicians (BAAP): Clinical Standards[103]

England

- Transforming Services for Children with Hearing Difficulty and their Families; A good practice guide[99].
- Quality Standards in the NHS newborn hearing screening programme[104]
- Quality Standards: Early Years Support for children with a hearing loss NDCS 2016[105]

Scotland

- Quality Standards for Paediatric Audiology Services in Scotland[106]

Workforce implications of the standards or guidance

Audiovestibular services should be arranged and delivered through clinical networks, as described in the DH guide[99]. Increasingly, hearing testing and hearing aid management is delivered by scientifically trained audiologists, while doctors (paediatricians and audiovestibular physicians) concentrate on medical issues and more complex cases. The role of doctors in this area of practice is outlined in the BAAP standards document[103]. Given the shortage of specialists in this area, doctors should concentrate on those areas requiring medical expertise, working within a multidisciplinary team.

How the condition is dealt with / service currently delivered?

- Audiology/audiovestibular medicine (AVM) services are currently delivered in an inconsistent way across the UK[107].
- RCPCH censuses from 2011 to 2015 show a wide range of specialists involved in audiology including audiovestibular physicians, community paediatricians with and without audiology training, general paediatricians and ENT surgeons all providing aetiological investigations for permanent childhood hearing loss.
- In 2015, 33% of those providing this service for babies and 39% for any age were trained in AVM or paediatric audiology, an improvement from the 2011 census (28% for both groups).
- Despite the development of AVM as a specialty, 53% of the services for babies are provided by paediatricians (community 45%, general 8%) as are 55% of the services for children of any ages (community 48%, general 7%).
- Paediatricians are also still involved in providing tier 2 i.e. referrals from screening (34% of services) and tier 3 i.e. comprehensive assessment (23% of services) audiology clinics.

Options for future treatment of condition/delivery of service?

Both the RCP (Royal College of Physicians) and the RCPCH have raised concerns about the shortage of medical practitioners trained in audiology/AVM. The RCP has highlighted the shortage of applicants for training in AVM and in particular the shortage of paediatric trained applicants[107]. The RCPCH has also highlighted the decreasing numbers of community paediatricians trained in paediatric audiology in the 2013 census[108]. This is a quality issue impacting on children and families: those seen by doctors trained in audiology/AVM are significantly more likely to be investigated correctly and there is patchy access to specialist services across the UK[109] reflecting the variation in AVM physicians around the UK[110]. There is a need to further develop clinical networks of local and specialist centres as described in the DH guide. There will also be a need for community paediatricians to be able to gain competences in audiology/audiovestibular medicine for the foreseeable future, to contribute to the networks.

P: Vision impairment

Definition

Vision impairment (VI) is present when 'The child or young person's vision impairment interferes with optimal development, learning and achievements, unless adaptations are made in the methods of presenting learning experiences, the nature of the materials used and/or the learning environment. (The term 'learning' includes not just academic learning but the acquisition of mobility, life and social skills)[111].

For practical purposes, this level is usually reached when visual acuity is logMAR 0.5 (approx. Snellen 6/18) or less[111] (this level of VI is likely to require educational support), but visual field loss can also be an important cause of visual difficulties. Severe visual impairment (SVI)/blindness is defined as logMAR 1.0 or Snellen 6/60 or less. These definitions do not include CYP whose poor vision can be corrected with glasses or contact lenses.

Data on the national incidence or prevalence of the condition

Overall 0.2% of children and young people have moderate or severe VI. The incidence of SVI/blindness in the British Childhood VI study (2000) was 4/10,000 children with the RNIB[111] quoting similar rates (5/10,000 with SVI). SVI is a low incidence disability and therefore needs specialist provision[112].

At least 50% of children and young people with VI have additional needs, and a further 30% have complex needs. Visual impairment or difficulties can also complicate other conditions. An estimated 5.6% of children up to the age of 16 with a learning disability are blind or partially sighted[111].

Certain conditions are also linked with VI e.g. cerebral palsy, Down's syndrome.

In England and Wales, 66% and 70% children respectively who have a VI are educated in mainstream schools, rising to 83%[113]in Scotland. There are no comparable figures for Northern Ireland (NI). The remainder mostly attend special schools in line with their comorbidities. Only a tiny proportion (2% in England, less than 1% in Wales) attend specialist schools designated for blind and partially sighted learners[112].

Clinical and service planning guidance for this condition or service

UK-wide

- The UK NSC recommendation on Vision defects screening in children[114]
- For families and carers – Vision – Down's syndrome association[115]
- Royal College of Ophthalmologists – Vision screening for children[116]
- Guidelines on visual screening in children[117]
- Evidence for vision screening of children (NICE)[118]
- RNIB CYP Evidence-based reviews for each UK country[112]
- Ophthalmic Services for Children[119]
- Guidelines and Pathway for putting the UK Vision Strategy into Action for Children and Young People (0 to 25 years) with Vision Impairment, and their Families[120]

England

- Framework for provision of eye care in special schools in England 2016[121]
- Developing a Local Offer for children and young people with vision impairment: RNIB advice to LAs)[111]

Scotland

- VI Network for Children and Young People (Scotland) standards[122]
- Generic pathway[123]
- Cerebral visual impairment pathway[124]

- Annual reports from Vision impairment network for children and young people (VINCYP) (Scotland)[125]

Wales

- Growing up and Moving On[126]

Workforce implications of the standards or guidance

- About two thirds of CYP with SVI are diagnosed before the age of 1 year, usually through parental concern, screening or risk factors[127]. About half will present to hospital paediatricians. Children will generally be referred direct to ophthalmology for ophthalmic evaluation and diagnosis.
- The community paediatrician, working closely with other professionals from health, education and social care, has a key role in making a holistic assessment of the child's needs and ensuring that the child's developmental needs are adequately met. In particular they will need to ensure that other aspects of the underlying cause of the VI are fully addressed, through aetiological investigations and referral to relevant tertiary services e.g. clinical genetics, endocrinology, paediatric neurology.
- They will also be required to provide SEND advice.
- Community paediatricians also have a role to play in ensuring that children with other disabilities are appropriately evaluated for ocular or visual disorders alongside their disability. They should seek to advocate that ophthalmic care and evaluation takes account of any wider developmental condition and be able to interpret the ophthalmic information in light of the child's other difficulties. They may also have a role in teaching and training a range of health and other professionals about visual impairment and its implications.

How the condition is dealt with / service currently delivered

- 17% of services provide a specific multidisciplinary clinic for children with vision impairment.
- 12 out of 13 teams involve a community paediatrician, orthoptist and vision support teacher.
- Community paediatricians may be involved in screening through their lead role in the healthy child programme.

Options for future treatment of condition/delivery of service

Given the small numbers involved, the need for specialist assessment[128] and the need to develop an expertise and understanding of a variety of conditions leading to VI, community paediatric services are likely to require a paediatrician with a special interest in VI. Such paediatricians are likely to work within a network, similar to those for hearing impairment, with clear referral pathways[124] and working arrangements as is already the case in Scotland[122].

Q: Constipation, soiling, urinary incontinence

Definition

Constipation means not passing stools regularly or being unable to completely empty your bowel. Constipation with no anatomical or physiological cause is termed 'idiopathic'

Nocturnal enuresis is defined as ‘the symptom of involuntary wetting during sleep without any inherent suggestion of frequency or pathophysiology’ (NICE 2010).

Data on the national incidence or prevalence of the condition

- Constipation affects up to 30% of children; without early diagnosis and treatment it can become a chronic condition that is difficult to resolve. One third of children suffering with idiopathic constipation may need referral to secondary care for the management of chronic constipation[129].
- 21% of children aged four and a half years and 8% of nine and a half years wet the bed occasionally.
- More frequent bedwetting is known to affect 8% at four and a half and only 1.5% will still have the problem at nine and a half (Butler and Heron 2008[130]).
- There is a hereditary link and boys are affected more than girls.
- There is evidence that children with bedwetting are more likely to have behaviour problems[131] and stress within families can be considerable with an increased risk of child punishment including child abuse[132].
- At the age of seven approximately 3% of girls and 2% of boys experience daytime wetting at least once a week. Less than 1% of daytime wetting is caused by organic causes but it should always be assessed. Daytime wetting may be functional with no underlying anatomical or neurological problem.

Clinical and service planning guidance for this condition or service

- Enuresis: The management of bedwetting in children and young people (NICE) [133].
- Urinary tract infection: diagnosis, treatment and long-term management of urinary tract infection in children (NICE)[134]
- Constipation in children and young people(NICE)[135] offers strategies to support early diagnosis and timely and effective management.

Workforce implications of the standards or guidance

While these services are mainly provided by nurse-led services, paediatric advice may be needed in complex cases especially if an organic cause needs to be investigated or medication prescribed. In such cases, these services would be included in general community or acute clinics.

How the condition is dealt with / service currently delivered

- 30% of services provide enuresis clinics and 10.5% constipation/encopresis clinics.

Options for future treatment of condition/delivery of service

Services should ensure that paediatricians review only those cases needing medical input.

R: Long term medical conditions

Definition

Long term conditions (LTCs) are conditions that cannot currently be cured but can be controlled with the use of medication and/or other therapies. They result from disease, damage, disorder to the body which then impacts on the individual and their family, such as diabetes, epilepsy, asthma, congenital heart disease and multi-system disorders such as cystic fibrosis or autoimmune disease. Neurodevelopmental and neurodisabling conditions such as ASD, ADHD, genetic syndromes and motor disorders are not usually classified as LTCs & are covered elsewhere in this guidance.

Data on the national incidence or prevalence of the condition

- Around 1.1 million children and young people (1 in 11) in the UK have asthma, making it the most common long-term medical condition[136].
- Some 600,000 people in the UK have epilepsy - around 1% of the population - with young people under 18 accounting for around 10% of this total[137].
- At least 31,500 children and young people under 19 in the UK have diabetes, with about 95.1% having type 1 diabetes, 1.9% having type 2 diabetes, and a further 2.7% with diabetes whose diagnosis is unknown[138].
- In 2012-2014, there was an average of 1,756 new cases of cancer in children per year in the UK The crude incidence rate shows that there are 164 new cancer cases for every million boys aged 0-14 in the UK, and 147 for every million girls aged 0-14[139].

Clinical and service planning guidance for this condition or service

It is important that CCH services work collaboratively with local hospital based paediatric services and tertiary services for this client group, facilitating a smooth patient journey but not duplicating services provided elsewhere. They may be required to give advice to schools or the local authority as part of their SEND responsibilities. Managing these issues requires a local multiagency team to complement the specialist elements of care provided often in hospital settings.

Workforce implications of the standards or guidance

Where community paediatricians are involved in providing these services care would include assessment, diagnosis, care planning and management in conjunction with primary, secondary and tertiary services, specialist clinics, education and social care to develop a single care plan[140].

How the condition is dealt with / service currently delivered?

The survey did not collect data on involvement in this area of work, but the RCPCH census shows a continuing decline in consultants working jointly in general and community paediatrics.

Options for future treatment of condition/delivery of service?

It is not possible to provide specific guidance on CCH workforce requirements for this group of patients. However, it is important to be mindful of the limitation of scarce availability of community paediatricians nationally, and therefore maximising skill-mix to reduce demand on community paediatrician resource is crucial. Where community paediatrics is providing such services, they should be paid by tariff.

S: Mental health and behavioural problems

Definition

There is a wide range of emotional and behavioural problems which present during childhood and adolescence. This section does not discuss neurodevelopmental disorders e.g. ADHD, ASD as these are covered in sections J and K above, but refers to specific mental health conditions e.g. 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.

Data on the national incidence or prevalence of the condition

1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is around three children in every class[141].
The risk of a mental health disorder is increased in a number of groups seen by community paediatricians:

- Almost half the children in care have a mental health disorder[54]
- Children with learning disabilities and other neurodevelopmental conditions have an increased likelihood of mental health and behaviour disorders and problems[142]
- Behaviour and mental health problems are more commonly encountered in families with psychosocial risk[143].

Clinical and service planning guidance for this condition or service

NICE guidance covers: (for England and Wales)

- Social and emotional wellbeing early years[144]
- Social and emotional wellbeing primary education[145]
- Social and emotional wellbeing secondary education[146]
- Looked after children and young people[59]
- Chronic Fatigue Syndrome[147]
- Depression in children and young people[148]
- Bipolar disorder psychosis and schizophrenia quality standard[149]
- Eating disorders in over 8s[150]
- Antisocial behaviour and conduct disorder in children and young people[151]
- Children's attachment[152]
- Self-harm[153]
- Substance misuse interventions in vulnerable under-25s[154]
- Conduct disorders[155]

NHS Scotland have considered the NICE guidance where appropriate, supported the action points, subject, where appropriate, to adaptation to fit Scottish organisational arrangements.

The Northern Ireland assembly produced a comprehensive paper on Mental Health in 2017 which describes care pathways with specific reference to CAMHS[156].

Workforce implications of the standards or guidance

While community paediatricians may often identify CYP with these conditions, they are not usually trained to assess and treat them. Effective management requires access to psychological therapies and, sometimes, psychotropic medication which most community paediatricians are not trained to use. Therefore community paediatricians have a different set of competences from CAMHS professionals[129,143,157].

How the condition is dealt with / service currently delivered

- These conditions should usually be seen and treated within a comprehensive CAMHS service. Underfunding of CAMHS services can lead to increased pressure on community paediatrics. It is important to make use of the skills of both services efficiently; it is inappropriate for community paediatricians to cover inadequately provided CAMHS. Effective services require clarity in commissioning and clear referral pathways in place.

- The RCPCH Workforce Census 2013 revealed a decline in regular educational meetings with CAMHS from 15.4% in 2011 to 12.8% in 2013, ad hoc meetings 42% to 26.8% and an increase from 11.7% to 15% of services who have no direct contact with their local CAMHS[108].

Options for future treatment of condition/delivery of service?

Future in Mind[158] recognises the contribution of paediatricians to targeted and specialist mental health services. Clarity is required in contracts about referral pathways and in relation to who sees what conditions.

Child public health

Child public health is largely concerned with improving the health of children through population or community based interventions. Community paediatricians have additional training and skills in this area and are well placed to lead and contribute to a range of public health initiatives[159,160,161]. The organisation of child public health and the contribution of paediatricians differ markedly across the 4 Nations. In some areas they work closely with public health colleagues in planning and delivering local interventions whereas in other areas their input is minimal. Implementation of the Health and Social Care Act has had a marked effect on their current role in England. A number of the statutory roles include a public health focus e.g. for child deaths, and further details about 2 specific areas of work that were included in the survey can be found below.

T: Childhood immunisation

Definition

Strategic and clinical advice for the routine and targeted childhood immunisation programme including liaison with families whose children have not been immunised, targeting vulnerable children, oversight of uptake database, advising other health professionals regarding individual children and training around programme developments and local issues.

Data on the national incidence or prevalence of the condition

Although uptake overall remains high, the 2015-16 annual immunisation statistics for England[162] show that coverage for most childhood vaccines by 12 and 24 months of age, has fallen for the third consecutive year. The uptake in Wales, Northern Ireland and Scotland is consistently higher than in England.

Clinical and service planning guidance for this condition or service

Most childhood immunisations are delivered by primary care, midwives and school immunisation teams with promotion by health visitors. The role of immunisation coordinator was usually provided by a community paediatrician, providing clinical expertise, training and local leadership but the transfer in England of this function to Public Health England has changed the contractual arrangements.

UK-wide
- The scientific rationale and guidance for the programme is determined by the UK-wide Joint Committee on Vaccination and Immunisation[163]
- The Green Book[164] provides extensive information on vaccines and immunisation requirements and is updated regularly online

England, Wales and Northern Ireland
- There are national minimum standards for immunisation training[165].

England
- NICE guidance[166] on increasing uptake.

Wales
- Child Health Immunisation process standards for Wales[167].

Workforce implications of the standards or guidance

There are clear targets for immunisation and coverage is measured at 12 months, 24 months and five years across the UK. Staff must be well trained, regularly updated and be able to access expert advice. There are particular pressures on staff in the early winter when childhood ‘flu immunisation is offered annually to large cohorts of children.

How the service is currently delivered?

- In England, implementation guidance comes through Public Health England, in Scotland it is led by NHS Health Scotland, in Wales by Public Health Wales and in Northern Ireland by the HSC Public Health Agency.
- In 2015, 27% of clinical departments responding to the RCPCH census provided the role of immunisation co-ordinator, falling from 54% in 2011 and 52% in 2013.
- The role was filled in 38/39 organisations, 24 by paediatricians.
- On average 0.54 PAs were allocated for the role (23 responded out of 39)
- In the UK survey of CCH 2016, 26% (20/78) of responders provided a specialist immunisation service with an average of 0.6PAs spent giving advice per week.

Options for future treatment of condition/delivery of service?

Pharmacists, non-clinical staff and private organisations providing immunisation e.g. nasal ‘flu. Regional advice services are now in place in England, covering more than one CCG. However, there is a risk of loss of local coordination and clinical expertise.

U: Healthy child programmes (including screening)

Definition

The universal programme of health promotion, monitoring and support for children and their parents with additional services where needed is delivered by health visitors, primary care and other practitioners.

In some areas, the role of child health promotion lead/coordinator was covered by community paediatricians providing local guidance, training and overall co-ordination of the programme as part of a multi-disciplinary/multi-agency team[168]. Community paediatricians may also provide clinical expertise and coordination of the new-born blood spot screening.

Clinical and service planning guidance for this condition or service

The details vary across the four nations but all provide a programme of universal health care for pre-school children. In England this is The Healthy Child Programme, Pregnancy and the First Five Years of Life[169] and from 5 to 19 years old[170]. In Scotland The Child Health Programme[171] in Northern Ireland Healthy Child, Healthy Futures[172] and Healthy Child Wales[173]. The commissioning of the programme also varies between nations.

Workforce implications of the standards or guidance

No standards currently exist for the role of healthy child programme coordinator and the number of clinical departments providing the role is decreasing despite it being a requirement of The Healthy Child Programme[174]. A paper by Blair in 2001 describes the benefits of the role for the programme and Strengthening the Care of Children in the Community[175] notes the special skills of community paediatricians in developmental, social and educational paediatrics and their special responsibility in supporting GPs in these aspects of their work.

How the service is currently delivered

- In the 2011 RCPCH Census, the coordinating role was provided by 20% of clinical departments. In 2015, 58/199 did not respond. Of the remaining 141, only 17 (12.1%) said it existed in their organisation and 6 said role provided by another organisation
- Paediatricians had on average 0.4 PA for this role
- Health promotion/child health surveillance clinics are now usually provided in primary care. However from 103 departments in survey, 4% provided routine health promotion clinics, 96% did not provide and 25 did not respond to this question.

Options for future treatment of condition/delivery of service

Components of the programme in England are now commissioned by different organisations with a risk of fragmentation and gaps in service provision. There remains a need for coordination of an evidence based programme, training and cross agency local pathway development.

V: Palliative care services

Definition

Paediatric palliative medicine is the medical care of children suffering from conditions that will limit their lifespan, particularly those who are not expected to survive beyond childhood.

This care is usually delivered by children's community nursing teams and/or hospices and local palliative care teams linked with acute or community paediatricians. This team might include nurses, psychologists, therapists and healthcare assistants, social workers and hospice services providing medical advice to the child and family and planning the service delivery. Some community paediatricians with specialist expertise contribute to the pathways, medical input and leadership to (usually) nurse led team.

Highly specialised palliative care is centrally commissioned as a specialist service by NHS England[176].

Data on the national incidence or prevalence of the condition

Fraser et al[177] estimate that there are at least 49,000 children and young people under 19 years old in the UK living with a life-limiting or life-threatening condition that may require palliative care services; around 16/10,000 population aged 0-19 and around 1 per 10,000 neonatal population.

Clinical and service planning guidance for this condition or service

England and Wales

- NICE guidance End of Life Care for Infants Children and Young People[178].

Scotland

- In Scotland there is a framework for the delivery of children's palliative care[179] which requires every health board to identify a lead doctor and lead nurse for palliative care.

Workforce implications of the standards or guidance

Provision is usually by caseload - there are usually no fixed clinics - and depends upon the design of the team around the child in terms of the level of involvement of the community paediatrician. This work can be time-consuming and, where provided by community paediatricians, would need to be appropriately resourced.

How the service is currently delivered?

We did not specifically ask about palliative care in the survey, three services identified this as a specific service they provided.

Options for future treatment of condition/delivery of service?

Network provision managed across several local areas to combine expertise and offer 24/7 coverage and advice to support local paediatricians and children's community nursing teams.

6 Workforce calculator

6.1 Rationale

This is an evidence-based tool to calculate the number of paediatricians needed to provide a CCH service given the input of a range of factors. The tool and guidance can be found at www.rcpch.ac.uk/cch.

The tool has been designed to help teams demonstrate the paediatric staffing required for the delivery of services. It should be used in conjunction with detailed dialogue with the clinical team to ensure that the full demand on the service is identified and that nursing, therapy and other agency support is being used as much as possible, under the oversight of the paediatricians where appropriate, so their expertise is used as effectively as possible.

There are two options for using the calculator (simple and detailed) which provide an output of the number of WTE consultant and SAS doctors required for a service. This requires the input of activity data and other information. The key information required for both options is the number of new and follow up appointments provided by the service in a year. For current activity, the user should use actual figures and, if desired, add estimated figures for future demand in the appropriate cells. Users may wish to run the calculator more than once to test the impact of different levels of future demand. This can then be taken forward in dialogues about the service with service planners/commissioners. Table 5 sets out the estimated number of new and follow up appointments in a service given a range of population and referral data. These estimates are based on returns from the UK survey of CCH service 2016 using the first quartile (small), median (average) and third quartile (large) of services which were able to provide data for all activity indicators.

Table 5: Appointment numbers by service and population size

	Total population	Child 0-19 population	Referrals to CCH	New appointments	Follow up appointments
Small service	133708	35094	700	595	1231
Average service	319754	83925	1674	1423	2943
Large service	573036	150403	3000	2550	5274

6.2 How the calculator works

Simple calculator

The simple model is intended for services who have limited information about their activity and demand. Seven input values are required:-

1. The number of new appointments currently available in your service per annum (include WNB/DNA) for all services you offer. This should be the number you have offered in the last year or calculate you can offer given your current capacity. Include all clinical activity - work in special schools, IHAs, safeguarding assessments.
2. The number of additional new appointments you should have offered in order to meet demand. You may choose to use the difference between the number of accepted referrals in your service and the number of new appointments you are able to offer (i.e. the figure in 1. above) as a way of estimating this. Alternatively an estimate based on waiting lists could be entered.
3. The number of follow up appointments currently available in your service per annum (include WNB/DNA) for all services (as above). This should be the number you have offered in the last year or the number that you calculate can be offered given your current capacity.
4. The number of programmed activities allocated to provide statutory roles per week. To help you, recommended guidance for the number of PAs for each of these roles are provided in the notes to the calculator.
5. Allowance for child protection rota commitment in PAs per week for the whole team e.g. if the team provides an afternoon rota each weekday this amounts to 5 PAs per week, or if the team provide 9 to 5 cover Monday to Friday this will equal 10 PAs per week.
6. The average number of supporting professional activities (SPAs) per doctor per week. The BMA standard for England is an average of 2.5 per doctor. This varies across the UK for example In Wales, new consultant contracts are currently offered with 3 SPAs
7. An estimate for travel time in PAs per week per doctor.

The simple calculator uses fixed values for the following factors based on our survey results. These cannot be changed in the calculator:-

1. New patient appointment length – 60 minutes
2. Follow up patient appointment length - 30 minutes
3. Patient administration per clinic time – 1.0 PAs

4. Minutes per PA - 240 (4 hours) (Contract standard).
5. PAs per doctor per WTE week - 10 (Contract standard).

If you wish to input your own values for these, use the detailed calculator instead. The fixed values in the simple model will also be reviewed when up-to-date benchmarking data becomes available in the future.

Outputs calculated

- Additional follow up appointments required to meet demand. This calculation uses the ratio of follow up to new appointments entered and applies that ratio to the estimate of additional new appointments entered.
- Total clinic PAs per annum i.e. total time for all appointments plus patient admin per year for the service.
- Total clinic PAs required per week.
- Total DCC PAs required per week for your CCH service i.e. total clinic PAs plus statutory roles and child protection rota PAs.
- Total WTE consultants and SAS doctor equivalents required accounting for SPAs and travel time.

NOTE: Many CCH services are staffed largely by part time clinicians and so the total number of PAs required may exceed those for a body of whole time staff in order to accommodate SPAs.

Detailed calculator

The detailed calculator allows users to input many of their own values instead of using the fixed values of the simple model. First, it allows, if required and knowledge exists, for the input of different factors for individual types of clinics and services on different lines in the model, so for example different appointment lengths could be input for general clinics, ASD clinics, MDTs, etc. In addition, users can set the WNB/DNA rate for new and follow up appointments in their own service if known. Only the value of 10 PAs for a WTE consultant remains fixed in the detailed model.

Outputs calculated by the detailed calculator are the same as the simple calculator.

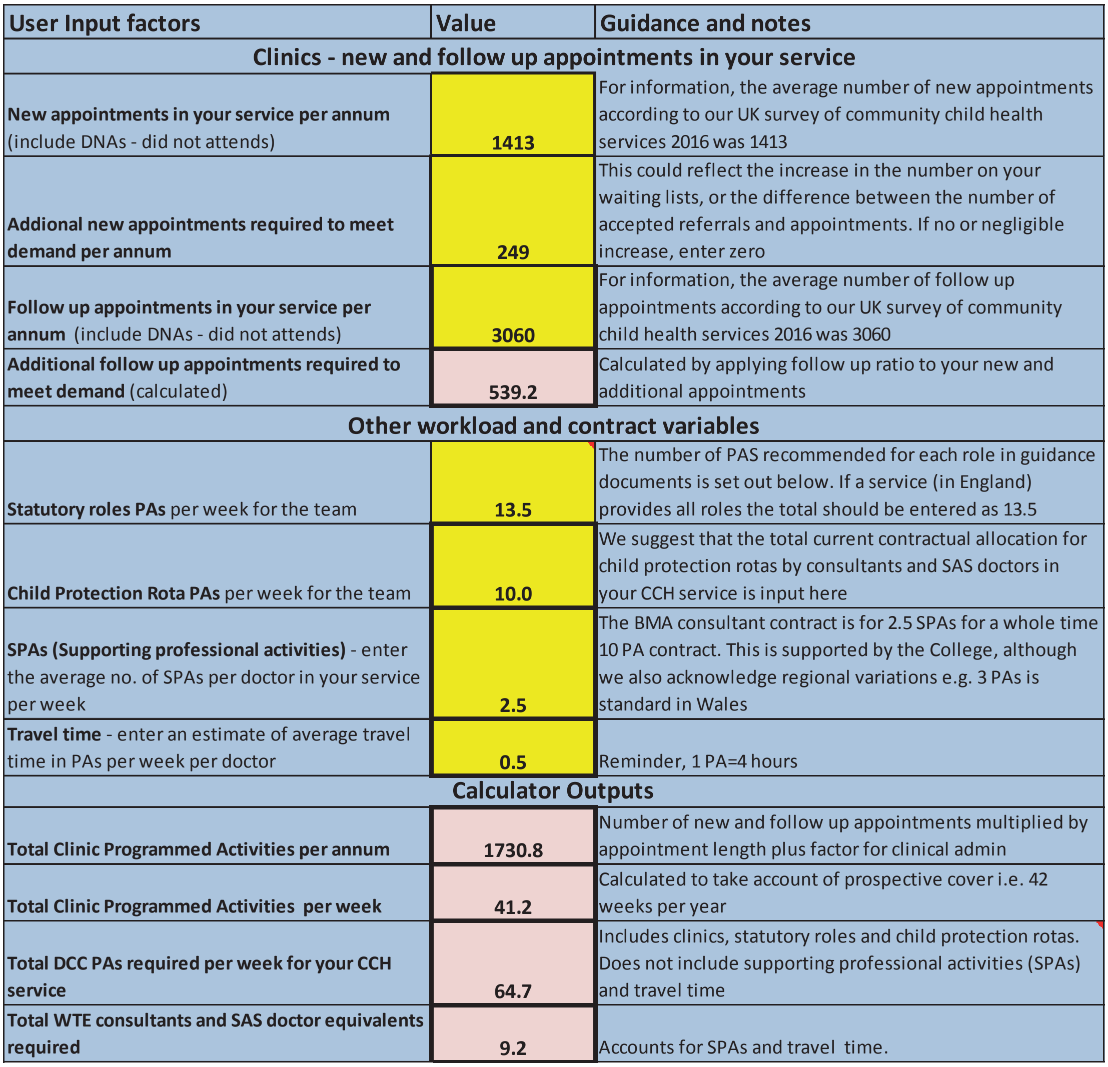
6.3 Calculator examples

Example 1: A medium sized service using the simple calculator

New and follow up appointments in this example are taken from the estimates for an average size service in table 6. The estimate for additional new appointments in this example is based on the difference between referrals received and appointments offered, assuming all referrals are accepted. However this may not always be the case and would require adjustment depending on referral acceptance rates. The estimates for PAs for lead roles are based on a service in England providing all the lead roles with the exception of immunisation co-ordinator and healthy child programme co-ordinator which are increasingly public health roles. Travel PAs are an estimate of approximately 0.5 per doctor and PAs to cover the child protection rota are for 9 to 5 Monday to Friday.

Using these inputs, the output from the calculator suggests that 9.1 WTE paediatricians are required to support this level of service demand. This equals 2.8 per 100,000 total population or 10.8 per 100,000 0-19 population.

Table 6: A medium sized service using the simple calculator



User Input factors	Value	Guidance and notes
Clinics - new and follow up appointments in your service		
New appointments in your service per annum (include DNAs - did not attends)	**1413**	For information, the average number of new appointments according to our UK survey of community child health services 2016 was 1413
Addional new appointments required to meet demand per annum	**249**	This could reflect the increase in the number on your waiting lists, or the difference between the number of accepted referrals and appointments. If no or negligible increase, enter zero
Follow up appointments in your service per annum (include DNAs - did not attends)	**3060**	For information, the average number of follow up appointments according to our UK survey of community child health services 2016 was 3060
Additional follow up appointments required to meet demand (calculated)	**539.2**	Calculated by applying follow up ratio to your new and additional appointments
Other workload and contract variables		
Statutory roles PAs per week for the team	**13.5**	The number of PAS recommended for each role in guidance documents is set out below. If a service (in England) provides all roles the total should be entered as 13.5
Child Protection Rota PAs per week for the team	**10.0**	We suggest that the total current contractual allocation for child protection rotas by consultants and SAS doctors in your CCH service is input here
SPAs (Supporting professional activities) - enter the average no. of SPAs per doctor in your service per week	**2.5**	The BMA consultant contract is for 2.5 SPAs for a whole time 10 PA contract. This is supported by the College, although we also acknowledge regional variations e.g. 3 PAs is standard in Wales
Travel time - enter an estimate of average travel time in PAs per week per doctor	**0.5**	Reminder, 1 PA=4 hours
Calculator Outputs		
Total Clinic Programmed Activities per annum	**1730.8**	Number of new and follow up appointments multiplied by appointment length plus factor for clinical admin
Total Clinic Programmed Activities per week	**41.2**	Calculated to take account of prospective cover i.e. 42 weeks per year
Total DCC PAs required per week for your CCH service	**64.7**	Includes clinics, statutory roles and child protection rotas. Does not include supporting professional activities (SPAs) and travel time
Total WTE consultants and SAS doctor equivalents required	**9.2**	Accounts for SPAs and travel time.

Example 2: A large service using the detailed calculator

This example (table 7) reflects a service where there are a large number of referrals overall and the service has more detailed information on the number of appointments, WNB/DNA rates and appointment lengths for its ASD, ADHD and other services. The detailed calculator allows different factors to be entered for different clinics.

Table 7: Calculator example 2 - A busy service using the detailed calculator

Clinic	New appointments in your service per annum	Addional new appointments required to meet demand per annum	DNA rate for new appointments	Length of new appointment in minutes	Follow up appointments in your service per annum	Additional follow up appointments required to meet demand (calculated)	DNA rate for follow up appts	Length of follow up appointment in minutes	Patient admin allocation for this clinic (PAs per 1 Clinic PA)	Total PAs for clinic per annum
Example	*200*	*20*	*10.8%*	*60*	*400*	*40*	*12.0%*	*30*	*0.85*	226.7
ASD	500	100	*10.8%*	60	1274	**254.8**	*12.8%*	30	1	**763.5**
ADHD	350	75	*10.5%*	60	500	**107.1**	*11.0%*	35	1	**431.4**
IHAs	100	10	*11.0%*	80		**0.0**			1	**81.4**
MDTs	200	20	*10.9%*	75	450	**45.0**	*13.0%*	35	0.9	**299.8**
All other clini	1300	200	*10.8%*	55	2900	**446.2**	*12.8%*	30	1	**1705.4**
										0.0

Total Clinic Programmed Activities per annum	**3281.5**	PAs for new and follow up appointments, accounting for DNAs, appointment length and clinical admin
Average Consultant availability in weeks (prospective cover)	**42.0**	In order to account for annual leave, study leave etc. Standard = 42 weeks
Total Clinic Programmed Activities per week	**78.1**	DCC per week calculated to take account of prospective cover
Statutory roles PAs per week for the team	**13.5**	The number of PAS recommended for each role in guidance documents is set out below. If a service (in England) provides all roles the total should be entered as 13.5
Child Protection Rota PAs per week for the team	**10.0**	Total contractual allocation for CP rotas by consultants/SAS doctors in CCH service
Total DCC PAs required per week for your CCH service	**101.6**	Includes DCC, statutory roles, and child protection rotas
SPAs (Supporting professional activities) - enter the average no. of SPAs per doctor in your service per week	**2.5**	2.5 PAs = standard contract
Travel time - enter an estimate of average travel time in PAs per week per doctor	**0.5**	Reminder, 1 PA=4 hours
Total WTE consultants and SAS doctor equivalents required	**14.5**	

6.4 UK demand for community paediatricians

Calculating the workforce demand for consultants and SAS doctors in CCH is a difficult task and subject to many factors including trends in childhood illness, new legislation, changes in NHS structure and the views of different health professionals on the most effective way to deliver the service. In 1999, BACCH estimated that 4.5 WTE were required[1] per 100,000 population. However this estimate included PAs for several services which are now undertaken mostly or wholly by other professional groups; these include routine audiology, school health (including school entry medicals), health promotion activities, routine input to social care nurseries and immunisation/vaccination programmes.

Identifying and measuring demand not met by current workforce capacity is imprecise and relies on good evidence. Using the calculator tool and the findings from the UK survey of clinical leads, the following analysis provides an estimate which we believe is broadly in line with the current demands on the CCH workforce.

The method we have used is to look at the ratio of referrals to the number of appointments offered. The data from our survey gives a ratio of 1.176:1, or 17.6% of demand not met. An alternative method of looking at unmet demand is to consider waiting list times. Our survey found an average of 14.6 weeks. However, waiting lists are built up over a longer period than a year. If we assume 2 years, then unmet demand by using the waiting list measure would be 7.3 weeks, which equates to around 17.4% of time available in the average consultant job plan (taking into account prospective cover). This therefore supports our referral/new appointments ratio finding.

Not all referrals are accepted (and the survey was not able to provide that data). However, the working group believed it reasonable to assume that the proportion of referrals not accepted would be broadly balanced by those referrals which were accepted, the child was not brought and they were re-referred or re-appointed and therefore eventually seen.

Applying this increase to an average sized service through the calculator tool generated a demand of 9.2 WTE. By weighting this for the current UK population, an overall demand of 1578 WTE is obtained. The RCPCH workforce census of 2015 shows that there was a consultant and SAS doctor workforce of 1257 WTE in the UK or 1.93 WTE per 100,000 total population i.e. an increase above current staffing level of approximately 25% would be needed to meet our calculated demand. This increase assumes that all services will provide the recommended PAs for statutory roles and allocate appropriate PAs for clinical administration.

While a shortfall of 25% is higher than the RCPCH estimate[180] for the required increase in consultant numbers of 20% across the whole of paediatrics, data shows that community paediatrics has the highest level of vacancies in paediatrics and has been disproportionately affected by the decline in SAS doctors over recent years.

7 Information recording guidance

7.1 Activity and demand data

It has become clear from Invited Review visits and responses to the survey that some CCH teams are unable to collect and access data about activity and demand.

Set out below is the core data that the project group recommends every community team should be monitoring regularly in order to assess, plan and appropriately staff their service. They are derived from the service review template[181] and the BEST standards document available from BACCH[182] (web page).

The Children and Young People's Health Services data set (V1.5)[19] is mandated in England for collection by NHS trusts and enables national statistics, trends and policy to be determined. From 1 October 2017 this will be subsumed into the (all age) Community Services Data Set[183], and all NHS providers will be required to submit data centrally from 1 November 2017. Eventually better data should be readily available to clinicians and managers and more detailed diagnosis-related activity data may be extractable for monitoring commissioning contracts and disease management.

The data proposed for collection falls into two types – background demographic/service information, and dynamic performance data, which can be presented in dashboard model, and monitored regularly at governance meetings. An example dashboard is a practice example on the RCPCH CCH webpage.

7.2 Information that should be available to all CCH services

- Service specification/relevant section of contract with commissioners
- Details of tariff/contract funding.
- Complaints, compliments, incidents, risk assessments and root cause analyses, identifying overall numbers, themes and actions required.
- Serious case review and serious untoward incidence reports and recommendations.
- Information about patient feedback and involvement.
- Quality Improvement plan.
- Staff establishment, including WTE of all doctors and agreed individual job plans.
- Nurses and AHPs (including therapists and psychologists) directly supporting CCH Service (WTE for each role type).
- Statutory inspection reports, recommendations and action plans.

7.3 Population and activity data

This may be available from Public Health England[184], from the Welsh Government[185] .from the Scottish Goverment[186] and the Department of Health in Northern Ireland[187]

- Child population served by the service by age range.
- Five year trend of births (including low birthweight and prematurity).
- Five year trend of childhood deaths.
- Deprivation data.
- Number with child protection plan (SFR52 annual statistics DFE).
- Number of children looked after by the local authority (SFR41 annual statistics DFE).
- Number being newly looked after per year (SFR41 annual statistics DFE).
- Number presented to adoption panels per year.
- Number of children with EHCPs (SFR22 annual statistics DFE).
- Number of children in special schools (can be calculated from SFR22 provided all in special schools need EHCP/Statement for admission).
- Number requiring new SEND assessment/statementing (SFR22).

7.4 Clinical performance related data

- Local clinical pathways including referral and discharge criteria for all clinics (please refer to service templates and select clinics/services provided locally).
- Numerical data on the services, including accepted referrals, cases on review caseload, new and review appointments offered, waiting times, capacity and demand, and WNB/DNA rate, broken down into separate services e.g. general clinics, adoption work, EHCP work.
- Compliance with timescales for statutory and NHS work (local authority figures for LAC health assessments completed are available in SFR41 but not those completed on time and do not indicate the reason for any delays; local authority figures for SEND/EHCP completion available in SFR22, but does not indicate the reason for any delays).
- New to follow up ratio. Needs to be interpreted as it may vary according to patch and service characteristics such as deprivation.
- Numerical data on individual clinician caseloads, new to follow up ratios and WNB/DNA rates for appraisal purposes.
- Proportion of clinical letters and reports sent out within required timescale e.g.72 hours for child protection[28], 10 days (7 days from 1.4.18) for trusts in England.
- Local audit findings and action plans.

8. Signposting

The resources below provide further advice and support with implementing and planning CCH services.

RCPCH Invited Reviews Service

The Invited Reviews Team can provide informal advice and support for paediatricians and managers about their service, drawing on a wide range of experience working with paediatric teams. They can link to the workforce data held by the RCPCH from the Census and other returns.

Web: www.rcpch.ac.uk/invitedreviews

Email: sue.eardley@rcpch.ac.uk

Phone: 020 7092 6091

RCPCH Workforce Team

The Workforce Team gather data through member and organisational surveys links with Health Education England (HEE) and national workforce planning bodies in Scotland, Wales and Northern Ireland, to provide an up to date picture of the state of the paediatric workforce and projections for future staffing needs and pressures. The team can support members with advice on job planning and rotas.

Web: www.rcpch.ac.uk/workforce

Email: workforce@rcpch,ac.uk

NHS Benchmarking

The NHS Benchmarking initiative provides comparative information for member trusts. It is self-completed by members, provides data on service activity, which can be compared with findings from the UK survey of CCH services.

Web: www.nhsbenchmarking.nhs.uk

Appendices

Appendix 1: Steering group and stakeholders

Project steering group

Dr Gabrielle Laing	Clinical Lead and BACCH Chair
Jacqueline Fitzgerald	Project Owner and RCPCH Director of Research and Policy
Martin McColgan	Project Manager and Workforce Information Manager
Dr Ben Ko	Convenor, BACCH (2014-16)
Dr Sita Jayakumar	BACCH Academic Convenor
Dr Cliona Ni Bhrolchain	CCH College Specialty Advisory Committee representative
Dr Simon Clark	RCPCH Officer for Workforce Planning
Sue Eardley	Head of Invited Reviews
Anna Rossiter	Project Administrator
Isobel Howe	Head of Policy/Health Policy Lead

Project Stakeholder group

Call for evidence submissions group

Dr Ann White	Consultant Community Paediatrician, Sussex Community Trust
Dr Ben Marsh	Plymouth Child Development Centre, Plymouth NHS Trust
Dr Charmari Wijemanne	Lewisham and Greenwich NHS Trust
Dawn Wade/Dr Cliona Ni Bhrolchain	Wirral University Teaching Hospital
Dr Hazel Douglas	Heart of England NHS Trust
Dr Jane Williams	Consultant Paediatrician, CCH and Neurodisability, Nottingham University Hospitals NHS Trust
Dr Krutika Patel	Clinical lead Leicestershire Partnership NHS Trust
Dr Laraine Dibble	Torbay and South Devon NHS Foundation Trust
Dr Lesley Ross	Consultant Paediatrician, Lothian, Edinburgh
Dr Lindsey McKenna Maxwell	NHS Greater Glasgow and Clyde and NHS Highland
Louise Bazalgette	NSPCC
Peter Richards (CEO)	NSPCC
Dr Ratna Sundrum	Sussex Community NHS Trust
Shona Crichton	The Communication Trust
Dr Serena Haywood	St Georges University Hospitals NHS Foundation Trust
Dr Sian Bennett	Associate Medical Director, Children and Specialist Services Brighton General Hospital
Dr Virginia Monteoliva	Sussex Community Trust
Dr Wendy D'Arrigo	Dorset County Hospital NHS Foundation Trust
Dr Liz Marder	Community Paediatrics, Nottingham Children's Hospital, Nottingham University Hospitals NHS Trust

Other stakeholders (informal contacts or attended stakeholder days)

Dr Neil Douglas	Clinical Lead Child Health, Tower Hamlets CCG, Specialty Doctor Community Paediatrics, Barts Health NHS Trust
Dr Hilary Smith	Consultant/Designated Doctor, Southampton
Dr Kate McCann	ST7 CCH Grid, Severn Deanery
Dr Julie Doherty	Consultant, Designated Doctor safeguarding, Dorset
Dr Dulmini Birkett	Consultant (Neurodisability), Central and NW London
Dr Shade Alu	Designated Doctor for Child Protection, Croydon Health Services NHS Trust and NHS Croydon CCG
Dr Angela Moore	Retired former Community paediatrician and medical director, Wolverhampton
Dr Gabriel Whitlingum	Consultant Paediatrician, Royal Hampshire County Hospital

Dr Lisa-Renee Sharpe	Consultant Paediatrician, Named Doctor Safeguarding, Greenwich, Oxleas
Dr Amy Taylor	Consultant Community Paediatrician Nottingham University Hospitals Trust
Dr Varsha Sadavarte	Consultant Paediatrician, University Hospitals of North Midlands NHS Trust
Dr Renu Jainer	Consultant Community Paediatrician, Solihull Heart of England NHS Trust
Catherine O'Byrne	ICCYPH Joint Programme Manager, Nottinghamshire County Council
Dr Venkat Reddy	Consultant Community Paediatrician, Children's Directorate
Dr Andrew Lloyd Evans	Consultant Neurodisability Paediatrician (Retired)
Dr Naomi Sherwood	Consultant paediatrician, Wythenshawe Community Paediatrics, Manchester
Dr Rachael Hughes	Community Paediatrician, Sheffield Children's Hospital
Dr Fawzia Rahman	Consultant Paediatrician (Retired)
Dr Christine Arnold	Associate Specialist Paediatrician, DD LAC, Virgin Care (Surrey)
Dr Louise Ramsden	Consultant Paediatrician, Sheffield Children's Hospital
Dr Julia Hale	Consultant Paediatrician, Barts Health NHS Trust
Dr Karen Horridge	BACD chair, Sunderland Royal Hospital
Dr Tanya Richardson	Specialty Doctor Community Paediatrics, Gloucestershire
Mary Reeston	Solihull Approach Manager
Debra Moore	Derbyshire Healthcare Foundation Trust
Dr Lisa Kauffmann	Consultant Community Paediatrician, Central Manchester University Hospitals NHS Foundation Trust, RCPCH Treasurer, BACCH Chair elect.
Dr Geoff Debelle	Consultant Community Paediatrician, Birmingham Children's Hospital NHS Foundation Trust, RCPCH Officer for Child Protection.

Appendix 2: Literature review search terms

a	Pathway development	b	Workforce planning and staffing	c	Service design & modelling
1	Pathway(s)	1	Associate specialist(s)	1	Care closer to home
2	Care pathway(s)	2	Calculating workforce need	2	Collaborative working
3	Clinical pathway(s)	3	Case mix	3	Combined child health service
4	Pathway specific standard(s)	4	Child development team	4	Community
5	Joint pathway(s)	5	Child health	5	Community based intervention(s)
6	Multi-agency pathway(s)	6	Child health promotion coordinator	6	Healthy child programme
7	Multi-disciplinary pathway(s)	7	Child public health consultant	7	Improving access
8	Pathway approach(s)	8	Consultant in public health	8	Innovative programme(s)
9	Pathway development(s)	9	Clinical director	9	Interagency working
10	Pathway(s) of care	10	Clinical lead	10	Integrated child health service
11	Pathway specific standard(s)	11	Community based paediatrician(s)	11	Life course epidemiological approach
12	Network(s)	12	Community nurse(s)	12	Multidisciplinary model
13	Clinical network(s)	13	Consultant community paediatrician(s)	13	Non-attendance
14	Condition specific standard(s)	14	Community paediatric nursing service	14	Service boundaries
15	Patient journey / journeys	15	Community paediatrician(s)	15	Service components
16	Condition pathway specific standard(s)	16	Community team(s)	16	Service configuration
17	Condition specific standard(s)	17	Competent clinician(s)	17	Service co-ordination
		18	Designated doctor(s)	18	Service demand(s)
		19	Human resource management	19	Service design
		20	Immunisation coordinator(s)	20	Service evaluation
		21	Medical professional(s)	21	Service level agreement(s)
		22	Model job description	22	Service planning
		23	Multi-agency team(s)	23	Service standard(s)
		24	Multi-disciplinary team(s)	24	Shared care
		25	Named doctor(s)	25	Skill mix
		26	Operational support	26	Structured decision-making methodologies
		27	Paediatric SAS doctor(s)	27	Targeted programme(s)
		28	Rapid response team	28	Team(s)
		29	Specialty doctor(s)	29	Team around the child
		30	Staff grade paediatrician(s)	30	Team around the family
		31	Staffing resources	31	Whole systems approach
		32	Staffing structure	32	Workforce modelling
		33	Trust doctor(s)	33	Working together
		34	Workforce planning		
		35	Workforce requirement(s)		

Appendix 3: Literature review evidence table

		Reference no		
		1	2	3
Paper identification information	Paper author(s)			
	Year			
	Paper title			
Section 1: Study design	Please briefly summarise the study aim(s)			
	Please briefly summarise the study design			
	Was the study carried out at more than one site?			
Section 2: Quality assessment	Is the paper methodologically sound? *(Evidence based? Peer reviewed? Robust methodology?)*			
Section 3: Area of research focus	Does the paper add anything to the following workforce related areas? *Please specify the relevant number(s) and provide further details if possible: (1) Workforce planning and staffing (2) Service design and modelling (3) Pathway development (see attached guidance for more information on these terms)*			
	Is the paper providing evidence for a service intervention? *A medical condition (eg ADHD) may be used to illustrate a service intervention, but a clinical intervention e.g. assessing effect of ADHD medication should not be included. Please specify the relevant number(s) and briefly describe the services involved: (1) More than one organisation working together (2) Working across professional boundaries e.g. Paediatricians with CAMHS (3) Different skill mix e.g. nurses in place of doctors (4) Other (5) Not applicable*			
Section 4: Effectiveness of intervention	Has the intervention been shown to make a difference to quality, safety, efficiency / effectiveness, cost or outcomes?			
	Do you think this intervention can be replicated by other services / trusts?			

Section 5: Final assessment	Does the paper fit with the project's aims*? **to update the 1999 BACCH workforce guidance, to develop a new evidence-based resource to enable identification of the workforce requirements and service models for a high quality community paediatric service*			
	Is evidence given to show how workforce could be utilised better? Please briefly summarise if so			
	Are conclusions in the study supported by the results? Were all important outcomes considered? Is there other information you would like to have seen?			
	Can key information which meets the project aims be extracted from the paper? Please briefly summarise			
	Please add any further comments on your own assessment of the study			
	Should the paper be used in the final outputs of the project? Please state - 'Keep' or 'Discard'			

Appendix 4: The national call for evidence form

We would like to hear new ways of working, innovative service models or clinical pathways that have made a difference to patient outcome, clinical effectiveness, service efficiency and/or patient experience. If you have such examples, please share with us by answering the questions that follow.

Please use a separate form for each piece of evidence that you wish to submit.

Questions

6. Your details:

Name	
Job title	
Organisation	
Email	

7. What area of CCH does your evidence relate to? (please tick all that apply)

☐ Child public health

☐ Safeguarding

☐ Looked after children/adoption and fostering

☐ Child death pathway

☐ Neurodevelopment/neuro disabilities/ complex health needs

☐ Mental health

☐ ADHD/ASD

☐ Long term medical conditions

☐ Palliative care

☐ Paediatric Audiology/Audiovestibular Medicine

☐ Teaching and training

☐ Research

☐ Service evaluation and improvement

☐ Other

8. Does your evidence or example …?

☐ Relate to more than one organisation working together. NO

☐ Relate to working across professional boundaries e.g. Paediatricians with CAMHS (Part of it)

9. How long has the example been running?

☐ Under 12 months or still in planning ☐ 12 months to 2 years ☐ Over 2 years

Not applicable

10. Tell us briefly about the evidence or example
11. Has the example demonstrated it has made a difference to quality, safety, efficiency or effectiveness cost or outcomes? Y
12. If yes please provide details including references or links (if any) to published documents
13. Are you aware of any published literature on community paediatric workforce? If so, please insert references below. Please do not include BACCH/RCPCH documents.
14. Would you be willing to meet the project team or wider group to discuss and/or present this innovation)?
15. Any additional comments or evidence that may be helpful or relevant to this project.

Thank you for contributing to this project

We'll keep you informed through the BACCH newsletter, RCPCH Bulletin and on the webpage www.rcpch.ac.uk/workforce

Appendix 5: The reviewing proforma used for assessing the submissions from the call for evidence

			Submission ref. (eg)		
Name / Organisation			1	2	3
Tell us briefly about the evidence or example here. Has it has made a difference to quality, safety, efficiency or effectiveness cost or outcomes?					
Population	Is the focus on community paediatrics specifically? (Y/N)	NOTES: Should be from a CCH setting			
Relevance	Is the submission providing evidence for a service intervention? (Y/N)	NOTES: A condition may be used to illustrate a *service* intervention, but not a *clinical* intervention			
Research quality	Is the submission of good methodological quality? (Very weak / Fair / Good / Excellent / NA)	NOTES: Evidence based? Peer reviewed? Robust methodology? Published? Please detail type of intervention eg RCT			
Effectiveness of intervention	Does the evidence in the submission demonstrate effective outcomes? (Y/N)	NOTES: Has a difference been made to quality, safety, efficiency, cost or outcomes?			
Research outcomes / key information	Can key information or outcomes be extracted from the paper? Do these meet the project aims? (Y/N)	NOTES: Project aims are - to update 1999 guidance into a new evidence-based resource			
Overall assessment of evidence submission	Can the intervention be replicated? Is the intervention novel? (Y/N)	NOTES: Provide further details if possible			
Contribution to workforce related area -	Does the paper add anything to the following workforce related areas?* (Y/N)	NOTES: (1) Workforce planning (2) Workforce staffing (3) Service design (4) Service modelling (5) Pathway development			
Should evidence be explored further	Final decision - Follow up for more information? (Keep) Or leave (Discard)	NOTES: Please state - 'Keep' or 'Discard'			

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