This edition finds me thinking, well worrying really, about workforce. Ably led by Elaine Lewis as our CSAC (College Specialty Advisory Committees) chair and Cliona Ni Bhrolchain as our workforce lead, the BACCH executive have been discussing our priorities for workforce development.

We have been thinking a great deal about how we can support the improvement of pathways of care for our patients, and how we ensure that children and their families are seen by the most appropriate well trained and skilled professional at the most effective time for everyone. The aim is to make the system work better for all involved. We are considering how to encourage skill mix and ensure that training is available to develop professionals.

Perhaps the most important and worrying challenge facing us currently in relation to the community paediatric workforce is attracting and retaining community paediatricians. The statistics relating to the drop out rate (whether temporary or permanent) of doctors during training is alarming, as are the number of paediatricians retiring earlier than they had originally planned. I am not going to get into the debate about pensions (even though the BBC seemed to be very exercised by that this week!), as there are enough non financial factors to consider. Demand is increasing for our expertise in caring for vulnerable children, those with neurodisability and in public health, and Shape of Training is adding complexity. In addition, the demographic is such that we have a large cohort of community paediatricians about to reach retirement age.

So what can we be do to help? One of the most reported factors in stopping trainees following a career in paediatrics is the morale and behaviours that they see in their seniors. If undergraduate medical students and trainees experience stressed, burned out, unhappy senior trainees and consultants, inevitably they will be put off. When we are stressed, we are less likely to engage with teaching. But even more important, we are less likely to nurture and make our trainees feel valued and important. We know from trainee feedback that this is a real problem currently.

I'm sure most of you will remember, or for those of you who are not quite so old, still be working with, someone who inspired you and who you aspire to be professionally. We need to ensure that our trainees experience the enthusiasm, commitment and most importantly enjoyment that we saw in those who inspired us. I am absolutely aware of how difficult it can be to demonstrate that enthusiasm when you are overwhelmed with work. It is our responsibility though to ensure that our successors are able to appreciate the fantastic bits of the job, as well as seeing some of the cost, so we need to work out a way to do it. (We need to start by looking after ourselves – but that is a topic for another day).

I can hear the rumblings coming from you readers: even if we can find the energy to engage and enthuse those junior to us, that is of no use if the trainees don't have the opportunity to see that enthusiasm. What can BACCH members do to encourage medical students and paediatricians to come and have a go in the community and see what a great career it is. With thanks to Cliona, here are some ideas (most of which seem to involve infiltration!):

*Many medical schools have paediatric societies; contact them and offer to give a talk or to organise some taster sessions. My experience is that they are a really enthusiastic and responsive group of students. Go and wow them

*Offer special study modules to undergraduates wherever they are available in the curriculum.

*Offer taster sessions to the local foundation school: some foundation trainees have the opportunity to do paediatrics, but most don't. And those that do rarely access community. So also ensure you are part of the foundation programme for those including paediatrics.

*Go to deanery roadshows and let people know about grid training

*Offer ST1-3 posts if you possibly can

*Get yourself into the general paediatric ST1-3 teaching locally.

BACCH is working with the RCPCH to improve recruitment into paediatrics generally – we need to make sure we grab our share of those who are attracted to paediatrics by showing them what community paediatrics has to offer. We do know that some areas are much more successful at recruiting into community child health than others, the variation being very significant. In collaboration with the RCPCH, we are planning to explore this - to identify why, and determine how we can share the successes.

Go out there and sell community paediatrics – it's a great career, and you are investing in your colleagues. Good luck - and please let us know how you get on and what works locally.

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Why are medical examinations carried out infrequently in cases of suspected or disclosed child sexual abuse (CSA)?

(A version of this article has also been published in the July/August 2019 NOTA newsletter)

A CSA medical examination, also known as a paediatric forensic medical examination (FME) or assessment may be considered whenever there is an allegation of sexual abuse, sexual abuse has been witnessed, or when there is a suspicion by the referring agency that sexual abuse, including exploitation has occurred, whether this be acute (recent) or non-acute (historical). The role of the medical examination is not only to look for any findings which may support a disclosure and may be considered evidential but just as importantly to consider the overall physical and emotional health and well-being of the child or young person and the wider family. However it is estimated only about 1 in 4 children known to the police and or social care in the context of suspected CSA have a medical examination undertaken – why is this?

The reasons are likely to be wide-ranging (figure 1);

- Research tells us that some professionals perceive the examination as harmful (Rachamim and Hodes, 2011)
- The medical assessment may be declined by children, young people or their carers (Hotton and Raman, 2017)
- The focus may be on the use of the medical examination for 'forensic evidential' reasons, usually limited to DNA or other sample retrieval from a victim's body or the identification of injuries. The perception among agencies may be that the examination has little to add if the 'forensic window' has passed (Rachamim and Hodes, 2011)
- There may be inadequate number of suitably trained staff to undertake these examinations (RCPCH/FFLM, 2015)

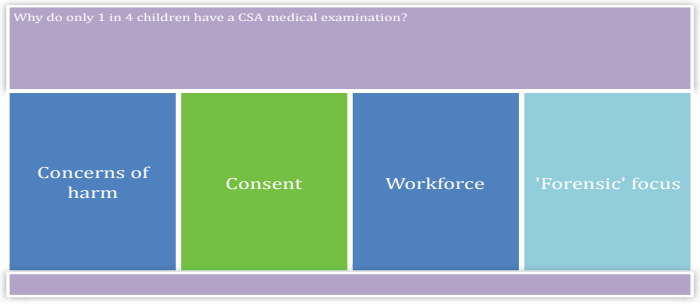

Figure 1: Why do only 1 in 4 children have a CSA medical examination?

Let us explore the reasons why medical examinations are carried out infrequently in further depth

Some professionals perceive the examination as harmful

There is limited research into the lived experience of children and young people who have had a medical examination to tell us 'How did it feel for you?' but the research that does exist does not support that it is a harmful experience. There is sometimes professional anxiety about the anogenital aspects of the examination in particular and this may be perceived by professionals to be 'intrusive' or painful. For most children this phase of the examination is not painful and is at most a light touch (Steward et al, 1995, Gulla et al, 2007). Anxiety before an examination is common but can be mitigated by careful preparation of children and carers which they report is often lacking (Marks et al, 2009, Waibel-Duncan and Sanger, 1999, Steward et al, 1995). Significantly most children report the medical examination as a positive experience; that it made them feel better and was helpful.

The medical assessment may be declined by children, young people or their carers

This was highlighted as a barrier to medical examinations in the CSA Centre practitioner's survey (Cutland, M. 2019) both by those that refer for medical examinations and those health professionals that undertake them. Four fifths of the respondents agreed this was a barrier.

To agree to or consent to a medical examination as a child, young person or a carer on behalf of a child you have parental responsibility for means that you should have been provided with all of the accurate and available information to make an informed decision. This means that the professional explaining the role and purpose of the medical examination needs to hold that information and share it with you in a way that you can understand. Preparation in the UK prior to attending a facility for a medical examination is likely to be undertaken by the police or a referring social worker who do not have a health background. If they do not have accurate information or understanding of the medical examination then it will be impossible for them to inform well enough for the child, young person or carer to decline the offer of a medical examination in an informed manner. In some situations frontline staff, trying their best, have fallen upon their own knowledge of what they 'think' it might be like, which may be wholly inaccurate and not evidence informed.

Some local health providers and SARCs provide age specific information to help frontline staff explain the process and the CSA Centre have recently produced a short informative film that explains the process in detail; the aim being to provide frontline non-health staff with help in talking to children, young people and carers about medical examinations so they are preparing in the best way rather than 'doing their best'.
https://www.youtube.com/watch?v=gOWX1xxnTWg

This resource is freely available for use in a number of professional education settings.

The perception among agencies may be that the examination has little to add if the 'forensic window' has passed

The word 'forensic' relates to scientific tests or techniques used in connection with the detection of crime. This term is often used by professionals only when applying it to DNA samples from a victim's body which are usually only a viable evidential sample up to 7 days after a sexual assault.

The potentially evidential value of a medical examination is not limited to DNA sampling from a victim's body and to consider only this may limit the options available to professionals and families in investigating a crime. Other potential supportive evidential findings can include physical findings and healed injuries or sexually transmitted infection for example.

Moreover the broader benefits of a medical examination cannot be over emphasised and include but are not limited to:

- Feedback and reassurance
- The identification of unmet general health needs
- The identification and treatment of sexually transmitted infections
- The provision of emergency contraception or the early identification of pregnancy
- Screening for blood borne infections and the provision of treatment that can lessen the likelihood of HIV transmission or Hepatitis B acquisition following abuse
- Risk assessments including those for self-harm and suicide and appropriate and timely referral for support

It is advisable in all cases that early discussions and all strategy meetings take place involving a doctor with paediatric sexual offences medicine expertise (often available via local sexual assault referral centre (SARC) services). This is so specific guidance can be provided in relation to an individual child or young person's situation about their likely health needs and forensic sampling options. National guidance advises these conversations take place within an hour of first disclosure or suspicion of CSA.
https://www.rcpch.ac.uk/resources/service-specification-clinical-evaluation-children-young-people-who-may-have-been

There may be inadequate number of suitably trained staff to undertake these examinations

This was identified as a barrier in the ***https://www.csacentre.org.uk/knowledge-practice/medical-examinations/the-role-and-scope-of-medical-examinations-when-there-are-concerns-about-child-sexual-abuse-a-scoping-review/*** and maintaining the workforce in this field remains a challenge as it does in many aspects of child protection work. This has also been identified as a priority in the 2018 report ***https://www.england.nhs.uk/2018/06/lifetime-nhs-mental-health-care-for-sexual-assault-victims/*** and is likely to be less of a barrier moving forward.

Conclusion

It is likely that a medical examination is an underutilized tool in the armoury available to professionals, children and families in the investigation and management of many CSA cases. A medical examination can enhance the scope for support and care of the child and wider family and has no 'expiration date' in terms of its usefulness. Better understanding of the role and scope of medical examinations and early engagement of expert health professionals in discussions around CSA cases is likely to be beneficial.

Continues overleaf

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The NHS Long-Term Plan - the turning point we wanted.

Time now to invest and reap the benefits.

Turning point

"a time at which a decisive change in a situation occurs, especially one with beneficial results"

If every member of your Community Child Health Department came together and wrote down three things that would most improve patient care and then you distilled the collective desires into the top three proposals, I am fairly sure your wishes would be included in the NHS Long-Term Plan. The NHS plan now has its own website (***www.longtermplan.nhs.uk***) at least read the two-page summary and sign up for updates!

Lisa Kaufmann in her BACCH Chair column in March reflected there is much to be optimistic about when reading the NHS Long-Term Plan, children are mentioned frequently, pathways and networks within integrated care systems are recommended, alongside investment in community services together with the need to value the NHS workforce.

I too had a little jump for joy when I read that an NHS based on competition and contestability would be replaced by systems relying more on collaboration and cooperation, with a patient focus for quality improvement and all forms of prevention integrated into patient care. This is a real turning point for the way services for children and families should be planned, delivered and improved.

Analysing complex policy papers is always challenging, since with what do you compare the proposals? Fortunately BACCH has described how services might work in the future in the 2014 paper entitled "the Family Friendly Framework" which built on the previous 2012 paper "the meaning of integrated services for children and families".

The BACCH NHS Long-Term Plan review paper is now on the BACCH website, where I have contrasted the family friendly proposals with those contained within chapter 7 of the long term plan. You will see there is a remarkable congruence between the two. ***https://www.bacch.org.uk/policy/documents/2019.04_NHS_LTP_BACCH_response.pdf***

Three independent but mutually reinforcing concepts require special mention:

1. The development of networks based on pathways all of which integrate quality improvement to improve experience and outcomes
2. The development of population health management which could also be described as public health for providers
3. The triple integration agenda (physical and mental health, health and social care, primary and specialist) to reduce fragmentation

Networks. The concept of networks is remarkably simple, it is merely the coming together of teams that deliver the component parts of the pathway in order to continuously improve outcomes, experience and safety.

Population health management. Population health management is effectively public health approaches relevant for the providers of health care. Critical is the focus on prevention at every level of health care including a greater contribution to primary prevention in order to reduce NHS demand.

Triple integration. Triple integration talks about integration of physical and mental health, primary and specialist care and between health and local authority services. Better holistic care is the intention particularly for those with multiple morbidities.
The intention of all three is to create ***better health, better care and better value***.

Implications for paediatricians

- the boost in resources for out-of-hospital care is an opportunity for paediatricians to propose new roles for new organisations to facilitate the delivery of better care for children and families
- population health management, tackling determinants of health, organising preventative programmes and implementing best practice will be central to their new roles working closely with partner organisations in public, private and voluntary sectors.
- increasing merger of commissioning and providing functions within integrated care systems (probably better called integrated health systems) could offer opportunities to paediatricians with an interest leadership within health system management
- Paediatricians also have a wide set of clinical competencies that have the potential to be shared with staff within integrated health systems in order to expand their roles and responsibilities in the reformed world envisaged within the long-term plan.
- Paediatricians must continue to effectively advocate for investment for children and tackling relevant determinants, since investment in early life reaps long-term rewards in terms of health and well-being.

The challenges

No doubt there will be many! But none are insurmountable. Some will require changes in current legislation to reduce obligatory competition, some will require changes of role, for example