Implementing Change
THE UPHILL STRUGGLE

Special Reports: DOWN’S OBESITY CAF
From the Editor

T his Summer Edition is packed with articles - reflecting the uphill struggle to provide Community Child Health Services. Some of the guidance which we receive is not always straightforward to implement in practice.

Along these lines you will find three Special Reports: the first is on services for children with Down’s Syndrome (p10-13), the second on the Measurement of Childhood Obesity (p14-16) and the third on the Common Assessment Framework (p18-19). In each case, I have included divergent points of view, the form of report and counter report!

We start with our regular contributions from the BACCH Officers, which keep you up to date with the work which goes on in our committees - and about the way in which BACCH is developing. There are three book reviews for your Summer reading starting on p.21, and much more besides.

It was pleasing to hear from James Robertson that, following writing in the Spring Edition about his website for parents, carers and health professionals, the number of ‘hits’ have increased. (www.yourchildinhealth.nhs.uk). It confirms that you do make use of the information in these pages.

I must apologise that in the Spring Edition, the Informatics section on page 15 was incorrectly attributed to Mitch Blair. This reflective insight into Community Paediatrics from a Trainee’s perspective came from Kate Marin.

This is the first full Edition produced with our new publishers - Wyndeham Gait. Let me know what you think of the altered presentation - it’s your News.

The new post of Deputy Editor commences in September 2006 - Shadow me for a year and the Editor’s job could be yours in September 2007! (See p5 for details.)

The future of the academic community child health

More than 30 years ago, Donald Court made a plea that we should apply the success of the bench to the study of social as we do to cellular behaviour’. However, as acknowledged in ‘Strengthening the care of children in the community’, academic community child health (CCH), an essential requirement for training Donald Court’s vision, remains weak.

The combined effects of the Research Assessment Exercise (RAE) and the research funding strategy of the Treasury have led to a crisis in academic clinical medicine. Even those academic departments dominated by a biomedical and cellular focus are struggling with these changes; between 2000 and 2004 there was an overall decline of 22% in academic posts, with the clinical lecturer grade (the starting point for many academic careers) being particularly hard hit, declining 42% across all specialities and 35% in paediatrics. An academic career in paediatrics is not an attractive option - only 11% of respondents in the recent Royal College of Paediatrics and Child Health (RCPCH) survey of final year Specialist Registrar (SPR) intentions were planning an academic career, and only 1% intended to seek a senior lecturer post, the inference being that the remainder would seek to pursue an academic career from an NHS consultant post.

Although it is increasingly difficult to develop a strong academic base for community child health in this climate, the need for such a base is ever more pressing if we are to ensure a sound evidence-base for primary and secondary child health services and provide suitably trained paediatricians educators to undertake the training of future paediatricians and doctors.

This article sets out the current state of academic CCH, the problems of succession and possible ways that BACCH and the College could work together to ensure a more viable academic CCH presence in UK medical schools.

CURRENT STATE OF ACADEMIC CCH

The challenge for academic community CCH can be summarised as follows:

1. CCH academics are often working in isolation
2. Few departments have the critical mass needed to make a significant contribution to child health research - the possible exceptions include ICH, Bristol & Cardiff
3. Many of the CCH academic posts are either recently retired (Nick Spencer, Steve Jarvis, Margaret Lynch and David Hall) or are due to retire in the near future (Jo Silbott, Leon Boulton & Brent Taylor), and there is a paucity of Senior Lecturers to replace them
4. There is a Chair in Newcastle and there have been difficulties finding suitable candidates elsewhere, resulting in child health chairs being lost or transformed into other speciality chairs
5. Many CCH academic posts are funded by NHS Trusts and not by HEFCE possibly rendering them less secure when

BACCH news

present incumbents retire or move on. Established chairs in CCH exist in Bristol (Emmond), Cardiff (Sibert), Exeter (Logan), London UCL (Taylor), London ICH (Deeurai). Charlotte Wright in Glasgow and Mary Rudolf in Leeds have personal chairs
6. There are fewer training posts. Many lecturer posts have been lost in the last 5 years and it is increasingly difficult to obtain a community child health consultant post.

WAYS FORWARD

We must start recruitment to academic child health at medical school - firstly by promoting a skill mix within academic departments of paediatrics and child health that enables them to provide comprehensive undergraduate medical education,
including both the practical and theoretical aspects of individual care at primary and secondary care level, and child public health at a population level. Secondly, by encouraging paediatric SSCs, SSMs and intercalated BScs, identifying interested bright students and nurturing them. All of us need to acknowledge that competition to attract the best trainees is severe and we need to become advocates to recruit them into paediatrics. After interesting students in child health, it is vital to supply accurate information on potential careers, emphasising that there is now a very clear career pathway for paediatric clinical training with academic paths mapped to it. The flexibility offered by the new training programmes should be an extra attraction to those anticipating taking career breaks to start a family.

The next step for those wishing to enter academic training is to obtain an academic Foundation post, and it is essential that community paediatricians provide clinical and academic input into Foundation programmes. The 3 year academic clinical fellow (ACF) rotations will give all trainees exposure to clinical community paediatrics and to child public health. The big hurdle in the new structure will be the gaining of a research training fellowship, and whilst funding opportunities are few we can give advice and support to optimise applications. What is needed is the establishment of further research training fellowships jointly with academic support to gain some post-doc funding and publications and acquire a CST.

Other potential benefits of the new academic pathway include: i) increased job-sharing, ii) protected academic training with a reduced or no on-call commitments, iii) facilities for distance learning for those confined to one geographic location and iv) opportunities to enter and exit academic pathways at all levels. Some paediatric SFRs may choose to move into an academic path later in their training. This will be facilitated by standardising and further developing the existing university-accredited MSc programmes with a view to incorporating them into the training of specialist registrars as has been done in Leeds.

Once trained, the young academic needs a job in a department with sufficient critical mass to support teaching and research. It is probably realistic to promote the establishment of a critical mass of multi-disciplinary community child health researchers in only 4 or 5 UK departments, with the remit of addressing the key research questions for the health of child populations and for child health service delivery. Research networks are the vehicle through which government funding is going to be channelled, so we need to be organised and collaborate rather than compete with each other - the recently awarded trial of Melatonin in learning disabled children being a good example.

In the current research environment few if any departments of child health can stand alone, and closer alliances will be needed to promote child health within big themes - e.g. with epidemiology in population health, or with psychology in neuroscience. Each university will have its own strengths and traditional links, but to survive academic child health will need to become more multidisciplinary, cross-faculty and cross-university.

In conclusion, although academic community child health has struggled to develop in the last few years, the new academic training programmes give fresh hope to improve recruitment, and offer new possibilities in careers paths. Proposed changes in NHS research funding may offer more opportunities for community-based research, and the need for excellence in teaching has never been greater as medical schools continue to expand.

REFERENCES

Professor Alan Emond - Chair BACCH alan.emond@bristol.ac.uk

THE YEAR SO FAR

I recently attended the College Speciality Board along with Gabrielle Laing (Chair of CSAC). This is a twice-yearly meeting when the specialty committees report their activities to the College. The status of the convoys of specialty groups, chairs of the Specialty advisory Committees, with various College Officers. Discussion was dominated by issues around training and the significant changes coming, both with Modernising Medical Careers and the introduction of PMETB. The issues for Community Child Health are similar in many ways to other specialties, but with perhaps the difference being that our speciality is much larger and, therefore, there is less tension between the needs of those training to become specialists and those training to become community paediatricians with a special interest. One area of concern is that the College no longer undertakes educational visits and PMETB has recognised that it is problematic to do visits for higher specialist training with a generic team. The College is represented by Mary McGraw, the new Vice-President for Education & Training, on a committee that is looking further at how to develop this area of inspection.

I had to leave the meeting early because my stepson was taking his Year 6 SATS and I had promised to pick him up from school that afternoon. Waiting at the school gates made me reflect on a number of issues that affect community child health. Parenting and behaviour were prominent in my thoughts as I observed a number of examples of what can only be described as poor parenting on collecting children. We need to continue to work on developing support for parents to help them in this difficult area and also to work out what exactly is the role of the paediatrician? Increasingly, parenting support should come from a multi-agency and primary care-based service, with specialists supporting in areas which are particularly difficult and problematic.

One area of on-going concerns must be the relative contribution of community paediatricians versus child and adolescent mental health services to this area. Locally our child and adolescent mental health service has re-organised itself to become a more specialist service, with the result being that a number of referrals that are made to them because of parenting/behavioural issues are re-diverted to community child health for an initial assessment. I am not sure that we are best placed to provide specialist support in this area, particularly given that we do have local primary care-based support systems and therefore where these do not work, I suspect the children need more specialist mental health intervention.

The other thing that I observed was that childhood obesity is a real issue although perhaps not to the extent (certainly in my unscientific survey at the school gates) as it might be portrayed in the media. Elsewhere on this issue, there is debate about the Government’s policy on body mass index screening in school. Tam Fry from the Child Growth Foundation writes passionately from his perspective as a parent. There are also interesting responses from Penny Gibson and the Expert Advisory Group. Personally, I think Penny’s comments on the need to have proper interventions in place before doing screening are important. I have concerns locally about implementing this programme, both because I do not believe that we should screen unless we have an intervention to offer (although I do understand the public health arguments for financial reasons) and because the Department of Health proposal that parents should not be given information on the results is, in my view, unworkable and in contradiction to all other advice on working in partnership with families.

The Executive Committee and Council met on 16th May. At Council, we had an interesting debate about the future of the NHS and in the light of the White Paper “Our Health, Our Care, Our Say” and the re-organisation of Primary Care Trust (I gather I am moving from Croydon to Cambridgeshire PCT to Cambridgeshire PCT), Michael Dixon, Chair of the NHS Alliance, spoke passionately about the opportunities offered by these developments.

Simon Lenton, Vice-President Health Services of the College, replied to this, expressing concerns about the impact of these changes, particularly on the provision of multi-agency integrated service for children with developmental problems, disability and chronic health needs.

We all recognise that this is an area of difficulty and that the Choice Agenda and desire to see competition fits uneasily with developing properly integrated services. The changes to Primary Care Trusts, GP Commissioning and PCT Commissioning also sit uneasily with the idea of Children’s Trusts as commissioners.

We recognised that there are opportunities here and the message from Michael Dixon, which I would support, is that community paediatricians need to continue to put themselves forward as advisers on child health issues locally. The issue about the place of employment is probably less relevant now than it ever was and indeed the idea that we can solve problems by having all paediatricians employed by one Trust I think is wrong. We need to ensure that, whoever the employer is, there is integrated working and that children’s services are delivered along integrated care pathways.

Professor Alan Emond - Chair BACCH
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On collecting children.
The final part of the college BACCH/CPHG session was a series of presentations by pediatric specialists on their involvement in public health. We heard complementary presentations by a neonatologist, a gastroenterologist and an endocrinologist. David Field, the neonatal specialist, discussed the changing public health emphasis on outcomes of neonatal intensive care, Warren Hyer the gastroenterologist warned of the impact of the huge increase in allergic, atopic and autoimmune conditions, while Nandu Thalange considered a wide range of topics, from public health training, the obesity epidemic, and the ideal structure of childrens health services in the NHS.

"However, thoughts now turn to the next academic highpoint in the calendar - the September BACCH annual scientific meeting."

I will see you there, I hope.

Dr Richard Reading - Academic Convenor BACCH
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Sotiria is now fairly quiet one for the BACCH Treasurer. The subscriptions for the year have been sent out (and no one has tried to complain or threaten me) and the end of the financial year although close, does not require much action. The main activity seems to be to negotiate with the ASN team over how much value should be added as opposed to profit made. At the moment, they seem to be winning so I would encourage you to put 20 and 21 September in your diary as it will be a good meeting.

Speaking of the ASN, it is then that we should be able to unveil our new Treasurer who will serve from September 2007-2010. Unfortunately, I had no response to the invitation I made last time to discuss this opportunity. The post is actually generally interesting but not unduly demanding as it is well supported by BACCH staff. As well as money, the post gives great insight into and involvement with the decision-making processes within BACCH. It also provides a very good reason to escape the increasing pressure of life within one's Trust and one that seems generally acceptable to Trust management.

Calling all BACCH Finance wizards!

The post of BACCH Treasurer will be vacant in September 2007. We elect the Treasurer a year in advance, to allow the Treasurer elect time to familiarise themselves with the financial cycle and what needs to be done.

The key responsibility is to maintain the BACCH coffers in a healthy state. David Bennett, the Membership and Finance Administrator, does all the sums and day-to-day accounting, and does it very well. The Treasurer takes an overview of the finances, setting financial strategy and making sure we remain viable. In addition, as a senior officer of BACCH, you will be involved in other projects and activities as they arise.

If you have an interest in BACCH, and feel you can make a contribution at senior officer level, here is the opportunity. It is a responsible task, but not, in my experience, too onerous! I would be delighted to discuss this with anyone who thinks they might be interested. Please call me on 01604 544538 or email below.

Mark Hunter, May 2006 mark.hunter@ngh.nhs.uk

Parents and Paediatricians Together Project

Within year three of the UK wide Parent and Paediatricians Together project, some specific work will be carried out with families from black and minority ethnic communities. The aim will be to encourage these families with information and help to create better awareness of the health care and support networks. Project officers are developing links with different community groups and voluntary organisations in different parts of the UK and will be working to a targeted way with these agencies to see how they can help with this work.

Contact a Family already has a network of offices, staff and volunteers across the UK who offer support to families from different communities and through them we are currently increasing our efforts to reach out to those families who are traditionally more isolated from services and support. For example, we offer targeted support to families in Southall and Ealing, have a South Asian Family Worker in Bradford and have close working links with the Somali community in the West Midlands.

Additionally, we have a team of Area Volunteer Representatives from the South Asian community who operate in Warwickshire, North Birmingham, Bradford and Newcastle. All are able to speak a range of community languages which enables us to reach families where English may be a second or even third language.

Our work with families caring for a disabled child involves face to face support, workshops, information giving, help in developing groups and promoting accessible materials. For details of each Contact a Family office, and where our Family Workers and Area Volunteers are based, please visit our website at www.cafamily.org.uk

Some of our current publications are available in other languages and can be downloaded from our publications page on our website.

BACCH Report Summer ‘06

My two years as the BACCH representative for BACCH have just passed. I am now handing over to my colleague, Adrian Dighe, who I am delighted to say was elected as Vice Chair for BACCH at our AGM in January 2006.

BACCH Study Days

27th January 2006, London; “20 years Old and 20 years On”

This was an excellent day with diverse presentations, as well as the Birthday Celebrations! The presentation on current research into congenital CMV and hearing loss (by looking at the viral load on the Guthrie card) was fascinating as was the talk on long QT syndrome. The other presentations all gave much food for thought including a personal reflection on the changes in paediatric audiology over the last two decades by Dr Hope Forsyth, CCF(Audiology) and an exciting vision of the future of the specialty by Dr Ann Mackinson (our-going Chair of BACCH).

30th June 2006, York.

A date for your diary! The provisional programme includes presentations on Non-organic hearing loss, Tinnitus and Hyperacusis in children/young people

For further details please contact Mrs. Pam Williams:
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Name Change for BACDA

As mentioned in the previous newsletter, a name change for the Organisation is being planned and at the AGM in January there was a unanimous vote to proceed with this. The main changes being considered are: replacing “doctor” with “paediatrician”; omitting “community” and replacing “audiology” with “audiovestibular”. It is clear from the discussion at the AGM that there are strongly held views both for and against these options. A postal ballot is being organised. In addition, a working group will be set up to amend the constitution and the proposed changes will be brought to the AGM in January 2007 for ratification.

Workforce Issues and Training

BACCH are currently trying to gather comprehensive information about the current workforce, not only of BACDA members but of all paediatricians working in audiology. The initial response rate to the census has been disappointing. If you are working in the field (or have been within the last 5 years) and have not yet completed a census form, please do so. The form is available on the BACDA website: www.bacda.org.uk.

There is concern about the rapidly reducing workforce and much effort is being put into raising the profile of Paediatric Audiology.

The very good news is that BACDA has been granted Special Interest Group status by the RCPCH. Many thanks go to Lesley Batchelor who has put huge effort into achieving this.

Other ongoing work includes:
- BACDA and BAAP working with the RCPCH to develop level 3 competencies for Higher Specialist Training.
- Input by BACDA to the Royal College of Physicians Working Party to consider the future of Audiovestibular Medicine.
- BACDA and BAAP were represented at the Workforce Review Team Meeting in March when Paediatric Specialties were discussed.

Audiovestibular Medical Federation

The Federation is now well-established, with reciprocal representation on each other’s Executive Committees and increasing collaboration between the two organisations.

Proposed Cochlear Implant Health Technology Appraisal by NICE

BACDA was recently asked to contribute to a proposed appraisal of cochlear implants for severe to profound deafness in children and adults. Written submissions were requested initially and I then represented BACDA at a Scoping Workshop in February. This was attended by representatives from a wide range of Patient/carer groups, Professional groups and Manufacturers/sponsors. The information from this will then be collated and go before Ministers for a decision as to whether the appraisal should go ahead.

Postgraduate Medical Education and Training Board (PMEB)

It would appear that many UK trained Staff Grades and Associate Specialists, currently leading audiology services and acting as independent clinicians, who have postgraduate qualifications in audiology and extensive experience in the field, will be unsuccessful if they apply for inclusion on the Specialist Register through article 14. BACDA is seeking clarification on these issues.

My term as BACDA Chair is just beginning and I anticipate an extremely busy two years ahead. I have enjoyed my time on the BACCH Committee. Please contact either Adrian (adriandighe@nospetl.nhs.uk) or me if you have any queries or comments.

Susann Rose
BACCH Chair
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The UK Down's Syndrome Research Foundation (DSRF) is a UK charity dedicated to improving the lives of those with Down's Syndrome (DS) through medical research. Their work has included promoting and part funding a study on vitamin and mineral supplements for children with Down’s Syndrome, run from the Institute of Child Health, and publication of a glossy pamphlet ‘Bright Beginnings’ for new parents of children with Down’s Syndrome. In this edition, they promote the idea of developing a few large specialist DS centres in the UK and, in due course, lack of services in this country. The conference’s aim was to bring the two teams who have set up a specialist clinic in Nashville in the USA, to “educate” about how this should be done, as well as to bring over some research experts from the USA.

Prior to the conference, I had been in correspondence with DSRF, in my role as chair of the Down’s Syndrome Medical Interest Group (DSMIG) UK, about their leaflet ‘Bright Beginnings’. The leaflet focused almost entirely on US services and literature, and failed to mention any of the services, support organisations or publications in the UK. We were concerned that it was both discouraging and misleading for parents of new babies with Down’s Syndrome born in the UK and Ireland. It was, therefore, with mixed feelings that I went to the conference - although DSRF had welcomed DSMIG members to attend as their guests. The conference was held on two days - for health professionals on the Friday, and for parents the following day.

The professional’s day was opened by Sheila Shillman, National Clinical Director for Children, who gave an overview of current UK government health policy, including the need for better informed parents. She emphasised the benefits of locally managed clinical networks, with joint working across agencies, providing locally based services for children with disability.

We were then shown a DVD from the USA, ‘Down’s Syndrome and the medical professional’, featuring parents’ experiences of being told the news that their child had Down’s Syndrome and drawing from this patient to good practice. This was reassuringly familiar and similar to UK practice guidance.

This was followed by a series of presentations from members of the Down’s Syndrome clinic at Vanderbilt Children’s Hospital in Nashville, Sheila Moore, director of Down’s Syndrome Association, Ronnie Snyder Craft, programme co-ordinator, and Robert Vandervoort, medical director. They described their set up of a one-stop Down’s Syndrome clinic, providing access to a range of health professionals in a single visit to one state-of-the-art children’s hospital, and their programme of health surveillance. This is a referral-only service, with ‘routine well care’ being provided by primary care physicians. They take referrals from all over the USA, with some families travelling up to 6 hours for their clinic visits. I was particularly interested to hear of the reasons that they felt people attended their specialist clinic - that is, about a third had specific medical problems, a third wanted to ‘keep up with the latest trends’ in medical care and a third were curious.

Question time followed this, which I had anticipated with some anxiety. I hoped the debate would highlight that we do have some specialist Down’s Syndrome services in this country, and that they are closely linked in with Down’s Syndrome centres, and Community Child health services. I was not disappointed, and parents put pressure on the speakers to do something for their children. The following day, the Conference report from Liz Marder refers to the difference between US and UK provision for people with Down’s Syndrome. We felt that it would be helpful to include an overview of U.K. services.

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**Healthcare provision for people with Down’s Syndrome in the UK**

*Dr Liz Marder (Chairman) and Dr Jennifer Dennis (Director of Information) - DSMIG*

In an ideal world, all healthcare professionals would have a detailed knowledge and understanding of all medical conditions. This is however impossible, and the NHS tries to meet the needs of people with a wide range of disorders, such as asthma and diabetes, by encouraging the development of special clinics and by issuing good practice guidelines. DSMIG is working towards the same level of provision and understanding for those with Down’s Syndrome.

DSMIG is a network of healthcare professionals, predominantly paediatricians, who aim to ensure equitable provision of medical care for all those with Down’s Syndrome in the UK and Ireland. We do this by disseminating to health care professionals, information about best practice medical care through the publication of guidelines, through our medical meetings, through our information and advisory service and through our website, www.dsmig.org.uk. We collaborate with Down’s Syndrome support organisations in the UK and Ireland and work closely with the DSA.

There are now at least nine dedicated specialist clinics for children with Down’s Syndrome within NHS community child development services. These are in Nottingham, Oxford, Cambridge, Perth, Leeds, Northampton, Derby, Aberdeen, and Southwark. In many other general child development clinics, a Down’s Syndrome-specific care pathway is in use. Parents need to be multidisciplinary and have input from a wide range of professionals, such as physiotherapists and geneticists, as well as integrating with local education and social services.

However, as with all medical conditions, the overall situation is far from perfect and we are committed to helping empower parents to fight for appropriate care if they feel this is not being delivered locally. The reason why we have produced the 20 page special Down’s Syndrome insert for the Red Book (the parent-held Personal Child Health Record or PCHR), which is given to all babies at birth.

The PCHR special insert contains additional information for parents and professionals, to help them maintain the health and wellbeing of babies with Down’s Syndrome. In addition to general information, there is information about expected developmental progress, possible health problems, advice about feeding and growth, UK Down’s Syndrome-specific growth charts and a suggested schedule of health checks. The insert is widely available and should reach all families free of charge very soon after their child is born, through their midwife, health visitor or paediatrician (also see www.dsmig.org.uk). If you have a child under age 5 and have not received a copy of the insert, please let us know on info@dsf.org.uk so we are trying to find out where

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**What about services for adults?**

We know that in many areas, this is a deep, dark hole in spite of our best efforts.
A COMEDY OF ERRORS

On May 10th the Acting Permanent Secretary at the Department of Health [DH] admitted to the House of Commons’ Public Accounts Committee (PAC) that he doubted that the target to halve the year-on-year rise of obesity in children under 11 yrs was on track. Children Now quoted Hugh Taylor verbatim. “We don’t know if we are going to hit it”, he said, “It’s true to say that the trend at the moment is going in the wrong direction”. This statement was immediately denied by a DH spokesperson - but she would say that, wouldn’t she?

Against this level of confusion and contradiction, Measuring Childhood Obesity – Guidance to PCTs, the two part document issued by the Department in January and May, struggles to be taken seriously. Within a week after Taylor’s statement a workshop at the DH, called to swap notes on progress, broke up in polite disarray after hearing that all the PCTs in Oxfordshire, for starters, were going to ignore guidance and defer implementation. Unless funding was forthcoming, Oxfordshire implied, PCTs in Oxfordshire, for starters, were going to ignore guidance and defer implementation. The guidance clearly explains, in Appendix 3, why the annual measurement of an individual child’s growth when the EAG is clear that measurement to the nearest 1mm is the clinical standard expected. Additional guidance to PCTs is being given to clarify that the aim, in this population monitoring, is measurement to the nearest 1mm.

Centiles: The guidance describes the variety of BMI cut-off points used in defining childhood obesity, recognising how different definitions are applicable to different populations and purposes. The link between morbidity and mortality and BMI is not as clearly demonstrated in children as in adults.

When the Department of Health analyses data for performance management purposes it will use the 85th and 95th centile of the 1990 UK reference population, in line with the definition of the PSA target. These cut-offs were chosen, for the PSA target, as valid for population monitoring. Growth charts for individuals would not be expected to use these cut-offs as their purpose is wholly different.

Reporting of BMI: It is important to recognise the difference between monitoring populations and measuring individuals. The guidance clearly explains, in Appendix 3, why the annual measurement of individuals’ BMIs (i.e. screening for obesity) is not appropriate. This was made very clear to the CMO and the EAG by the National Screening Committee. The purpose of the measurement is not to identify individuals who have problems, as this is not supported by the evidence as being an effective way of tackling obesity. The measurement will help target population-level services, which the evidence does suggest will reduce obesity levels. It will also be available to each of these services and performance manage PCTs.

Another Guidance gaffe in January was to allow PCTs to choose which definition of a weight/obesity cut-off to use when reporting their BMI figures. Rather than simply stating that the 85th/95th centiles are to be used since they are the choice of Ministers, the document listed all 3 definitions currently being used - the other two being the 91st/98th centiles and the 95th cut-offs. BACCH readers will already know that a June 2005 multi-disciplinary workshop organised by the Child Growth Foundation sent Ministers a strong message by clearly voting for the 91st/98th definitions with Professor Sir David Hall emphasising that the DH ought to accept the vote. Furthermore, a leading public health doctor warned the DH against even mentioning any other definition. Prophetically she said that, if it did, the media and the food industry would rubbish the statistics. The food industry got in first and, in a March Millbank conference on childhood obesity, its spokesperson promptly used every figure he could to show that the epidemic was being hyped. The Sugar Bureau Spring Newsletter weighed in, too, by stating that the obesity epidemic was only half of its DH reported level.

The Guidance is pitiful when, whilst acknowledging that parents have a right to know their child’s height and weight measurements, it states that they should not be given them routinely. Fortunately common sense again prevails at the back end of May, the Minister for Public Health overruled the advice of her advisers who fear that telling parents such information would stigmatised children and lead to them being bullied. Having heard the Chairman of the PAC, Edward Leigh, call some of the excuses being made “absolute nonsense” and “drivel”, it seems that the Minister went back to the drawing board. The outcome is that, from next year, parents may get letters applauding them if they are keeping their children in shape and pointing out the medical dangers if they don’t. Leigh has certainly pleased a mother who recently contacted the Foundation as a health professional and Obesity Lead in her patch. “Make no mistake about it”, she growled, “the Guidance is patronising guff. If anything happens to my child at school I want to know what it is.”

You won’t want me to go on because you’ll have got the message. Allow me, however, finally to bemoan the fact that the final error perpetrated by the Guidance is to ignore the considered advice of a second influential House of Commons’ Committee, the Select Health Committee. In 2004 it recommended an annual BMI measure at primary school but all the Guidance requires is one at Yr 2 and Yr 6. It passes up the opportunity to monitor at ages when the literature confirms that schoolchildren are piling on the pounds. The UK hasn’t monitored the growth of its child population properly for the last 25yrs and now we have a huge obesity problem. We – you – must now bite the bullet, regularly monitor and intervene with any schoolchild who looks as if it’s headed towards becoming dangerously overweight. In fact, now there is to be a total ban on all junk food in schools, wouldn’t it be rather sensible to audit what effect the ban is having by introducing a yearly assessment?

Tam Fry, Honorary Chairman
CHILD GROWTH FOUNDATION

This is one subject on which I know all our readers will have views! Tam Fry’s article on the recommendations for measuring, published opposite, has responses from Helen Walters, Chair of the Expert Advisory Group and from Penny Gibson who is the RCPCH Obesity Advisor. As Chair of the Child Growth Foundation Tam has contributed much to Child Health, but his views are his own, and must be read alongside Helen and Penny’s contributions. Please do e-mail with “letters to the Editor” on this and any other Child Health topics.

Mary Jones - Editor
As RCPCH Obesity Advisor and a member of the External Advisory Group (EAG) for measuring childhood obesity for the Department of Health, I have been asked to respond to Tam Fry’s letter “comedy of errors”.

I would prefer that this response was unnecessary and that his letter was not published, as I feel that BACCH should not demean itself by publishing this inflammatory and inaccurate document. I am totally supportive of Dr Helen Walters approach and response, also in this edition. For a more balanced description of the history and political imperatives behind the measuring children decisions, I refer readers to my letter in the last edition of BACCH news.

My main concern about Tam’s comments is that he still fails to understand the difference between:

- measurement for screening
- measurement for clinical assessment of an individual
- measurement for population monitoring

There is extensive evidence on the negative, unwanted consequences of ill thought through screening procedures. Although I would not rule out the possibility of screening for obesity being sensible in the future, at the moment, there are very strong grounds against it. We need to have effective, available and acceptable interventions before we can justify telling children and their parents that they are obese, unless they have come to us for help.

We are learning more about how to intervene constructively and there are some very promising research projects in the UK right now. Meanwhile we all need to use the existing evidence of what works, be more supportive of those who want to control their weight, whilst evaluating what we do in order to inform future developments.

By the time this is published, the NICE guidance on prevention and treatment of obesity will have completed its consultation phase in preparation for publication in November 2006. Please do look at the consultation draft on www.nice.org.uk for the summaries of evidence. Other useful tools include:


Dr Penny Gibson
Consultant Community Paediatrician
RCPCH advisor on Childhood Obesity
I ask you to consider the size and diversity of this group. There are in excess of 12,500 of us. There has been little formal review or audit to understand the type and extent of work we do; however a 2004 survey showed that there are at least 693 paediatric SAS doctors who constitutes 29% of all paediatricians (excluding training grades). The contribution of such a significant percentage must be acknowledged. In my time working with BACCH so far I have learnt of the diversity of this group:

- a) experience
- b) expertise (from a full range of post registration degrees to complete lack of post registration formal jobs)
- c) length of service (up to 30 years or more)
- d) expertise (from a single clinical week to a full time 11 sessions acute rota)
- e) the degree of autonomy (from lack of expectation even of prescribing to full autonomy with an own list) and
- f) the ability to access CME, CPD, audit, governance etc.

This last, of course, impacts upon the appraisal process.

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The Common Assessment Framework: will it work?

Dr Catherine Powell is a Senior Lecturer at the University of Southampton School of Nursing and Midwifery. During the time that the CAF was developed and trialled, she was Nurse Advisor for Children and Young People at the Department for Education and Skills.

It is understandable that concerns may exist when a new process is introduced and it is important to address these. First, it is important to set the context. The Common Assessment Framework (CAF) is not a standalone process, but a key component of the Every Child Matters (ECM) programme which sets out to improve the life chances of all children and young people, to reduce inequalities and to help to achieve the outcomes derived from consultation with children and young people themselves: to be healthy; to stay safe; to enjoy and achieve; to make a positive contribution; and to achieve economic well-being.

Every Child Matters

ECM is an ambitious programme that involves everyone who works with children, young people and families whether they are employed or volunteers; not just in health and social care; but education; early years and childcare; youth offending; police; youth support and Connexions services; advocacy and support services; and leisure. One of the key aims of the programme is to provide tools to enable frontline staff across these services to work together more effectively and to help to ensure that children and young people receive timely intervention and support for any additional needs. The CAF is thus a tool that can be used by practitioners in England, across all agencies delivering services to children.

CAF development process

Development of a common assessment process was one of the recommendations of Lord Laming’s report into the death of Victoria Cline. The CAF was developed by combining the underlying model of the Framework for the Assessment of Children in Need and their Families with the main factors used in other assessment frameworks. In common with the Framework CAF has been designed to identify the family’s strengths as well as needs of the child or young person. CAF has been further developed and refined through consultation with a wide range of stakeholders and groups and a detailed evaluation of local authority trials. Indeed, approximately two-thirds of local authorities and their partners have already started to introduce the CAF process. The CAF is therefore a tried and tested process and there is emerging evidence demonstrating its effectiveness.

Summary of the CAF trial evaluation

Detailed evaluation of the CAF approach to identify the role of local professionals was carried out in 12 local authority areas.

More than half said implementation had improved multi-agency relationships

75% said that it would lead to better outcomes for children

72% said that the training very useful

Training

Not everyone in the children’s workforce will be required to have the expertise to complete a CAF but all should know where to go to get one completed. Local authorities are responsible for providing CAF training for all relevant practitioners in their local workforce; over 2000 CAF trainers have already attended ‘train the trainer’ courses with literally thousands of frontline staff already benefitting from subsequent training. Feedback on the courses was overwhelmingly positive.

Referrals

Evidence from the evaluation of the trials has shown that where a CAF has identified that a referral to another service is necessary the referrals are more evidence based. Any specialist assessment that follows can build on the information already gathered for the CAF rather than starting from scratch. This can reduce duplication, not only for the practitioner, but more importantly for the child, young person and their family. Frustration at having to repeat ‘their story’ over and over again was a message that we heard frequently in our consultation.

In some cases the child or young person’s needs may be able to be identified without the completion of a CAF and, in those instances, the referral process remains the same. The CAF would only be complete if the unmet needs require clarification.

Conclusion

The CAF is not compulsory, but the early evidence from the trials has demonstrated that it is emerging as an effective tool that can help identify unmet needs at an early stage thus leading to more appropriate and timely referrals and contributing to more effective integrated delivery of service. I anticipate that this may well reflect Dr Cundall’s welcome call for more effective care pathways and inter-agency networks.

http://www.cem.gov.uk

CAF: Managers’ guide

CAF: Professional Managers’ guide

Local professionals’ guide

Information on the Common Assessment Framework

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The conference section is regularly updated with information on the latest BACCH and RCPCH meetings as well as other meetings felt to be relevant to community paediatricians.

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Accreditation: CPD 5 credits

This one-day conference will explore ways in which children’s agencies could collaborate to ensure that physical and mental difficulties are identified at an early stage. Proposals for adopting optimum care and educational strategies for children and parents will also be discussed.

Topics will include: 'The first signs', 'The impact of the Hall Report', 'Young offenders: a further cause for concern', 'A parent’s view: The real work of the classroom', 'The importance of therapists', 'The parent as expert', 'The multi-agency approach: 'The role of the doctor', 'The way forward - a summary'.

For a full programme and online registration, visit:

http://www.rsm.ac.uk/academ/A10_children.htm

Dr David Lewis

david.lewis@wssa.wfpct.nhs.uk

David Lewis, Consultant Community Paediatrician, Leeds, david.lewis@wssa.wfpct.nhs.uk

The BACCH website has had some recent additions you may wish to refer to. Firstly, within the training section is an update of CPD requirements, including a link to the college site for those who have not already done so to register for their CPD scheme. We would strongly encourage all community paediatricians to register with a CPD scheme. Other colleges also do run similar schemes and your submissions are intermittently audited.

The conferences section is regularly updated with information on the latest BACCH and RCPCH meetings as well as other meetings felt to be relevant to community paediatricians.

Soon to be added will be information on the submission process for national clinical excellence awards including application forms and criteria.

Another addition which I hope will become popular will be a discussion forum. This will be for members only and will allow for critical debate around the many contentious political movements recently, as well as other matters including clinical conundrums that any members of BACCH feel fit to post. As part of this process a database of members is soon to be created within the website and you will in the future need to log on with name and password to access this new area. More information about the practicalities of this will be made available nearer to the time of launch.

As ever, if members feel anything is missing or would further advance the usefulness of the website please make contact.

Dr David Lewis

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David Lewis, Consultant Community Paediatrician, Leeds, david.lewis@wssa.wfpct.nhs.uk
I hope you all had a good spring. I'm back from leave and it's time to write my regular update on relevant issues for trainees and trainers in community child health.

**TRAINING IN COMMUNITY CHILD HEALTH**
Keeping our database of trainees and trainers up to date is a constant struggle so a big thank you to all those who have completed update forms. Please remember that if you are a Specialist Registrar who is aiming for a consultant post in community child health that you should let the College know, through the office for higher specialist training, that this is your intention. You are allowed to change your mind at a later date but this is the best way we have of knowing how many trainees we have in post, of letting you know if critical changes are in the pipeline and for manpower planning purposes. In the near future we will also be contacting programme directors and regional advisors to check that we have accurate information about both trainees and trainers.

**PMETB**
PMETB (Postgraduate Medical Education and Training Board) has been up and running since September and, as I have explained previously, has become the body responsible for the specialist training of doctors and for ensuring that doctors have reached a level of competence appropriate for inclusion on the register. They have also started to visit centres to quality assure training programmes, replacing the previous visits programme which was run and co-ordinated by the College. The perceived value of these visits has been variable and is under review. If you have any concerns about the training in your centre and have been unable to make progress at a local level, please contact me (e-mail below).

**PROCEDURE FOR APPROVING NEW TRAINING POSTS/PROGRAMMES**
I have received a number of enquiries about the procedure for establishing new training posts and getting them approved. Firstly, you need complete the PMETB approval forms which can be obtained from the College. Then you need to get approval from the Regional Adviser. Posts in community child health will also need approval from CSAC. In order to do this, we will send you a virtual visit form to be completed by the trainer and by the trainee if there is one in post. The paper work is then submitted to PMETB for final approval.

**COMPETENCY UPDATE**
As I have explained in previous newsletters, we continue to work on the competences required at all stages of training for all paediatricians and for those specialising in community child health. The documents on basic and core training are available on the RCPCH website and those for higher specialist trainers will be published later this year. These competences relate to the new run through training grade and all curricula will need to be submitted to PMETB. The College are also developing assessment materials to cover the standards against which future trainees will be assessed. These competency documents provide a useful source of reference for current trainees and trainers. However, remember that those currently in post are being trained on a time, rather than competency, based programme. Therefore to gain your CCT you continue to need to demonstrate that you have covered the “old” syllabus which can be found on the BACCH website.

**WEBSITE**
Keep an eye on the training section of the BACCH website as over the next few months we will be posting a number of new documents there. This will include job descriptions and a range of related materials. This is a time consuming process and if anyone would like to help, suggest materials that they would find useful let me know if the posted materials are helpful or not, then I would be very pleased to hear from you.

**AND FINALLY…**
- I am running a workshop at the ASM in Reading on Thursday 21st September.
- As always I can be contacted at gabrielle.laing@bpch.nhs.uk and my trainee advisor is Cliona_Nib@lineone.net or david.eckers@southcambs.pct.nhs.uk

**TRAINEE NEWS**
At our most recent BACCH Council meeting we have just had an interesting and lively debate surrounding the impact of “Our Health, Our Care, Our Say” on community paediatric services. It did raise more questions than answers, but we will have to be very clear to commissioners about exactly what service we provide. At the next meeting in July, we will be discussing the strategic direction of BACCH. This will be your chance to have a say on the future direction of BACCH and I am sure your views will be welcomed by the committee. If you would like to make an impact on the way in which BACCH can work for you, both as a trainer and as a future consultant, now is the time to speak up.

I hope you have found some time to look at the BACCH website. There will soon be a members’ discussion area, which should provide a quick and easy way of networking with colleagues across the country.

The college keeps a database of community SPR trainees. If your name is not down yet, please make yourself known to the HST office.

I am now in the seemingly endless task of applying for a CCT and will be taking up a consultant’s post this autumn. This means that the EC are now recruiting a new trainee representative (two if necessary). Please contact me or my regular update on child health.

When handed the book for the first time after I agreed to review it, my first thought was that it seemed a bulky document which might be rather daunting for a parent of a sick or recovering child to read. However, my fears were quickly allayed once I began to read. The contents pages and chapters are extremely well laid out with tabs indicating the beginning of different chapters, therefore making it easy for the reader to flip back and forth in order to find relevant information. It is a book that is visually reader friendly. There are clear titles at the top of every page, with subheadings and bullet points breaking up the text into small pieces. There are also clear contents pages and indexes at the end of each chapter. I have really enjoyed my work in a set way. It would have been useful for the authors to have stated the purpose of the flowchart early on, indicating what the effects of the illness, with a broad, yet detailed overview of the effects of encephalitis on the child, the pathway through the services, including education, and finally fairly extensively exploring the impact of the illness on the family as a whole.

The contents of the book cover the stage of the acute illness in hospital rapidly taking one through the effects of the illness, with a broad, yet detailed overview of the effects of encephalitis on the child, the pathway through the services, including education, and finally fairly extensively exploring the impact of the illness on the family as a whole.

At the end of the first chapter is a flow chart that gives a useful overview about the child’s journey from the initial symptoms of the disease, through admission to the acute ward or Paediatric Intensive Care Unit, concluding with the discharge home and rehabilitation in the community. My only criticism of the flowchart is that, whilst doing a great job of simplifying the pathway for parents, it gives the impression that all services work in a set way. It would have been useful for the authors to have stated that the purpose of the flowchart is to serve a general pathway through but that services vary widely. In the current climate of inclusion, not every child who is referred to the Local Education Authority following rehabilitation from encephalitis will be issued with a Statement of Special Educational needs as is suggested.

I have no other criticism of the book. Complex medical terms are explained in the glossary and information is provided about contact details for support groups. Finally, lists of further reading material are also included. I am impressed at the detail in the book. It is extremely well written, the whole being attractive, support and inform parents who have just seen their child weather a horrific illness and emerge a very different child, with needs they could never have envisioned. It comes highly recommended. A pocket version is also available in other common languages and should be the next endeavour of the authors.

Well done.

Published by the Encephalitis Society

Dr Ngozi Olusanya
Consultant in Community Child Health
Edwin Lobo Centre
Luton Teaching PCT
Bedfordshire, UK.
14th May 2006

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As a Speech and Language Therapist working with Developmental Movement Play, it was a joy to read this book, which outlined the origins and origins of the work and proceeds to identify theories which underpin it. Veronica Sherborne trained as a teacher of physical education and dance. While studying at Bedford College of Physical Education, she was taught by Rudolf Laban. His movement analysis and philosophy of ‘free dance’ had a profound effect on the development of movement and dance in this country. His theories also had a powerful effect on Sherborne.

Following posts as lecturer in Dance at Bedford and Bath, she worked as a movement therapist with people suffering from severe depressive illnesses. Both she and Laban had an interest in the psychological impact of movement and this became the starting point for her future work. She subsequently had a monumental influence on special education in the ‘60s and ‘70s, working with children who had previously not been seen in the school system. In response to her approach, children were beginning to engage, acquire communication skills, experience physical activity and have fun. ‘Relating happens as a result of being with children’, she says in being what the authors would like to encourage parents to do.

As parents, paediatricians and human beings, we continually strive for answers that are beyond our understanding. Whether it can be described as an important contribution to disability literature, I believe it is far too soon to tell. Nevertheless, I would unhesitatingly recommend that Paediatric Departments purchase it for all their staff to read and also to have it available for parents or prospective parents, (where there is a confirmed antenatal diagnosis), to read at the start of their journey with their own ‘Star child’.

The course provides a range of teaching aids and learning materials, including videos, which are useful for parents and professionals alike. It also includes a comprehensive guide for parents, which covers topics such as communication, behaviour management, and strategies for supporting children with special needs.

It is evident that the book is written with a great deal of love and passion, and it is obvious that the authors have put a lot of effort into creating a comprehensive guide for parents, which is both informative and practical. The book is highly recommended for all parents, professionals, and anyone interested in supporting children with special needs.

Published May 2006
ISBN 0 955246 2 0
Andrew Williams, Northampton General Hospital
awa@doctors.org.uk

As parents, paediatricians and human beings, we continually strive for answers that are beyond our understanding.

"...physical movement in its purest sense and the Arts as a source of intensive expression have, until very recently, been marginalised."
From the Academic Convenor

BACCH Annual Scientific Meeting, Reading University 20th-21st September 2006

‘New Problems, New Solutions’

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<tr>
<th>Wednesday 20 September</th>
<th>DAY ONE</th>
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<tr>
<td>9.30</td>
<td>Coffee and registration</td>
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<tr>
<td>10.00</td>
<td>Welcome - Dr Richard Reading, BACCH Academic Convenor</td>
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<td>10.10</td>
<td>Keynote lecture The Medicines for Children Research Network - our chance to improve treatment for children Professor Ronald Smyth, Brough Professor of Paediatric Medicine, University of Liverpool, and Director of Medicines for Children Research Network</td>
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<td>10.50</td>
<td>Child Public Health keynote lecture Using routine data as a child public health diagnostic and research tool - the example of childhood obesity Dr Ian Buchanan Senior Lecturer in Public Health Informatics, University of Manchester</td>
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<tr>
<td>11.30</td>
<td>Coffee and exhibition</td>
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<tr>
<td>12.00</td>
<td>Free paper session, chair TBC 4 Free Papers (each 15 mins)</td>
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<tr>
<td>1.05</td>
<td>Lunch, posters and exhibition</td>
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<td>2.00 - 3.00</td>
<td>Workshops Early diagnosis and early intervention in CFS/ME - whose responsibility is it? Dr Helen Venning, Consultant Paediatric Rheumatologist, Nottingham Incorporating children’s rights into practice and teaching Dr Tony Waterston, Consultant Paediatrician, Newcastle-upon-Tyne The RCPCH training scheme for child protection - Dr Noreen Shadde, Consultant Paediatrician, North Tyneside and Mr Sue Wieteska, CEO, ALSG &amp; Project Manager Child Protection Training Programme Transitional healthcare for adolescents with a chronic condition - Dr Janet McDonagh, Senior Lecturer in Paediatric and Adolescent Rheumatology, Institute of Child Health, Birmingham Children’s Hospital Rapid assessment of evidence to answer clinical questions - Professor Stuart Logan, Peninsula Medical School, Exeter Connecting for Health - what’s in it for community paediatricians? Dr Clemen Ni Brochbain and Dr Fauzia Rahman The British Paediatric Surveillance Unit and Community Paediatrics - Mr Richard Lynn, BPSU scientific coordinator</td>
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<tr>
<td>3.10 - 4.10</td>
<td>Workshops (as above)</td>
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<tr>
<td>4.30</td>
<td>Tea and exhibition</td>
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<tr>
<td>4.40 - 5.20</td>
<td>Keynote lecture, chaired by Professor Alan Emond New challenges for paediatricians in family justice Professor Judith Mason, University of Bristol</td>
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<tr>
<td>5.30 - 6.00</td>
<td>BACCH Annual General Meeting</td>
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<tr>
<td>8.00</td>
<td>Dinner (Bar opens at 6.15pm)</td>
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<tr>
<td>9.30</td>
<td>Steve Salfield and the Back Seat Jivers</td>
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<tr>
<th>Thursday 21 September</th>
<th>DAY TWO</th>
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<tbody>
<tr>
<td>8.30</td>
<td>Coffee and registration (2nd day attendees)</td>
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<tr>
<td>9.00</td>
<td>British Academy of Childhood Disability Keynote lecture, chaired by Dr Jane Williams TBC</td>
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<tr>
<td>9.40</td>
<td>Parallel sessions: Free Paper Session, chair TBC 4 Free Papers (each 15 mins) Personal Practice Session, chaired by Dr Annabelle Bundle PP Paper 1 (each 15 mins)</td>
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<tr>
<td>10.55</td>
<td>Coffee and exhibition</td>
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<tr>
<td>11.20</td>
<td>Child Protection Special Interest Group Session on Neglect, chaired by Dr Jacqueline Mok TBC</td>
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<td>12.00</td>
<td>Workshops Early support - is a programme supporting families with a disabled child effective? Dr Alya Young, Consultant Paediatrician, City &amp; Hackney PCT Delivering genetic diagnoses in developmental disorders - parents views Dr Hilary Burton, Consultant in Public Health Medicine, Public Health Genetics Unit, Cambridge Genetics Knowledge Park and Dr Moira Pinkney, Consultant Paediatrician, Ipswich Epilepsy: new syndromes, new therapies - are things really changing? Dr Richard Beach, Consultant Paediatrician, Norwich Counselling parents about immunisation Dr Helen Bedford, Senior Lecturer in Community Child Health, Institute of Child Health An update on management of ADHD Professor Chris Hollis, Consultant Child Psychiatrist, Nottingham Treatment approaches to cerebral palsy Dr Elspeth Will, Clinical Specialist Paediatric Physiotherapist, Evelina Children’s Hospital, Guys &amp; St Thomas 1.00 Lunch, posters and exhibition</td>
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<tr>
<td>2.00</td>
<td>Workshops (as above)</td>
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<tr>
<td>3.10</td>
<td>BACCH ‘University Challenge’ Compered by Professor Nick Spencer Teams from each of the Special Interest Groups 3.45 Award of challenge, CATCH and ‘Child’ prizes Professor Alan Emond, BACCH Chair 4.00</td>
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Programme subject to change

For online registration & abstract submission and programme updates, visit the BACCH website www.bacch.org.uk Forms can also be downloaded or requested from the BACCH office

BACCH Office Tel: 020 7307 5625 Fax: 020 7307 5601 bacch@rcpch.ac.uk www.bacch.org.uk

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