RCPCH
Milestones
The magazine of the Royal College of Paediatrics and Child Health

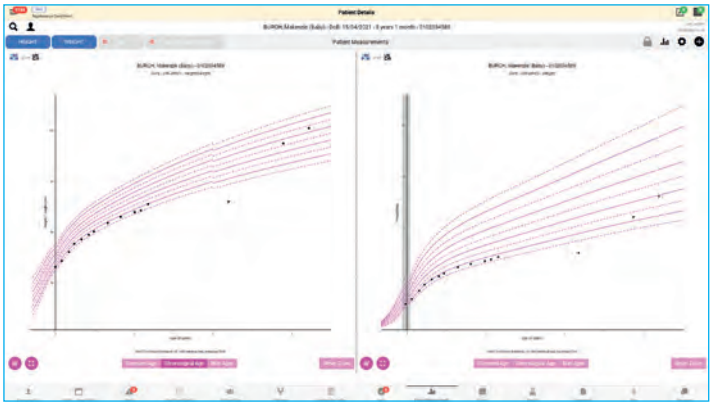
ONE JOURNEY, MANY ROUTES

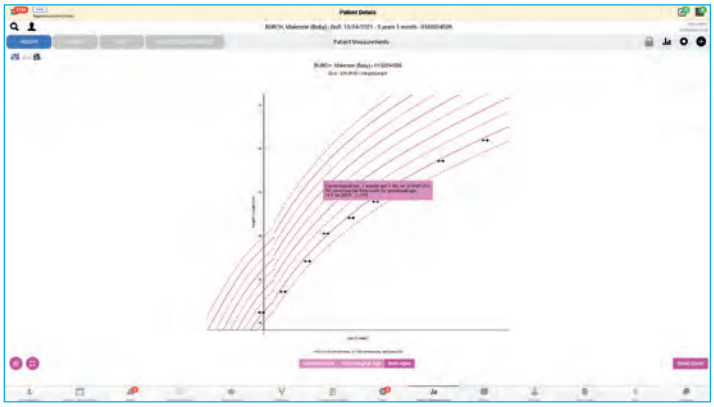
SUMMER 2024

INSIDE

Precision Paediatrics: Charting Digital Growth

Introducing a revolutionary tool for modern healthcare: Digital Growth Charts





Developed by a multi-disciplinary group of experts, from clinical paediatrics, nutrition, health informatics and statistics – the RCPCH Digital Growth Charts automate calculations of children's height, weight, head circumference and BMI using UK-WHO standard growth data and include specialist charts for Down's and Turner's Syndromes.

MHRA-accredited as a medical device, RCPCH's Digital Growth Charts provides highly accurate and consistent growth calculations to every clinician at the point of care, reduces the risk of errors, saves clinical time, and improves patient care.

The Digital Growth Charts technology has already been integrated into patient platforms and portals in NHS Trusts across England, Wales and Scotland.

"This is an exciting and valuable addition to our work. It allows us to see measurements taken in all different locations, providing a joined-up service with other health professionals."
Sabine Grosser,
Consultant Paediatrician
at NHS Forth Valley

"Cambric was asked to provide growth charting capabilities within our Morse community EPR platform. We reviewed the market for existing tools and solutions and concluded that the RCPCH Growth Chart API was the most capable solution to match (and exceed) the needs of the Morse user base.

The RCPCH team are the subject matter experts and have created the gold standard for digital child growth calculation and charting via their API. Integrating the API with the Morse EPR was fast and painless thanks to the excellent technical and clinical support provided by the RCPCH team to our developers and, of course, our clinical stakeholders."
David Welsh, Product champion at Cambric Systems

Integrate the RCPCH-approved Digital Growth Chart technology in to your place of work today and start enjoying the benefits.

Email us at growth.digital@rcpch.ac.uk to get started.

growth.rcpch.ac.uk

Editor's pick

Welcome to the summer edition of *Milestones*! Featuring an introduction by Professor Steve Turner, our new College President (page 4).

I have particularly enjoyed the articles by our 2024 medical student RCPCH conference prizewinners (pages 10-11) – bright young people who we will look forward to welcoming to paediatrics in the future! Congratulations to all of them, I can't wait to see them reappear in *Milestones* in years to come.

Take a look also at Medicines for Children (page 22) – if you're not already using this extremely useful resource, you should be! (And maybe you could consider applying to volunteer?)

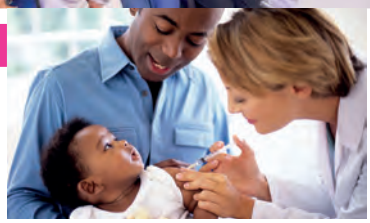
But my favourite article was Fresh off the treadmill (page 14), by Drs Wan, Gowai and Bamigbade, all newly CCT'd consultants who have shared their stories of the immediate new consultant period – three different experiences and a wealth of choices; so many "Oh, I didn't know that!" and "What a good idea!" moments for those trainees who, like me, are starting to see glimpses of the peak of Mount CCT appearing through the fog. If you're a higher specialty trainee I hope you can take away some excitement and practical tips from this fantastic piece!

Dr Maddy Hover

Contact
We'd love to hear from you – get in touch at
milestones@rcpch.ac.uk

Contents

Summer 2024



THIS ISSUE

EVERY ISSUE

Milestones

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

jamespembroke media

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Update

The latest news and views

KEEP IN TOUCH

We'd love to hear from you, get in touch through our channels

- X @RCPCHTweets
- Facebook @RCPCH
- Instagram @RCPCH
- milestones@rcpch.ac.uk

PRESIDENT'S UPDATE

Professor Steve Turner

- *RCPCH President*

VERY NICE TO MEET YOU. Writing my first piece as your President gives me a blend of excitement, pride and surrealism. My big challenge is squeezing what I want to say into 300 words, but I know I will be back, so will start now and pick up in the next issue of *Milestones*.

Our College has nearly 23,617 members so the odds are that we have not met before, so I need to introduce myself. I am a general paediatric and respiratory consultant from Aberdeen. Or rather Aberdeen is my adopted hometown; I grew up in Lancashire and trained in North East England with extended spells in Australia and New Zealand. My identity is best described as a doctor, husband (one very understanding wife), father (four children aged 19-25, no doctors) and coffee-drinking sports fan. My main research interests are the causation and management of asthma.

In 2027, I hope that I can look back and see that I have been part of a team that has achieved the following:

- Our College's core activities continue to develop standards of practice and training, and to be a strong voice for paediatricians, children and young people
- continuing to improve the benefit to you as a College member
- continuing to advocate for investment in children and child health services.

"I am best described as a doctor, husband (one very understanding wife), father (four children aged 19-25, no doctors) and coffee-drinking sports fan"

RCPCH President Professor Steve Turner with Dr Camilla Kingdon, immediate past-President, at RCPCH Conference 2024

Everyone has been very supportive, kind and patient with me since I started – many thanks to you all. After "What do you hope to achieve in post?", the next most frequently asked question is: "How are you going to do the job when you live in Aberdeen?" The short answer: "When you live in Aberdeen you have to travel!"

An alternative response goes along the lines of: "I don't believe our College officer posts should be restricted to a certain geography, and I believe I can be an effective President from North East Scotland."

I have been in the College building two days a week so far, and the majority of meetings have been over Teams. Looking forward, we have arranged face-to-face meetings so that I don't leave Aberdeen one week in three.

Many of the Royal Medical Colleges are considered 'London-centric' by many members, but by having a President (and five of our six other senior officers) living beyond the M25, our College has a broad perspective. Shortly we will have two international members to bring an even wider perspective of membership. Wherever you live, there are plenty of opportunities to get involved with our College; if you have a moment, visit **www.rcpch.ac.uk/get-involved** where members can find opportunities across the College.

CEO's Update

Robert Okunnu

- *Chief Executive Officer*

@ROkunnu

WE ARE ALL part of an inspiring community of members, staff and trustees working collaboratively to take forward the College's aims. With nearly two years in post as Chief Executive, I've looked back on what we've achieved as a community. For my part, I work closely with the President and Chair of Trustees and lead a 199-strong staff team who perform a variety of roles supporting members.

In our education and training activities over this period, we worked hard to keep pace with delivering exams and assessments in an uncertain landscape. We launched RCPCH Learning, a range of online courses covering child protection and other clinical topics. And of course, we saw the formal launch of Progress+ and the new undergraduate curriculum. Workforce is high on the agenda, continuing to drive our Thrive Paediatrics project to improve working lives, our award-winning #ChoosePaediatrics campaign, and our online evidence library to support workforce advocacy UK-wide.

The College is frequently in the news advocating for child health. Examples include our work on health inequalities, a ban on single-use vapes, our campaign calling on Government to roll out an RSV vaccine, and our calls for equal protection from physical punishment in England and Northern Ireland. We've drawn attention to paediatric waiting times in the UK. And we continue to advocate for child health globally.

For research and quality improvement, our national audits covering neonatal care, diabetes and epilepsy provide much insight. We introduced a new clinical guidelines hub to support members in the development of clinical guidelines and have taken forward further work on patient safety with our Patient Safety Portal and supporting the Systemwide Paediatric Observation Tracking programme. Our ongoing work with the British Paediatric Surveillance Unit ensures that doctors and researchers can investigate and gain access to studies about rare diseases.

Our membership numbers are growing and we've also been working to foster other income streams aside from our traditional exams and assessment sources. An example is renting out part of our Theobalds Road offices. It's always important to hear from members and our member survey earlier this year was timely, as we develop our next three-year strategy.

There's only so much one can cover in a short article and you can read much, much more on the College website. The future promises to be just as exciting.

RCPCH FACTS

45

ATTENDEES AT FIRST ANNUAL CONFERENCE IN 1928

OVER 2,300

ATTENDEES AT ANNUAL CONFERENCE IN 2024

95

ANNUAL CONFERENCES IN TOTAL

2

ANNUAL CONFERENCES CANCELLED DUE TO WORLD WAR II

Could you write for *Milestones*?

THE MILESTONES TEAM is proud of the fact that this is a magazine written by College members, for College members. We're always looking for fresh points of view, news from around the membership, and personal stories to share – as you can see, each issue includes articles on new initiatives, responses to new guidance, even reviews and recipes. But we couldn't put it together without your input, so if you have an article idea to share, please contact us at **Milestones@rcpch.ac.uk** and you could see your piece in print!

JOURNAL: ADC UPDATE

Nick Brown
- *Archives of Disease in Childhood Editor-in-Chief*

@ADC_BMJ

ONE OF THE most exhilarating spokes to being an editor is handling papers that not only challenge conventional wisdom, but prove themselves to be scientifically robust to the scrutinous review process.

For those who haven't had experience as authors, here's a synopsis. After the initial submission, a manuscript undergoes a rapid Editor-in-Chief screen: for me, at least, a focus on the cover letter, title, abstract and methods. If a manuscript passes this phase, the next step involves more detailed assessment by a relevant specialist associate editor. They decide whether to send it for external (and often statistical) review, after which the piece is discussed by the editorial board. Inevitably, there's substantially more attrition at this stage when difficult decisions are made based on priority ('is this helpful in practice ?' often the decider), methods, analysis and inference. Those that get through this stage always require at least one further iteration, sometimes several.

So, while sticking one's neck out is part of the responsibility, the axiom about 'better to reject a good paper than accept a bad one' still resonates as a corollary 'fortune favours the brave' (if justified) and it is this blend that many of the best manuscripts possess. A perfect example is the recent paper on antenatal diagnosis of transposition of the great arteries and post-operative ventilation time (1) – no spoilers, but if you haven't already done so, do read it.

References:

Namachivayam SP, Butt W, Brizard C, et al Potential benefits of prenatal diagnosis of TGA in Australia may be outweighed by the adverse effects of earlier delivery: likely causation and potential solutions. *Archives of Disease in Childhood* 2024;109:16-22

JOURNAL: BMJ PAEDIATRICS OPEN UPDATE

Shanti Raman
- *BMJ Paediatrics Open Editor-in-Chief*

@BMJ_PO

BMJ PAEDIATRICS OPEN, the companion journal to *Archives of Disease in Childhood*, has strived to publish globally relevant and interesting material in paediatrics and child health, through 2024. As an open access journal, *BMJ Paediatrics Open*, we continue to publish papers that are judged on their scientific quality and not on their perceived importance. We are decidedly multidisciplinary and international, and welcome papers from all healthcare and related professionals from anywhere in the world. Recent publications to our journal have come from Africa, Asia, Europe, North America, Australia, Middle East and the UK and span a range of topics, methodologies and article types. Our "Health and Wellbeing of Street and Working Children" topic collection has already had several papers published, including a viewpoint/editorial: Street and working children: a call for rights-based approach to their health and well-being.[1] We are working hard on getting submissions to the other challenging topic collection for this year: "Preventing and Mitigating the Impact of the Climate Crisis on Child Health". Our intention with these collections is to stimulate research on important issues, while raising global awareness and advancing advocacy for child and youth health.

We recently put out a call for associate editors and social media editors and have had a great response, so we have now a vibrant and diverse editorial team, keen to tackle the big issues. We would love to encourage you to join us as reviewers and as authors. Thank you for reading and contributing in whichever way is possible.

We want to ensure that young, aspiring researchers, academics and policymakers who are not supported by institutional funds, also have a voice in our journal. If you have an idea that is out of the box, please reach out to us and we will see if we can commission a Viewpoint or a Review article. We are also very keen to bring out the voices and lived experience of children and young people in the 'Young Voices' section, so if you are aged under 25, or have anything to do with mentoring young people, we want to hear from you.

On the horizon for the next topic collection is "Disability and Development in Early Childhood", watch this space. Don't forget, we offer waivers for the full Article Processing Charge (APC) for authors based in low-income countries and a 25% discount for RCPCH members.

References:

1. Seth R, MacRae P, Goldhagen J, et al. Street and working children: a call for rights-based approach to their health and well-being. *BMJ Paediatrics Open* 2024;8(1):e002486. doi: 10.1136/bmjpo-2023-002486

Think pink!
The Powering up team at #RCPCH 2024 and beyond

p18

Diary dates

Listed below are some of the up and coming courses and events, which are online unless otherwise stated. We will add to this list over the coming months, so keep an eye on our website

Read more
Find more dates at
www.rcpch.ac.uk/courses
www.rcpch.ac.uk/events

- **Effective Educational Supervision**
  25 June
- **Advisory Appointments Committee (AAC) training day**
  26 June
- **Supporting named and designated doctors (Level 4-5)**
  8-9 July
- **How to Manage: Childhood poverty**
  10 July
- **Statement and report writing – England/ Wales (Level 3)**
  15 July
- **MRCPCH Applied Knowledge in Practice exam preparation**
  31 July
- **Effective Educational Supervision**
  9 September
- **Effective Educational Supervision**
  10 October
- **Effective Educational Supervision**
  14 November
- **Diabetes**
  25 November

RCPCH LEARNING

- **RCPCH-BPSU webinar: Vision impairment is a sentinel child health event**
- **Cleft Palate: Examination in the newborn**
- **MRCPCH DCH Foundation of Practice exam preparation for overseas candidates**
- **RCPCH and RPS joint College webinar: The why and how of pill swallowing**

learning.rcpch.ac.uk

PODCASTS

- **The Paeds Round from RCPCH and Medisense**
- **Pill swallowing in children**

Hear more
Listen to RCPCH Podcasts wherever you get your podcasts

LOOKING BACK AT RCPCH CONFERENCE 2024

More than 2,300 people attended the three-day event at ICC Birmingham to share key research, learn about the latest innovations and celebrate success

Dr Jonathan Darling

- *RCPCH Vice President for Education and Professional Development*

DO YOU STILL SEND POSTCARDS?

Maybe we needed 'Wish you were here' postcards at RCPCH Conference 2024. Wish you could listen to this amazing plenary. Wish you could join in this thought-provoking and practical workshop. Wish you could experience the blend of cutting-edge science and practical clinical updates in the Specialty Group sessions. Wish you could have experienced events like the 'Ride for their lives' city centre bike ride, the morning run, British Association of Physicians of Indian Origin (BAPIO) and conference dinners. Wish you could feel the buzz of being amongst hundreds of people who care about paediatrics and child health, and 'Building a bright future together' (our conference theme).

I have to confess some bias, as Chair of the Conference Committee, I thought it was our best yet. It was certainly our biggest ever, with 2,324 people joining us at the ICC Birmingham from 25-27 March (370 virtually) from over 40 countries. To try to capture the essence of Conference 2024, I suggest three words:

Communication: No conference can succeed without this, and there was evidence of it in abundance, from delegates sharing key research and quality improvement (QI) messages via high-quality posters and oral presentations, through to conversations over coffee and lunch as people renewed or made new friendships.

Inspiration: Who could not be inspired by our eminent plenary speakers? From Professor Sir Michael Marmot challenging us around child health inequalities, to Hilary Cass previewing her Review of Gender Identity Services and Dr Umang Patel bringing his unique perspective on general purpose AI in healthcare... And that's not to mention Dr Ronny Cheung on papers that change practice, Dr Richard Scott on genomics, and Professor Miranda Wolport on early intervention for anxiety and depression. And that was only the start. There were gems of inspiration, wisdom and challenge adding sparkle across all our sessions, for example on Bella's story, or Martha's rule. And our children and young people (RCPCH &Us) were centre-stage inspiration, both in the plenary sessions and the middle of the exhibition.

Celebration: This pervaded the whole conference, but for me especially when we celebrated success in the medical student and foundation prizes, the Honorary and Visiting Fellows, the James Spence Medal, the PAFTAs, and the RCPCH &Us Voice Champion Award.

Maybe the title of one of our early-morning workshops on the final day is a good summary of the whole event: 'Joy at work and how to grow this'. If you've been in recent years, you'll know what I mean. But if not, my postcard to you is 'Hope you'll be there – 26-28 March 2025, Glasgow!'

"It was inspiring to hear from senior clinicians"

Winners of the medical student annual prize share their experiences of RCPCH Conference 2024

Eleanor Bryant

IN MARCH, I HAD THE PRIVILEGE OF attending RCPCH Conference 2024 as a winner of the medical student prize, having been selected by my medical school based on my enthusiasm for child health. I particularly enjoy paediatric medicine because of the diversity of experiences I had during my medical school placement – no two days were ever the same.

Before conference, I had the pleasure of attending the medical student prize ceremony. This was a wonderful opportunity to connect with other medical students who share a passion for child health. We were able to exchange our experiences during medical school and our plans for the future. It was inspiring to hear from senior clinicians about their journeys into paediatric medicine giving us an insight into the exciting and varied paths our own careers could take.

Conference itself was a thoroughly enjoyable experience. It was fantastic to learn about projects from across the country, all united by the common goal of improving child health. A particular highlight of the conference was hearing from plenary speaker Professor Sir Michael Marmot, whose insight into society's health gaps left us with plenty of food for thought and inspired us as the next generation of paediatricians.

Kishan Patel

- *Final year medical student*
- *University of Nottingham*

@_kishan.p
Kishan Patel
@_kishan0709

I WAS VERY FORTUNATE TO have won the RCPCH 2024 medical student prize. It was a fantastic experience with entry into all three days of conference. I was privileged to be presented with an award by Dr Camilla Kingdon for demonstrating dedication to a paediatric career and highlighting the importance RCPCH places on training the next generation of paediatricians. The warmth and enthusiasm I received was refreshing and encouraging.

I have had several experiences within paediatrics, including completing my dissertation in paediatric oncology, having inspiring tutors on my paediatrics rotation and completing paediatric audits. These have been formative in my passion to pursue paediatrics as a medical career. Conference was great for networking and making friends with other medical students who share this passion.

It was a unique opportunity to meet paediatricians from a diverse range of backgrounds and specialties. Detailed seminars highlighted the latest developments in paediatrics, including using AI to predict paediatric sepsis, Genomics England's Generation Study evaluating neonatal whole-genome sequencing to detect rare treatable genetic diseases, and incredible work to improve paediatric care in Nepal. It was an incredibly rewarding experience, and I would encourage those with an interest in paediatrics to apply for the prize.

Niharika Jitender Kumar Tekchandani

@niharika.jpt
Niharika J. Tekchandani

INSPIRED BY THE WORDS ATTRIBUTED to Frederick Douglass, "It is easier to build strong children than to repair broken men," I aspire to be a caretaker of children's health, particularly in paediatric critical care. RCPCH Conference 2024 provided a platform to engage with experts, exchange knowledge and explore innovative advancements.

Topics ranged from Martha's rule to gender reassignment surgery in paediatric patients, alongside discussions on the history and contemporary relevance of eponymous syndromes.

The keynote speech by Dr Umang Patel about adopting AI to enhance patient care was a personal favourite. Workshops enriched my understanding, especially in paediatric oncology, and I witnessed interesting debates on challenges such as protecting child refugees. The conference augmented my professional growth and commitment to global child wellbeing. Gratitude extends to mentors such as Dr Camilla Kingdon, Dr Steve Turner, Dr Jonathan Darling, and Henna Davé among other key members for ensuring a rewarding experience for all medical students.

I am resolute in my paediatric career path and eager to apply the wealth of knowledge I have acquired from conference to convert my passion into my profession. I eagerly anticipate participating in future RCPCH events to further enrich and diversify my knowledge.

Lynda Khun
- *Barts and the London (QMUL)*
@sxlyndar

I HAD AN ABSOLUTE blast at RCPCH Conference 2024. It was an honour representing Barts and meeting medical students, doctors, and allied healthcare professionals from all over the world who are passionate about paediatrics.

The College treated us very kindly (massive shoutout to Henna) and it was amazing to meet Dr Camilla Kingdon in person after seeing her RCPCH President updates pop up in my inbox every few weeks.

The talks and workshops were eye-opening and I loved that we had the opportunity to hear directly from patients and families. My top three highlights were Professor Sir Michael Marmot's wonderful plenary talk on health inequalities among children and young people; Dr Rachel Rowland's deeply moving workshop, Bella's story, on how we can work with families when their child dies; and Dr Pam Dawson's insightful talk on chronic pain and functional illness across specialties.

Senior members and Fellows at Senior Members' Annual Luncheon

Conference reaffirmed my passion for paediatrics and I'm excited to continue down this path. I left Birmingham with so much food for thought and lovely new friends who I just know I'll cross paths with again in the future. Fingers crossed you'll hear from me again in a few years' time as a winner of the foundation doctor prize.

Getting it right the first time

GIRFT is working with the NHS Diabetes Programme on a national review of services for children and young adults living with diabetes

Dr Dita Aswani

- *National CYA diabetes GIRFT Clinical Advisor*
- *Consultant Paediatrician specialising in diabetes and weight management*

Dr Fulya Mehta

- *NHS England's national clinical lead for diabetes in children and young people*
- *Consultant in General Paediatrics and Diabetes, Alder Hey Children's Hospital, Liverpool*

CHILDREN AND YOUNG adults' (CYA) diabetes is to be one of the first paediatric medical specialties to be fortunate to receive the investment and spotlight of the national NHS England Getting It Right First Time (GIRFT) programme from June 2024.

GIRFT, which first originated in adult orthopaedic surgery, is data driven and evidence based, clinically led, and has delivered phenomenal improvements and financial opportunities to the NHS in England. It now operates in over 40 medical, surgical and cross-cutting workstreams.

Of particular relevance, the GIRFT programme in adult diabetes (national report 2020) identified three main areas and cross-cutting themes in trusts where improvement could, and subsequently did, improve quality and consistency of care, aided by the development of tools and interactive pathways.

In GIRFT CYA diabetes, each Integrated Care Board (ICB) will be invited to a deep-dive gateway review. A bespoke ICB data pack, derived from the National Paediatric Diabetes Audit (NPDA), the National Diabetes Audit (NDA) and Hospital Episode Statistics (HES) data, will inform focused peer-to-peer discussions between all stakeholders, commissioners, and decision makers within ICB leadership teams and their trust colleagues in paediatric and young adult services.

The purpose is to improve consistency of care across systems, both locally within ICBs, and between ICBs. A collaborative approach and bidirectional dialogue will aim to understand and address the reasons behind unwarranted variation in care and outcomes for all types of diabetes until the age of 25 years, thereby seamlessly examining service provision to include the vulnerable time of transition of care.

The NPDA report assesses the quality of care for children and young people with diabetes

The good news is that overall outcomes and care in paediatric diabetes have improved year-on-year, as demonstrated by NPDA data. Initiatives such as the Paediatric Diabetes Best Practice Tariff, a well-established National Children and Young Peoples' Diabetes network, and quality improvements and service investment driven by the RCPCH National Diabetes Quality Programme have all contributed to the reduction of median HbA1c in England and Wales from over 70mmol/mol in 2010/11 to 60mmol/mol in 2022/23.

There has been major advancement in monitoring with real-time continuous glucose monitoring systems, cloud platforms to share data between patients and healthcare teams, and intensive insulin treatments. The revolutionary NICE TA 943, published in 2023, recommends a hybrid closed-loop system for all children, recognising the unbeatable outcomes that can be achieved with this technology compared to other insulin regimes.

"There has been a persistent gap between the care and outcomes of those in the most and least deprived quintiles"

The bad news is that significant variation still exists between the outcomes of provider units, even when they are governed by the same ICB. There has also been a persistent and widening gap between the care and outcomes of those in the most and least deprived quintiles, and between ethnicities. An example of this is that a black child is almost half as likely to receive advanced diabetes treatment technology compared to a white child, and this gap is inexcusably widening.

There is also the challenge of increasing patient numbers, alarmingly so in Type 2, requiring recruitment and retention of a fully multidisciplinary clinical workforce with preservation of their time and expertise to deliver the care that only they can. There are ongoing training requirements to develop skills on newer and rapidly advancing technologies, and to understand the drivers of childhood obesity and improve services for early onset Type 2, recognised to be particularly aggressive with a high complication rate at diagnosis itself.

GIRFT is aptly named, as getting diabetes care right from the very beginning for every child or young person and their family will pay dividends in terms of a better quality of life and future life expectancy. This new GIRFT workstream offers a shift of the lens, from the confines of paediatric practice to the responsibility that the system holds for the life journey of this long-term condition. This is a real opportunity.

Looking to the future

Children and Young People were intent on making their voices heard at RCPCH Conference 2024

- Toby
- Demi
- Aiden

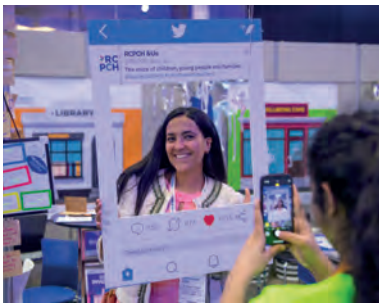
FOR RCPCH &US, this year's RCPCH Conference was a huge step forward, in that it was the first time that all major contributions that created our stand came from us, RCPCH &Us volunteers. It was an amazing experience that we had a chance to be a part of, watching the contributions of around 26 volunteers coming together to create an idea for a stand out of thin air, in a total of less than five hours' meeting time.

We should, of course, not forget all the youth workers and other staff at RCPCH &Us who put in a tremendous amount of effort in order to make our ideas come to life. Thanks to all of you who helped us.

In our three planning meetings, our village theme was brought up, discussed, and polished at lightning speed, with everyone at each meeting participating and giving their thoughts. This really enhanced the conference experience, as we were able to see all our ideas come to life on the stand.

Our stand was made up of a library which had lots of leaflets and resources explaining our different projects and ways to engage with children and young people (CYP). We also had an advice centre, so trainees or qualified paediatricians could find out how to get involved with what's offered by the RCPCH Children and Young People's engagement team, and how involving young people can improve the quality of their services.

We had our very own hospital, which was set up so that the roles were reversed, with young people playing the doctors, and the doctors taking on the role of patients. Some of the doctors had a good experience and some were not as good, as they were left feeling unheard or a little bit uncomfortable that we spoke to their parents (also played by a doctor) instead of them. We stressed the importance of having a voice, using it and speaking up.



The wellbeing cafe was where we hosted arts and crafts, offering time to ground yourself, have a chilled conversation and have some fun.

We did not want to be confined to our stand, so our touring bus went around the conference – we went out and engaged. We also got to use the public address system to make announcements, so our voice was heard everywhere.

RCPCH Conference 2024 was the biggest yet for both CYP and delegates. There were 26 CYP and parents/carers from RCPCH &Us, plus nine young adults from other organisations speaking in workshops, and 2,300 delegates.

As well as putting together the stand, both planning and presenting the open plenary was an amazing opportunity. The rehearsals for the plenary were different from the actual performance as we didn't have an audience, and it included audience participation. Thankfully, it went well. The planning was done over just three sessions and was very inclusive to CYP. We were included in almost every decision. As a result, it made us feel as if we were a building block for this year's conference.

ABOUT

RCPCH &Us: The Children and Young People's Engagement Team delivers projects and programmes across the UK to support patients, siblings, families and under 25s, and gives them a voice in shaping services, health policy and practice. RCPCH &Us is a network of young voices who work with the College, providing information and advice on children's rights and engagement.

RCPCH &Us
The voice of children, young people and families

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"Fresh off the treadmill"

Three ex-trainees share their experiences and aspirations after CCT

CONGRATULATIONS, YOU RECEIVED an Outcome 6 on your Annual Review of Competency Progression (ARCP). All that hard work, blood sweat and tears built up to those beautiful two words at the end of your final ARCP report on Kaizen. Hooray! But what happens when the Champagne is drunk and the happy tears have dried? We hope this article gives some guidance on the options after CCT, based on the experience of three ex-trainees who have completed CCT within the past year.

Congratulations on finishing training. How did you feel at the point of CCT and what did you do when you found out?

Jess: I was so relieved! I couldn't stop crying, so I couldn't do much all day apart from share the news with family and friends. I felt particularly relieved as I achieved an Outcome 5 at my last ARCP, pending some additional Kaizen bits that I had overlooked. Once all the ARCP requirements were met, Outcome 6 happened pretty quickly, thank goodness!

Hani: I received the email on a Monday when I was rostered for a night shift, first of three. It's hard to describe the feelings – a mix of elation, sense of achievement and wow! I started sharing the news with my family first, then friends. I can say, those night shifts were the best ever. During that first shift, I emailed the TPD, HR and HEE/deanery to inform them of my ARCP outcome and submit my resignation with a confirmed date.

Dammy: I was so relieved that training had finally ended. Eight long years of

rotating from hospital to hospital, moving homes and doing endless mandatory induction modules had finally come to an end – I could finally BREATHE. I then went on maternity leave, knowing that when returned to work I would be coming back as a consultant.

What are you doing now?

Jess: I'm working my three months' notice before I start a CCT clinical fellowship in infectious diseases in another city. (I've decided against a grace period, for a break and to spend time with my family.) So, for the next few weeks I'm basically doing the same registrar job as I've been doing for many years.

Hani: I've done two months as a consultant locum covering sick leave in a DGH. I am now in a full-time substantive post in another hospital. Everyone is friendly and I'm settling in.

Dammy: I am working as a locum, both in registrar and consultant roles. I am actively looking for a substantive consultant job, and preparing myself for consultant interviews, but I am in no rush.

What were your three most important considerations when it came to your options post CCT?

Jess

1) Career progression in a subspecialty
I wanted to gain more experience in infectious diseases after completing a PIID SPIN module during my training.

2) Working somewhere different
I've been based in the same deanery since medical school. I love South Yorkshire, but it's time to experience something different.

3) Having a break from out-of-hours shifts.

Hani

1) Family life
As a trainee it was tough to get that balance. My thinking was: no more night shifts at a registrar level.

2) Career progression in a subspecialty
When I got my CCT, I had already applied for jobs, been shortlisted, attended an interview and been given the job. I completed a respiratory SPIN module during my training, and my long-term goal is to go for full competency acquisition for the specialty. I thought about a fellow job, but the substantive post I secured had lots in its job description, as well as promises made during informal discussions before the interview, so I decided to go for it.

3) At one point I was thinking whether I should actually leave the UK for a better paid job overseas.

Dammy

1) I needed flexibility and autonomy, especially around my family life. I wanted to be able to pick my own shifts and not be constrained by a fixed rota.

2) I wanted to work wisely, so work fewer hours but make more money. I had just finished maternity leave, so making money was important. Locuming was the only way I could achieve this.

3) I wanted to ease myself back into clinical work after maternity leave. I found

> **"I wanted to work fewer hours but make more money. Locuming was the only way I could achieve this"**

that locuming first was the best way to do that before getting a consultant job where I would be the one making final decisions.

Did you do any preparation as a senior trainee in the run up to CCT?

Jess: I spoke to multiple departments and senior members of staff around the region about available consultant and clinical fellow jobs, and to people who have been ID clinical fellows in the past, who have directed me towards applying to certain hospitals and key contacts. Everyone has been really helpful. Otherwise, I haven't done much preparation, but I'm expecting to pick up some interview courses in the future to get ready for consultant interviews.

After my SPIN, I decided to go away for more specialty experience in another city as a post-CCT clinical fellow, particularly as there are no vacancies locally for General Paeds consultant jobs that included PIID in their job plan. The fellow job is also nine-to-five – the idea of no night shifts after many years of doing them was incredibly attractive. It's easier for me to decide this, as I have no children or mortgage to pay off. I hope that a consultant job comes up after my fellowship. In the meantime, I am signing up to locum agencies to keep an eye on consultant jobs that I could pick up during weekends.

Hani: I signed up with three locum agencies well ahead of my CCT date. I was worried that if I didn't get a job I would struggle financially. I was not interested in the grace period at all, as I felt exhausted.

As for the interview preparation, I spoke to people and did one actual mock with my clinical supervisor. One of the things I wanted to do was formally acting up. When I spoke to the TPD about it they said it was too late as the process takes time. This is one of the points

that RCPCH needs to explain better to senior trainees. I also started taking courses, such as effective educational supervision, management and leadership for senior trainees, and equality and diversity.

The two months I did as a locum consultant were excellent: nice team, reasonable workload and distance from home and, of course, a lucrative weekly pay cheque. Most importantly, it was a good start as a new consultant. It gave me an insight into the other side of the coin and helped prepare me for my substantive post.

Dammy: I was heavily pregnant when I completed CCT, so I was just looking forward to finishing work and going on maternity leave – and finally having a well-deserved break from the NHS. Since coming back from maternity leave, I have signed up to two locum agencies and have been working in both registrar and consultant roles.

I have recently applied for a substantive consultant role and I am currently practising for the interview, with consultant colleagues that have recently got posts rather than attending a course.

I'd always wanted to locum after CCT for at least six months, before picking a substantive consultant role. The locum pay and the flexibility of shifts was my main reason for this.

It was a good feeling not just to be a number on the rota and being used to fill gaps in service provision – even if I was now filling this gap as a locum doctor, at least I was being paid well. I also enjoy the fact that I can still spend quality time with my daughter and family. I've used this locum period to build my clinical skills back to a good standard (after maternity leave) to be a good consultant.

How have you found your first year post CCT?

Jess: I feel less constrained by training commitments, and I can enjoy clinical practice.

Hani: Consultant life is better than trainee life – I am less tired and less stressed. There is more admin and meetings, but you have more control over your life and more time compared to being in training. There is more responsibility but I feel ready – remember, with great power comes great responsibility. A major difference is that the patients are now 'your patients', and it's your sole responsibility to deal with their phone calls and emails.

Dammy: The year is going really well. I'm working wisely, as I wanted to (making money, working fewer hours). I'm enjoying my free time and the time I spend with family. I've had time to chase other interests. I'm currently doing a course on event planning, which is something I would like to do more of on the side. The consultant shifts I've done have shown me that consultant life is good and I'm looking forward to getting a substantive role.

What do you wish you knew before reaching CCT?

Jess

- The process at the end of CCT – I've learned all of this through chatting to others rather than from a formal document. I'm so glad to have had friends and colleagues that I could share my worries and thoughts with on WhatsApp.
- I would have liked more details on what supervisors and trainees need to fill out at the point of CCT on Kaizen, so that I could have overseen this a bit better and avoided the stress of Outcome 5.
- That you can resign at any time but need to work three months after that before you can leave your trust (if you're not taking your grace period).
- Outcome 6 means you can add your name to the GMC Specialist Register but this process requires up-front payment to the GMC.

"There is more responsibility but I feel ready – remember, with great power comes great responsibility"

Hani

- More details and a clear guide to formal acting up.
- How to prepare your CV for consultant job applications.
- That as a SPIN trainee, you can, and should, apply for jobs that say they need a grid trainee – you never know. I received this advice after I'd already accepted another job.
- I knew this, but I would like others to know: you need to inform your TPD whether you want your grace period or not, and you get to choose where to spend it. You need to inform your employer, HR, Deanery/HE that you have completed your training and give them a resignation date. Remember: you need to give three months' notice.
- Immediately start the process of applying for your CCT (fill in the portfolio form and pay the GMC fee).
- Don't forget to inform your ES and thank them for supporting you throughout training.
- If you want early CCT, start the conversation with your ES and TPD and be on top of your portfolio.

Dammy

- The different options available (locuming, a locum consultant post, work you can do outside medicine with your qualifications).
- How to apply for consultant jobs (searching, application, interviews etc).
- The revalidation process.

Feedback – a tool for development not for embarrassment

A survey asking for colleagues to share their experiences of receiving feedback delivered some interesting results – and lessons we can all learn from

Dr Gergana Topalova
- *Specialty Doctor in Paediatrics*

Dr Manohar Joishy
- *Consultant Paediatrician*

INAPPROPRIATE FEEDBACK HAS brought plenty of visible and hidden distress in our otherwise healthy and friendly paediatric department. So we decided to do a survey to allow our colleagues to express their opinion about feedback.

We risked it – we put down the questions and allowed open answers. And surprise – the results were a bit overwhelming, but also very honest.

It seems that almost half of the people had not had formal training in feedback, when it is sought on a daily basis. Some of us had heard and use the SMART model, but not all the time. The 'Sandwich' model was mentioned, 'advocacy with enquiry', but again there was a striking number that have no structured approach to feedback.

We asked what factors people consider when giving feedback, how they feel when they receive positive feedback in front of the public; how do they feel when negative feedback is given in the presence of their colleagues, what made negative feedback bad, and what made it good...

Open answers allow emotions, and emotions did come. We knew some of the stories tagged to the words in the answers. We remembered the distressed faces of the people sharing with us their dismay because of abrupt feedback. But also we were sure that some of the frustration had been caused by immature attempts to comment on others' skills or actions, without paying attention to the colleagues' feelings, or simply because they didn't have training.

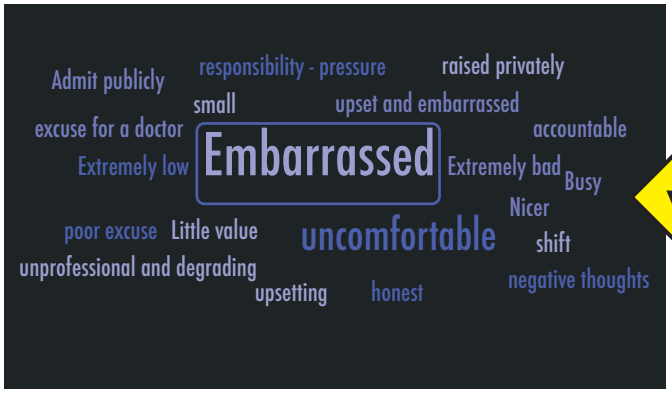
There were some repeating themes, which of course are not rocket science, but still.

No one likes to receive negative feedback in front of their colleagues. Good negative feedback is constructive and considerate, timely and well prepared. Most people do not mind receiving negative feedback as long as it is done well. This allows them to research, learn, improve themselves and even train others. Negative feedback that is well delivered is sometimes better appreciated than positive feedback that is poorly conveyed.

Interestingly, there was practical advice in the answers about what made feedback good; and one suggestion was to give a 'warning shot'. For those giving the information, it is a way of setting the 'scene'; for those on the receiving end, it allows the person to get in the right mindset for accepting the information.

Strikingly, there were some people in our survey who stated that they have never received negative feedback in front of their colleagues. So it can be done. Or the feedback was given so well that was not deemed to be negative?

We shared this small study in a departmental meeting and this sparked a huge discussion that got spiced with the different temperaments of the people present and with the cultural heritage everyone shelters. There was agreement though – we all need feedback. This is how we learn what to do and what not to do. And regardless of who we are and where we come from, we should treat each other with respect, be considerate, and plan and give feedback in a structured and constructive manner. It is possible and depends on us.



How do you feel when you receive negative comments in the presence of your colleagues?

VS

Think of an example of valuable feedback you have received, that was positive – what made it good?

Painting the town pink! Powering Up at #RCPCH2024 with #PinkHats and tote bags

SHOW, DON'T TELL

Powering Up is tackling health inequalities and taking medicine to the next level – with actions rather than words

Dr Guddi Singh
- *Consultant Paediatrician*
- *Director of WHAM (Wellbeing & Health Action Movement)*

@DrGuddiSingh

AS A WOMAN, IT'S TOUGH to be taken seriously. So pink, bejewelled cowboy hats are obviously the answer. I'll let the pictures do the talking, but at this year's RCPCH Conference, the all-woman collaboration of Powering Up tickled the profession pink.

Pink is contentious. Thrust towards newborns, pink paints girls' lives with Western gender norms from day one. Yet, especially when it's hot, pink is hard to ignore. It might be why it's the colour of female collectivism: from the 'Pink Ladies' in *Grease* to the 'Gulabi Gang', (gulab meaning 'rose' in Hindi), a searing women's empowerment movement against domestic violence in my birthplace in India. Pink declares: "I'm here. Don't mess with me."

"Prejudice persists, not only as a personal affront, but as an economic reality that shapes and limits lives"

Which is important when women's rights are not in the pink of health. Eight in 10 women will face sexual harassment in their lives,[1] while 2.4 billion women globally don't have the same economic rights as men.[2] The 'pink tax' refers to the higher prices applied to products or services marketed to women. For clinicians of all stripes, the gender pay gap, a lack of equal opportunities, and suboptimal conditions for rejoining the workforce are all examples of another kind of pink tax, also known as everyday sexism in the NHS.[3]

Prejudice persists, not only as a personal affront, but as an economic reality that shapes and limits lives. Of course, it's not

just women who are marginalised and minimised: people of colour, non-elites, LGBTQ+, the differently able... the list goes on.

It's time for that to change. 'Show, Don't Tell' is a journalistic aphorism that echoes the women's suffrage motto, 'Deeds, Not words'. In Powering Up, we're showing, not telling, how we want to take medicine to the next level: through meaningful co-production to address health inequalities.

With National Creativity & Wellbeing Week starting on 20 May, Powering Up gets creative.[4] Paediatricians Tami Benzaken and Hannah introduce Part 2 of our pilot, urging you to *Show Up!* Meanwhile, creatives Judi Alston and Tiara Ashworth demonstrate with words and pictures how art can level hierarchies in health. Finally, medical student Leyna Roy argues for education that empowers clinicians to fight for social justice.

Health inequality is a serious business, but disrupting the status quo can be playful and more effective for it. Show, don't tell. Where's your #PinkHat?

Powering Up is a multiprofessional collaboration between WHAM, CANAL and One to One Development Trust. For more information, visit: q.health.org.uk/idea/2023/powering-up-co-producing-solutions-to-health-inequality-with-young-people

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4. Creativity and Wellbeing Week 2024: creativityandwellbeing.org.uk

SHOW UP! – A PLAY BY POWERING UP

Dr Tami Benzaken
- *Paediatric Registrar*
- *UCLH*

Dr Hannah Zhu
- *Consultant Paediatrician*
- *Evelina London Children's Hospital*

Prologue: Health inequalities lead to worse physical and mental health outcomes among under-represented and deprived populations, disproportionately affecting young people (YP).[1]

While we all recognise the importance of co-production with YP to create new health solutions, are we doing this effectively and with the right audiences? Self-selecting patient groups often don't represent those facing the greatest inequalities, whose voices are crucial for improving healthcare delivery.

It's time for a radical change in co-production in health. We need to reach YP where they are, eliminate hierarchy, and engage them creatively. And maybe even have fun.

Creative health provides accessible opportunities to address the upstream determinants of health.[2] The arts offer alternative ways for YP from diverse backgrounds to express their feelings about health, wellbeing and lived experience.

***Show Up!* is a 'play' which aims to:**
- explore community-based approaches to YP health and inequalities
- empower YP to address social determinants by using creative methods
- co-create solutions to improve clinical services for YP.

Dramatis Personae
- Year 10 & 12 students and child health professionals
- **Scene:** Secondary School, South London
- **Time:** 15-19 July 2024

Act 1

YP facing health inequalities will take part in theatre, dance and poetry workshops to creatively explore:
"What are the barriers to living a good life in this community?"

Act 2

Multidisciplinary clinicians will engage in creative workshops to collectively understand:
"What are the barriers to delivering good healthcare currently?"

Final Act

The two groups, both alike in dignity, will collaborate theatrically to share perspectives, build empathy and co-create solutions. These will be presented in a 'grand finale' to local leaders in health and social care to influence system-level change across South London.

Auditions

Budding actors (clinicians) wishing to join this exciting production can register via the QR code.

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An example of artwork by Tiara Ashworth for the Powering Up zine

POWERING UP: INSPIRING CREATIVE CHANGE

Judi Alston
- *Creative Director*
- *One to One Development Trust*

Tiara Ashworth
- *3D artist*
- *One to One Development Trust*

Tiara: I first met Dr Guddi while volunteering on the project *Our Earth Your Choice*, a game she believed could help with climate anxiety. Now, 17 months later, I'm a 3D artist with One to One, collaborating with Dr Guddi again on Powering Up. In this project, I create artwork and help gamify an interactive zine.

I was amazed by a creative session with Powering Up's doctors. Unlike my usual experiences with stressed and rushed doctors, they were different. I'm getting to know doctors better, finding it inspiring to work with those who want to change healthcare. Powering Up gives young people a platform to create solutions and find their voice.

This project encouraged me to speak up myself. When I accompanied a family member to the hospital and felt they weren't being heard, I challenged it. I hope to help others speak out, particularly through art and creative expression.

Judi: We positively impact lives through creative projects that enhance health and wellbeing. The Powering Up partnership between clinicians and creatives aims to engage young people through creativity, fostering positive change and information dissemination. Our young creatives openly collaborate with doctors, offering ideas to improve health, which is uncommon as most young people lack social or familial connections with doctors. This opportunity builds confidence and resilience within our team. At One to One, we are passionate about challenging inequalities, aligning well with Powering Up. We look forward to co-creating projects through film and interactive media in the coming months. Stay tuned!

▶ ***Visit:*** ***onetoonedevelopment.org***

WHAT THEY DON'T TEACH YOU AT MEDICAL SCHOOL

Leyna Roy
- *Final Year Medical Student*
- *University of Birmingham*

Going into medical school, I believed medicine alone would suffice to make a meaningful difference in people's lives. However, as a final year student, I feel we're missing so much. Many patients I've encountered were failed by health services due to social conditions. I had exactly one lecture regarding social determinants of health, and despite enrolling in a Global Health MSc, I am none the wiser for helping patients in these circumstances. How will I be satisfied as a doctor if I feel helpless so frequently?

Fortunately, I recently discovered WHAM, led by Dr Guddi Singh. WHAM fights health inequalities and shares knowledge through its website, including resources on What they don't teach you at medical school in the WHAM Library. I'm inspired by WHAM's dedication to addressing gaps in healthcare education and training, and its emphasis on co-production with communities.

Working as part of this group is motivating, as I can be the change I want to see alongside like-minded people. Our current project, Powering Up, sees us working with YP and clinicians to learn their views on health, wellbeing and empowerment, and to develop feasible solutions to tackle health inequalities in practice. This project aligns perfectly with my beliefs, and I already feel more empowered to act, even as a medical student, not to mention as a woman of colour, in a field which still has a long way to go. I'm excited to co-produce solutions which can be used to widen the scope of practice of all clinicians, and maybe even change healthcare systems from the ground up.

▶ ***Find out more:*** ***www.whamproject.co.uk***

Working together for better healthcare

Children, young people and their families should be at the heart of quality improvement initiatives

Natalie Wyatt
- *RCPCH Quality Improvement Fellow*

PAEDIATRIC HEALTHCARE PROFESSIONALS undertake quality and safety improvement projects with the ambition to improve the healthcare of children and young people (CYP). However, often the improvement idea and design for the project reflect the priorities of the healthcare professional rather than the CYP and families they are designed for. This can result in improvements that miss the mark or that are unsustainable.

Working with CYP and their families to find out what improvements they think are needed and co-designing how to improve offers the potential for sustained meaningful improvements. Facilitating CYP to express their views and responding to them in a meaningful way also helps us to uphold their rights as laid out in the United Nations Convention on the Rights of the Child.

How to find CYP and families to work with on quality improvement

Finding people to work with is the first step in developing a quality improvement (QI) idea and improvement plan. Engaging all the stakeholders is key. Identifying the healthcare professionals and associated staff can be just a matter of talking to colleagues, however identifying CYP and families who want to share their expertise can be more challenging.

Within your healthcare setting there may be lots of different groups, such as the hospital school or education team, hospital youth worker or hospital youth forums. Here, you will find your Experts by Experience: CYP and families who are actively involved in your local healthcare system. Your local hospital teacher or youth worker may offer opportunities to combine their objectives with your request for CYP and families to become involved in QI. Discuss together how you could develop a QI engagement plan that meets all your needs.

There is also a wealth of options in the community to consider. Many improvements are needed that address the perspectives of those that haven't yet sought healthcare or are only minimally engaged. For example, improving vaccination uptake in your community could be most effective if you engaged with unvaccinated families in the community, to find out views and barriers and to co-create novel and useful solutions.

Engaging people outside of the healthcare setting may provide a broader viewpoint that is more representative of the wider community you serve. The RCPCH has created a map of the UK with links to youth councils, clubs, and parent carer forums across the country, where you may find keen participants to work with you to design healthcare improvements.

How to ensure healthcare professionals, CYP and families are working well together

Once you have worked out how you are going to locate QI-enthusiastic CYP and families, you need to develop an engagement plan so that you can work together safely and effectively. The RCPCH &Us team can support you in this.

Listening is meaningful when it is transformed into action. Seeking the views of CYP and families has the potential to be tokenistic, such as using tick-box surveys with no plan for action. Incorporating CYP and their families into QI projects needs to be authentically and meaningfully done. Before consulting with children, ensure all team members are on board and committed, and that the ideas and solutions generated are implemented in a proactive and timely manner.

Be bold, reach out to your local connections and bring CYP and their families into your QI ambitions. By working together, you can improve the quality of your QI.

Find links to youth councils, clubs and parent carer forums in your area at: www.rcpch.ac.uk/resources/engaging-children-young-people/map
For resources to help you get started on an engagement plan, visit: www.rcpch.ac.uk/resources/engaging-children-young-people

Medication made simple for parents and carers

Medicines for Children is an invaluable resource, providing jargon-free and easy-to-read information in the form of leaflets, web pages and video guides

Yincent Tse

- *Consultant Paediatric Nephrologist*
- *Great North Children's Hospital, Royal Victoria Infirmary*

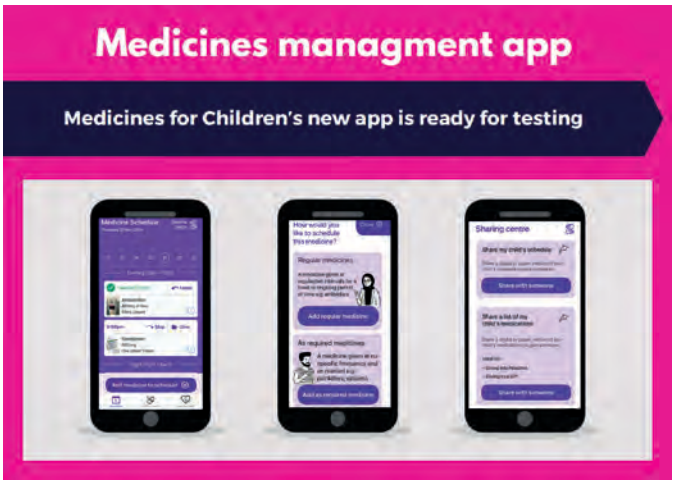
IN CLINIC, WHEN YOU start a patient on a new medicine, do you ever want to share simple, easy-to-read information with parents?

The Medicines for Children website has more than 200 medication leaflets, web pages and guides on how to give medicines, such as via gastrostomy tubes, and what 'Unlicensed medicines' means. It is written jargon-free for parents and carers, to an accessible reading age of 12 years. To help level-up inequality and improve health literacy, there are videos to explain the 'how to' and we are starting to offer additional languages such as Polish, Romanian, Urdu and Punjabi. The top leaflets accessed from the UK are: melatonin, amoxicillin, omeprazole, Movicol and glycerine suppositories. When first launched in 2009 there were 10,500 downloads which had grown to 4.5 million from around the world in 2023.

The seven-step leaflet development process

Leaflets are directly accessible via the BNF for children and the BNFC app, under each medicine on the 'Patient and carer advice' tab.

Every year RCPCH members work with the team behind this fantastic resource to update and create new content; I was delighted to join the team in 2022. Most gratefully, I was guided by Dr David Tuthill, also representing RCPCH on the board, who chairs the BNFC Paediatric Formulary Committee.



The Medicines for Children app will soon be available

Developing the patient information leaflets is a fascinating and a much more robust process than I imagined. Together with pharmacists, a professional medical writer, and parent representatives, each resource goes through a seven-step auditable process from identifying need, drafting, checking accuracy, readability and ensuring a process to keep them up to date.

Two partner organisations make this a truly multiprofessional collaboration: the children's charity WellChild and the Neonatal Paediatric Pharmacy Group (NPPG). WellChild offers the families' perspectives on what information they need and how it is presented, and WellChild parents offer feedback on all our new resources. NPPG members are just amazing in the depth and breadth of their expertise.

Volunteering for Medicines for Children has been very rewarding, meeting great people, and learning about the challenges our families face every day getting and giving medicines.

In exciting news, the Medicines for Children app is at the final review stage – currently with WellChild families for the last round of intensive user testing. Imagine an electronic medicines chart that parents can upload a photo of the medicine to, tick off when it has been given, easily share the schedule with the child's respite carer, and bring to clinic to show the complete list of the child's medicines. The initial version will be for iPhones but once perfected will be rolled out to Android devices.

The board is now looking for a new trainee representative to replace Dr Rachel Atherton, who has been an amazing ambassador for the programme. In addition to developing new resources, she represented Medicines for Children at conferences, and used survey data to produce a paper on the parental experience of giving multiple medicines. The role is currently being advertised on the Medicines for Children website, closing date 14 August.

Find out more: www.medicinesforchildren.org.uk
If you are interesting in writing new medicines leaflets, email the Programme Manager, Anna Rossiter: anna.rossiter@rcpch.ac.uk

Engagement matters now for a brighter future

Babies, children and young people have a right to be involved in their care and should be empowered to speak up in decision making

Rebecca Johnston

- *ST7 Paediatric registrar and RCPCH Ambassador for SEL ICS*

THE RIGHT of babies, children and young people (BCYP) to the best healthcare possible is enshrined in the UN Convention on the Rights of the Child alongside the right to make decisions about their healthcare and influence decisions which affect them. Paediatricians have a key role engaging BCYP and promoting these rights.

Engagement is a broad term that encompasses the many ways BCYP participate in and influence the decisions that affect them, for example in clinical discussions, providing feedback, joining interview panels or assisting service development. Engagement improves BCYP services but should also bring benefits for those involved including improved self-esteem, confidence, wellbeing, leadership and belonging.

The Health and Care Act (2022) legislated for BCYP engagement in every Integrated Care System (ICS). As RCPCH Ambassador for South East London ICS, I have been working to map existing engagement across the region, while RCPCH &Us has created a toolkit to help incorporate engagement into the strategic priorities of the ICS.

The 'You're Welcome' standards provide a checklist for youth-friendly services but limited time, resources and training are barriers to implementation. After ten years of a shared decision-making directive young people continue to have difficulty understanding what is being said and feeling involved in decisions about their care. There are however simple changes we can all make to promote BYCP rights in our everyday clinical practice.

The #OurVoiceOurCare campaign by the NHSE London BYCP Transformation team and its Youth Steering Group is empowering young people to know their healthcare rights while motivating professionals to improve their engagement skills. The young people involved agreed on four statements they want every health professional to know.

The NICE BYCP Experience of Healthcare guideline offers advice on how we can create positive experiences using developmentally appropriate healthcare: How we communicate needs to be tailored to the age, developmental stage and understanding of the BCYP and be adjusted as children mature and if specific needs are identified. Confidentiality and consent rights should be explicit.

Sending letters directly to patients improves patient satisfaction, health literacy and long-term outcomes. It is supported by recent AMRC/RCPCH guidance and discussed further by Parekvh-Hill et al in their recent article. Addressing letters directly to young people over 16 and CYP plus their families from age 12 is suggested, agreeing beforehand what can be shared and with whom. Copies to relevant professionals are essential and safeguarding issues need to be considered but the value of placing the CYP at the centre of their care often outweighs these complexities.

BCYP have a right to be involved in their care and should be empowered to speak up in decision making. Paediatricians can facilitate this by using developmentally appropriate care and by amplifying the BCYP voice in our organisation to impact change, but we all need to invest in this now if we are to create a better future for our patients.

Artwork produced for #OurVoiceOurCare campaign

'YOU'RE WELCOME':

establishing youth-friendly health and care services Guidance, June 2023

1. Involving young people in their care and in the design, delivery and review of services
2. Explaining confidentiality and consent
3. Making young people welcome
4. Providing high-quality health, wellbeing and care services
5. Developing digital approaches
6. Improving staff skills and training
7. Linking with other services
8. Supporting young people's changing needs

#OURVOICEOURCARE

Dear healthcare professionals:

- I am the expert of me: I know my mind and my body better than anyone, tap into that
- Accessing healthcare is complex (especially when you're young), recognise how much it's taken for me to get help here today
- Being listened to and valued helps me trust you, please know the little things really are the big things, a smile, cultural intelligence, a youth-friendly environment, really do matter
- How you engage with me empowers and builds my confidence in my mind and body

NEWTT2: early detection of the deteriorating newborn

Paediatricians from the working group across the UK explain how NEWTT2 fits within the wider framework – Deterioration of the Newborn – and the support available for implementation

Dr Wendy Tyler
- *Consultant Neonatologist*
- *Chair NEWTT2 BAPM working group*

Dr Amarpal Bilkhu
- *Consultant Neonatologist*
- *University Hospital Wishaw*

Dr Oliver Rackham
- *Consultant Neonatologist*
- *Glan Clwyd Hospital, North Wales*

THE NEWBORN EARLY WARNING TRACK AND TRIGGER 2 tool (NEWTT2), published by the British Association of Perinatal Medicine (BAPM), has passed its first birthday.

NEWTT2 is an evolution of previous newborn early-warning systems (EWS), principally NEW (Plymouth, UK, 2010) and NEWTT (BAPM, 2015). Five years on, BAPM led the development of a UK multidisciplinary collaborative framework, culminating in interlinking tools for consistent identification of the at-risk newborn, observation, escalation and clinical review. The framework brings together national guidance and standards for early care of the newborn whilst acknowledging that there are certain conditions where such national steer does not exist, and local and regional decision making is required.

Why should we implement NEWTT2?

Many perinatal centres will already have an EWS in place. A survey of UK centres in 2021 noted that 79% of respondents used NEWTT. Encouraged by this uniformity, the working group sought to minimise unwarranted variation in newborn observation by developing universally adoptable tools that would become familiar to all, including rotating paediatric trainees and temporary perinatal staff.

Which tools are available?

In addition to describing at-risk newborns requiring observation there are three tools: NEWTT2, an observation chart generating a total NEWTT2 Score (Fig. 1), a standardised escalation tool determining when and who should respond (Fig. 2), and a joint review tool. The framework, tools and training resources can be accessed at **www.bapm.org/pages/newtt-2**

What is new in NEWTT2?

The framework supports all those caring for newborns. Parents are included as partners in care, with 'parental concern' now included within NEWTT2. As there may be many reasons for escalation of care beyond observation findings, healthcare professionals can seek help at any time through escalation.

Mild hypothermia, highlighted in pale blue, triggers an action to warm baby. The use of oxygen saturation monitoring rather than reliance solely on colour is encouraged. The framework includes guidance on how to complete the observation chart including the assessment of colour.

Each observation within a set is plotted within the white (score zero), yellow/amber (score 1) and pink/red (score 2) boxes. Purple boxes are for critical observations and immediate escalation is warranted.

Every set of observations generates the total NEWTT2 Score, which triggers one of five escalation levels or advises continuation of routine care. Throughout, the framework encourages multidisciplinary engagement with the tools. Responsibility of care for the newborn remains shared following escalation, during clinical review and care planning.

A structured joint escalation and review tool is available to standardise response and reduce workload in documenting findings, based on the 'SBAR' format.

Next steps

We welcome feedback through the NEWTT2 BAPM web page. We are progressing with a digital specification and planning an evaluation project to determine whether NEWTT2 and the allied framework function in practice as intended: to detect deterioration early and limit adverse outcomes, while supporting families.

Thank you to the original and the follow-on working groups. Dr John Madar for leading the NEWTT2 tool update, Dr Shalini Ohja for her survey work, Dr Oliver Rackham for leading on escalation, Dr Amarpal Bilkhu for audit data, and Dr Kathryn Macallister our co-chair. This work has been in collaboration with Hannah Rutter and Dr Tony Kelly from NHSE and is supported in the devolved nations through BAPM.

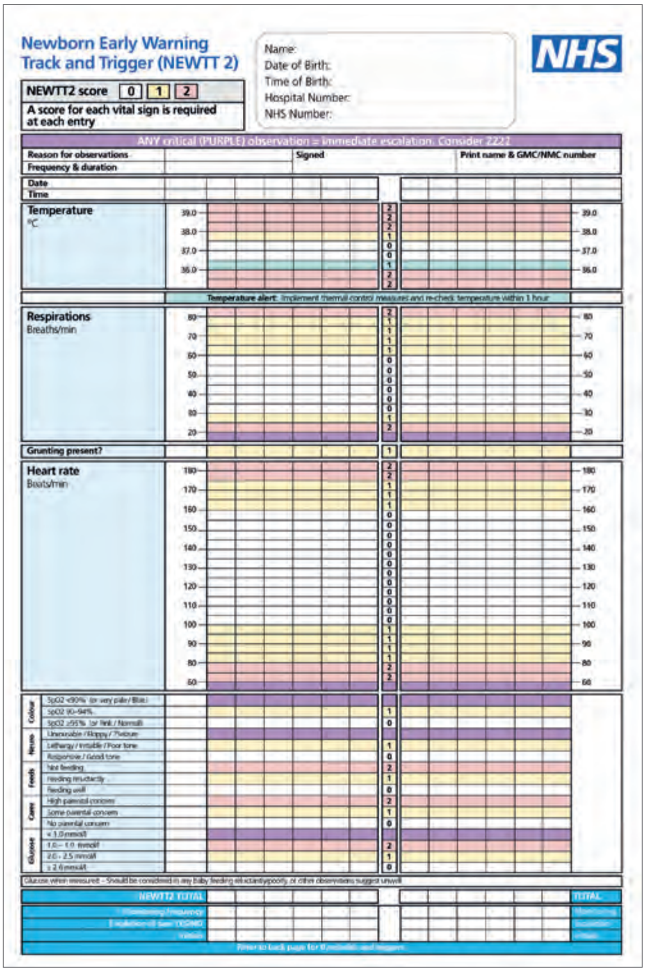
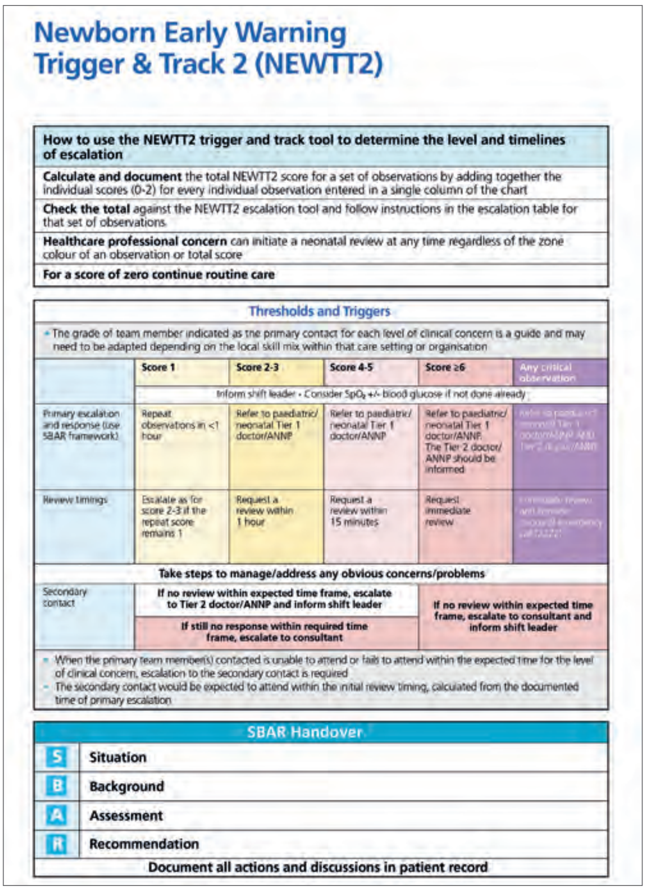


Fig. 1 (left): An observation chart generating a total NEWTT2 score

Fig. 2 (below): A standardised escalation tool determining when and who should respond



Newborn Early Warning Trigger & Track 2 (NEWTT2)

How to use the NEWTT2 trigger and track tool to determine the level and timelines of escalation
Calculate and document the total NEWTT2 score for a set of observations by adding together the individual scores (0-2) for every individual observation entered in a single column of the chart
Check the total against the NEWTT2 escalation tool and follow instructions in the escalation table for that set of observations
Healthcare professional concern can initiate a neonatal review at any time regardless of the zone colour of an observation or total score
For a score of zero continue routine care

Thresholds and Triggers

- The grade of team member indicated as the primary contact for each level of clinical concern is a guide and may need to be adapted depending on the local skill mix within that care setting or organisation

	Score 1	Score 2-3	Score 4-5	Score ≥6	Any critical observation
	Inform shift leader - Consider SpO_2 +/- blood glucose if not done already				
Primary escalation and response (use SBAR framework)	Repeat observations in <1 hour	Refer to paediatric/ neonatal Tier 1 doctor/ANNP	Refer to paediatric/ neonatal Tier 1 doctor/ANNP	Refer to paediatric/ neonatal Tier 1 doctor/ANNP. The Tier 2 doctor/ ANNP should be informed	[illegible]
Review timings	Escalate as for score 2-3 if the repeat score remains 1	Request a review within 1 hour	Request a review within 15 minutes	Request immediate review	[illegible]
	Take steps to manage/address any obvious concerns/problems				
Secondary contact	**If no review within expected time frame, escalate to Tier 2 doctor/ANNP and inform shift leader**			**If no review within expected time frame, escalate to consultant and inform shift leader**	
	If still no response within required time frame, escalate to consultant				

- When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required
- The secondary contact would be expected to attend within the initial review timing, calculated from the documented time of primary escalation

SBAR Handover	
S	Situation
B	Background
A	Assessment
R	Recommendation
Document all actions and discussions in patient record	

FREQUENTLY ASKED QUESTIONS

Following publication, users highlighted key areas for further clarification, shared within the FAQ section on the NEWTT2 website

Who is the chart aimed at?

NEWTT2 is recommended for use in at-risk newborns, as defined in the framework, in postnatal ward settings such as postnatal wards, transitional care and delivery suite for both term and late preterm newborns.

Do I need to fill in the whole chart every time?

All observations should be conducted every time (except for glucose, which should only be measured where and when indicated). The frequency of observations is determined by national guidance or, if none exist, by local clinical discretion.

Which newborns warrant a glucose measurement?

Glucose measurements are indicated only in those newborns who fall within the at-risk groups for hypoglycaemia, including those whose feeding deteriorates or who are feeding poorly. Glucose is not required at every set of NEWTT2 observations, rather only at times indicated in the BAPM hypoglycaemia framework.

Why is a glucose level 2.0-2.5mmol/L in the yellow/amber zone and warrant a score of 1 when it is considered normal in term babies?

A glucose value in this range in a late preterm newborn, or at term with abnormal clinical signs, is outside the normal range and warrants escalation. In an at-risk term newborn with normal clinical signs, a score of 1 triggers a repeat set of observations (excluding a repeat glucose) within the hour, which provides an opportunity to give additional support.

How does the NEWTT2 tool work with the KP Risk calculator / NICE Categorical Framework?

Newborns at risk of early-onset infection are an at-risk group and warrant monitoring. The Kaiser Permanente sepsis risk calculator and the NICE Categorical Framework are tools to determine the risk of early-onset infection in newborn babies. These two tools can be used to determine which babies need additional observations. The NEWTT2 chart can then be used to track these observations and provides recommendations on escalation where necessary.

For more information and to give feedback, visit www.bapm.org/pages/newtt-2

Members

The latest member news and views

KEEP IN TOUCH

We'd love to hear from you, get in touch through our channels

- X @RCPCHTweets
- Facebook @RCPCH
- Instagram @RCPCH
- milestones@rcpch.ac.uk

Developing a CESR programme

Dr Nicola Storring

- *General Paediatric Consultant*
- *East Surrey Hospital*

TWO YEARS AGO, I wrote an article for *Milestones*, 'My CESR journey', explaining how I left training at ST6 to complete my progression to becoming a consultant through the Certificate of Eligibility for Specialist Registration (CESR – now Portfolio Pathway). I return with this article to explain my next chapter: the development of a CESR programme within East Surrey Hospital.

I am now a General Paediatric Consultant with an expertise in cardiology. East Surrey Hospital is a very busy DGH just south of London that requires 18 doctors to safely staff the middle grade rota. A third or less of this number is filled by paediatric trainees. Hence, we require a large number of clinical fellows to complete our team, which can be a challenge to recruit for.

Our solution is to create a Portfolio Pathway programme based at the hospital. The aim is to increase recruitment by providing an attractive post that will enable doctors to gain all the necessary competencies with the support of a consultant team experienced in the CESR pathway. It will hopefully also increase retainment by enabling our current clinical fellows to gain experience in tertiary and community paediatric centres without having to end their contract with us to take jobs elsewhere.

The programme would last three to six years, depending on the doctor's previous experience. The doctors would be based at East Surrey Hospital and then attend six-month placements to develop their skills in various areas. St George's Hospital, London PICU and NICU, and the Surrey Community Team have kindly agreed to be part of our programme. As I and some of my colleagues have completed CESR, we will provide a supportive team with ARCPs and meetings to help support the registrars through the process.

Being able to stay at East Surrey Hospital for many years will give the registrars time to learn how our hospital functions, enabling implementation of service improvement projects and advancement of management skills, and the development of the registrars and the department.

If you would like to find out more about the programme or are thinking about developing a similar scheme, please email: **nicola.storring1@nhs.net**

HISTORY TAKING: A PAEDIATRIC LOVE STORY

Dr Richard Daniels

- *ST6 Registrar*
- *Evelina London Children's Hospital*

@DrRDaniels

I'VE ALWAYS LOVED THE fantasy dinner party game. How would you get the balance right between spending an intimate night conversing with your heroes – getting to understand what made them tick – and creating a pleasant convivial atmosphere for all? You might love Karl Marx, but plonking him next to John Terry with a plate of chicken would end up like an episode of *Come Dine With Me*.

Innovation often occurs when two worlds collide. Sometimes, those worlds are unrelated. Other times, it might be as simple as two medical polymaths falling in love and pushing each other to greater heights. Enter Lilly and Victor Dubowitz. They have humbly referred to their careers as 'accidental' and 'peripatetic' but their impact has been enormous.

He, a South African GP cum ophthalmologist cum neurologist converted to a paediatric practice by Ronald Illingworth (previously mentioned here as one half of another Paediatric Super Couple). She, a Hungarian Holocaust survivor, who escaped to Australia via Sweden where she studied medicine while working as a waitress and a biochemist. Lilly started off in endocrinology but, after meeting Victor at a picnic in 1960 and marrying him three months later, she too ended up in paediatrics in Sheffield, under the Illingworth eye.

They both thrived, with Lilly focusing on neonatology and Victor working in developmental neurology. In 1970, they published a method for calculating the gestation of a newborn from neurological and anatomical findings – the Dubowitz Score is still in use to this day. In 1972, the couple moved back to London, where they both took positions at Hammersmith Hospital. Amongst other achievements, Lilly pioneered the use of cranial ultrasound and MRI, while Victor was named chair of Paediatrics and Neonatology and co-founded the British Paediatric Neurology Association.

Lilly died in 2016 aged 85. Victor and their four sons survive her.

Lilly and Victor

We put 10 questions to a consultant paediatrician and their paediatric trainee

Bob Phillips

Professor of Paediatrics and Evidence Synthesis, CRD and HYMS, Honorary Consultant in Paediatric Oncology, Leeds Children's Hospital

𝕏 @drbobphillips

1) Describe your job in three words.
Finding and helping.

2) After a hard day at work, what is your guilty pleasure?
Cooking.

3) What two things do you find particularly challenging?
Spleling annd reeding drug namez.

4) What is the best part of your working day?
When a teenager trolls me by showing their hair is longer than mine, and they're barely six weeks out of chemo.

5) What is the one piece of advice you wish you could impart to yourself as a junior trainee?
Try to change fewer things at a time.

6) Who is the best fictional character of all time, and why?
The Doctor. A surgeon-innovator, physician-detective, clinical pharmacologist, microbiologist, radiologist, obstetrician, psychiatrist, palliative care provider, and (above all) a paediatrician.

7) What three medications would you like with you if you were marooned on a desert island filled with paediatric patients?
Caspofungin, doxorubicin and dexamethasone. (I would say Piperacillin/tazobactam but Maya's bringing that.)

8) If you were bitten by a radioactive gerbil, what would you like your superpower to be, and why?
Dancing through time. Then I could return to the early 2020s and redo a series of TikTok videos which are crimes against art.

9) What is the single, most encouraging thing that one of your colleagues can do to make your day?
Smile (while bringing coffee).

10) How can you and your colleagues inspire the next generation of paediatricians?
Keep being playful and honest, uncertain and questing, and keep telling stories about how children understand the fundamental truths better than grown-ups and you'll be given the honour of their company if you stick with us.

Maya Garside

ST3

𝕏 @MayaWhite2611

1) Describe your job in three words.
Challenging, emotional and rewarding.

2) After a hard day at work, what is your guilty pleasure?
Medical TV shows. I love *Ambulance* and *Grey's Anatomy*.

3) What two things do you find particularly challenging?
Covering multiple bleeps/areas due to lack of staffing.
People that are rude or obstructive when taking referrals.

4) What is the best part of your working day?
When parents are genuinely thankful for your time, or chasing a playful toddler around as you try to examine them.

5) What is the one piece of advice you wish you could impart to yourself as a junior trainee?
You don't have to be perfect at everything and it's okay to find things difficult. Also, you can attach a syringe directly to the back of a butterfly needle to take bloods – that would have saved me a lot of time.

6) Who is the best fictional character of all time and why?
Hermione Granger. She is intelligent, caring and loyal. She can perform magic and she has a time turner – both of which would be very helpful in paediatrics!

7) What three medications would you like with you if you were marooned on a desert island filled with paediatric patients?
Tazocin, paracetamol and difflam.

8) If you were bitten by a radioactive gerbil, what would you like your superpower to be and why?
Teleportation. I'd be able to immediately attend crash calls and I wouldn't have to commute to work.

9) What is the single most encouraging thing that a colleague can do to make your day?
Tell you that you've done a good job, or simply ask how you are.

10) How can you and your colleagues inspire the next generation of paediatricians?
Be that friendly face students or foundation doctors will remember from paediatrics. Be approachable and answer all their questions honestly.

ASH'S BAKING SCHOOL

Salted caramel crumble bars

Spoil your teams with a deliciously sweet treat

Dr Ashish Patel

- *ST8 Paediatric Nephrology & Sim Fellow*
- *Birmingham Children's Hospital*

𝕏 **@DrKidneyAsh**

TRAYBAKES ARE a staple of any baker's repertoire. Minimal effort but super effective – just like the response to a fluid bolus in a septic patient! Caramel can sometimes be fiddly but the beauty these days is if you are feeling super lazy you can cheat with a tin of Nestlé Carnation caramel. These crumble bars were such a delightful treat on a recent trip to Toronto that I could not help but recreate them. The crumble is a cheeky shorthand version of shortbread, without all the work. Combine this with salted caramel (the queen of indulgence) and you have a bake which gives the perception of complexity, but actually needs little labour. Have a crack at this recipe and spread the joy of baking to your teams!

INGREDIENTS

350 g cold unsalted butter, cubed
200 g caster sugar
150 g icing sugar
1 teaspoon vanilla extract
550 g plain flour
Sea salt flakes

Caramel – makes 1 batch, use half for this recipe
175 g unsalted butter, cubed
1 x 397 g tin condensed milk
75 g soft dark brown sugar
75 g soft light brown sugar
2 tablespoon maple syrup
½ teaspoon vanilla extract
½ teaspoon sea salt flakes

OR cheat with **1 x 397 g** Carnation caramel tin

OPTIONAL STEP TO MAKE THE CARAMEL

Put all the caramel ingredients in a big, heavy-based plan. Start on low heat to melt, stir regularly. Once all melted and no lumps, turn the heat to medium and keep stirring until the mixture comes to a boil. Once there are big bubbles breaking over the surface, take it off the heat. Allow to cool before using.

INSTRUCTIONS

1. Preheat the oven to 180°C (160°C fan-assisted). Line a 14 x 9-inch rectangular traybake tin with baking paper.
2. Add the butter, caster and icing sugars, and vanilla to a stand mixer and mix on low speed until everything is mixed together and mixture looks lighter in colour (you can do this by hand).
3. Add the flour and mix again on low speed until the mixture looks like chunky breadcrumbs.
4. Spoon half the mixture into the tin and press down to make a solid base. Bake for 18-20 minutes until the base is beginning to go golden brown. Allow to cool.
5. Spread half the caramel (or full tin of caramel condensed milk) across the base leaving a 2 cm border from the edge. Evenly sprinkle over the sea salt flakes.
6. Create small lumps of the remaining crumb mixture, and dot these over the top of the caramel. Don't cover the caramel completely so the caramel can ooze and bubble out.
7. Bake in the oven for 25-30 minutes until light golden brown. Allow to cool and then cut into generous slices.

Civility – changing our behaviour one word at a time

Incivility in the workplace can affect productivity and patient safety. **Dr Jess Morgan** explains how the Thrive Paediatrics project is empowering colleagues to stand up to bad behaviour

Dr Jess Morgan
- *Dinwoodie Clinical Fellow RCPCH*

I LIKE TO THINK of myself as a friendly and approachable colleague, one that is kind and respectful. However, as a white, cisgender, heterosexual woman, I've realised over recent years how my privilege has played into the relationships I make at work. It can be hard to sit with the discomfort of realising you have unknowingly acted in a racist manner, snapped at a colleague on the phone or watched on as someone was humiliated in public. Yet reflecting on these feelings and challenging our own behaviours is the first step to changing them.

As paediatricians, we are generally a cheery, friendly community and I'm pretty sure that people don't come to work with the intention of being rude to one another. Yet, through the Thrive Paediatrics project, we are hearing stories up and down the country of incivility in the workplace. Be it eye-rolling, talking over others, being difficult on the phone, belittling, shouting or swearing... The list goes on.

The pressures of working in the NHS are undoubtedly taking their toll on staff. Add in exhaustion, car parking troubles, hunger and personal stress and it's easy to see how that might play out in our behaviour. This, combined with a permissive culture where incivility goes unchecked, can lead to devastating consequences.

Data from the Civility Saves Lives campaign show that 80% of recipients of incivility lose time worrying about the event, with a 61% decrease in their cognitive ability. I can certainly relate to the way these incidents become all-consuming and how my bandwidth and ability to focus decrease in the aftermath. Worryingly, there is also a ripple effect throughout the team. The performance of

witnesses has been shown to reduce by 20%, with more diagnostic and procedural errors and less ability to recognise this. So, in the words of the campaign: "When we condone rudeness in our teams, we accept poorer outcomes for our patients."

The vast majority of employees come to work with the intention of being kind and civil. However, every so often we might need a nudge or reminder to keep us on track. This is not about shaming or blaming, but instead enabling reflection in a bid to modify behaviour. The professionalism pyramid, outlined in detail in the NHS Civility and Respect toolkit, provides a tiered approach to addressing incivility with the understanding that most single incidents can be effectively managed with an informal 'cup of coffee conversation'. This offers a compassionate and supportive space where people can reflect on their behaviour, why it might have happened and how they might avoid it in the future.

Our Thrive Paediatrics community members have been sharing their experiences and drawing on the excellent work of colleagues throughout the UK to empower one another to address incivility. Using our monthly online drop-ins, blogs and face-to-face events, we've been working to educate and explore ways that our community can stand up to incivility.

At our South East Scotland pilot Wellbeing and Innovation Network (WIN) event, we had a session dedicated to incivility. The network lead, Dr Philippa Wood says this: "A session led by Dr Catherine Stretton (consultant anaesthetist with expertise in human factors and civility) at our recent Thrive in-person event, very powerfully presented the evidence on the effects of incivility on productivity and patient safety. This takes the message beyond 'wouldn't it be lovely if we could be nice to each other' to 'people might die if we are rude'. We're noticing that people are starting to feel more comfortable about raising this issue. It's great to have the resources and evidence to highlight to colleagues why this matters so much."

To support paediatricians, we have been developing content on the topic of civility for the Thrive Resource Hub, featuring links to evidence, podcasts and toolkits as well as examples of departments that have developed initiatives in this area. We hope this will empower our paediatric community to take action. This needn't be a large-scale organisational change. Reflecting on our own behaviour and the experiences of our team, with a commitment to learning more might be a good place to start.

▶ ***If you have done work in your own department on tackling incivility, please let us know via thrive@rcpch.ac.uk so we can celebrate our collective efforts and share good practice.***

A DAY IN THE LIFE

"I count myself lucky to work with children"

Shaarna Whitton (Shanmugavadivel)

General Paediatric Registrar at Nottingham Children's Hospital and our new addition to the Milestones *editorial team*

𝕏 @HeadSmartFellow

I became a paediatric trainee because of a serendipitous work experience placement on the neonatal unit. My teenage dream was to be a journalist but my work experience placement at ITV didn't live up to the dream and I was devastated. My father worked in the finance department of the local hospital at the time, and asked a nursing colleague if I could spend a week with her and I begrudgingly accepted. It's safe to say, I left full of wonder and love for paediatrics, and applied for medicine. No other specialty got a look in.

My typical working day starts with negotiating with my children, which is good practice for work. Negotiations typically involve uniform, hairstyles, breakfast choice, and whose house they want to be dropped at before school, based upon which friend provides the preferred second breakfast. I then arrive at work where ongoing negotiations involve which teddy's chest I examine first, how much fluid needs to be consumed before home and which up-and-coming TikTok musician is the 'GOAT'. Alongside clinical commitments, I am attempting to finish writing my PhD (although the PhD is trying to finish me!) so my LTFT days involve coffee in bed with my laptop, questioning my life choices and trying to find the will to write.

The most difficult part of my job is breaking bad news to families. The truth is, it never gets easier – if anything, it has got harder with time. I still remember the first family I spoke to after a CT head identified that their child had a brain tumour. It was moments like those that took me into the world of research and advocacy for early diagnosis of childhood cancer.

The best parts of my job are the children and young people we meet. There is not one day that goes by where a child or young person hasn't made me smile or laugh. Working in the NHS currently is tough. Morale is low and the work is hard BUT I count myself lucky to work with children who brighten our days when we least expect it, as that is something special.

My most memorable time was working as the HeadSmart Fellow. During med school, the two topics I liked least were neurology and research, yet here I was doing a job that amalgamated both. The role was a steep learning curve but has shaped me into the clinician I am today. I learnt some neuroanatomy. I found a love for research, guideline development and knowledge translation. I worked closely with charities, learning about campaign strategy, branding, public engagement, and website development (SEO is super important). I feel so lucky to have had the opportunity to learn from one of the best humans, Professor David Walker, who taught me the power of awareness, advocacy and standing up for our children and young people. David would walk into a room of strangers and somehow infect everyone with his energy to fight for the cause. This whole experience led to my NIHR Doctoral Research Fellowship but also took me into advocacy, working in other areas I feel passionate about with the DFTB Skin Deep project and the RCPCH Climate Change Working Group.

When I finish work,

I love playing games with the kids. "Taco, cat, goat, cheese, pizza" is a firm favourite! Once the kids are in bed, having a glass of wine, catching up with friends or escaping in a novel. However, the current reality is getting my laptop back out to write the never-ending thesis...

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SLENYTO® PROLONGED-RELEASE TABLETS 1mg and 5mg
PRESCRIBING INFORMATION: Please refer to Summary of Product Characteristics (SmPC) before prescribing. **ACTIVE INGREDIENT:** Melatonin 1mg or 5mg. **INDICATIONS:** Insomnia in children and adolescents aged 2-18 years with Autism Spectrum Disorder and / or Smith-Magenis syndrome, where sleep hygiene measures have been insufficient. **DOSAGE AND ADMINISTRATION: Dose titration:** Recommended starting dose is 2mg once daily. If an inadequate response is observed, increase the dose to 5mg, with a maximal dose of 10mg. Data are available for up to two years treatment. Monitor at regular intervals (at least every 6 months) to check that Slenyto is still the most appropriate treatment. After at least 3 months, evaluate treatment effect and consider stopping if no clinically relevant treatment effect is observed. If a lower treatment effect is seen after titration to a higher dose, consider a down-titration to a lower dose before deciding on a complete discontinuation of treatment. **Administration:** Once daily 0.5-1 hour before bedtime with or after food. Swallow whole, do not crush, break or chew. To facilitate swallowing, tablets may be put into food such as yoghurt, orange juice or ice-cream and then taken immediately. **CONTRAINDICATIONS:** Hypersensitivity to the active substance or to any of the excipients. **SPECIAL WARNINGS AND PRECAUTIONS:** Use caution in patients with renal insufficiency. Not recommended in patients with hepatic impairment. Children under 2 years: not recommended. Slenyto may cause drowsiness, therefore use with caution if the effects of drowsiness are likely to be associated with a risk to safety. Not recommended in patients with autoimmune disease. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine. **INTERACTIONS:** Concomitant use with fluvoxamine, alcohol, thioridazine, imipramine, benzodiazepines and non-benzodiazepine hypnotics should be avoided. Use caution with 5- or 8-methoxypsoralen, cimetidine, oestrogens, CYP1A2 inhibitors, CYP1A2 inducers, NSAIDs, beta-blockers and with smoking. **FERTILITY, PREGNANCY, LACTATION:** Avoid use of melatonin during pregnancy. Consider discontinuation of breastfeeding or discontinuation of melatonin therapy taking account of the benefit of breastfeeding for the child and the benefit of therapy for the woman. No known effects on fertility. **DRIVING:** Melatonin has a moderate influence on the ability to drive and use machines. **UNDESIRABLE EFFECTS: Very common:** None. **Common:** Mood swings, aggression, irritability, somnolence, headache, sudden onset of sleep, sinusitis, fatigue, hangover. Consult SmPC in relation to other adverse reactions. **PHARMACEUTICAL PRECAUTIONS:** Do not store above 30°C. **LEGAL CATEGORY:** POM. **MARKETING AUTHORISATION HOLDER:** RAD Neurim Pharmaceuticals EEC SARL, 4 rue de Marivaux, 75002 Paris, France. Marketed in the UK by Flynn Pharma Limited, Hertlands House, Primett Road, Stevenage, Herts, SG1 3EE, Tel: 01438 727822, E-mail: medinfo@flynnpharma.com.

Product	NHS List Price	Pack Size	Marketing Authorisation Number
Slenyto 1mg	£ 41.20	60 tablets	PLGB 52348/0003 EU/1/18/1318/001
Slenyto 5mg	£ 103.00	30 tablets	PLGB 52348/0004 EU/1/18/1318/003

Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk/. Adverse events should also be reported to RAD Neurim Pharmaceuticals EEC Limited Medical Information e-mail: regulatory@neurim.com

DATE OF REVISION OF PRESCRIBING INFORMATION: June 2021

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