

# Milestones

The magazine of the Royal College of Paediatrics and Child Health



## WINTER IS COMING

DEALING WITH SEASONAL PRESSURES

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WINTER 2019

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Developing a national standard for PEWS

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# We are looking for experienced Paediatricians

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CARTER BROWN



## Who are we?

Carter Brown are the UK's leading independent provider of expert witness psychologists, psychiatrists, social workers and paediatricians.



## Referrals

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Visit: [www.carterbrownexperts.co.uk](http://www.carterbrownexperts.co.uk)



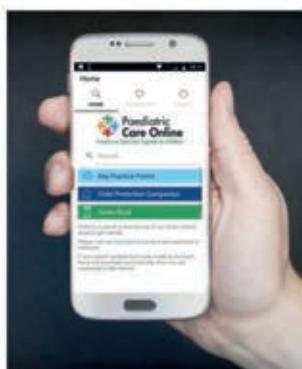
Paediatric  
Care Online



## POINT OF CARE DECISION SUPPORT

The UK's only  
clinical tool dedicated to  
child health and safeguarding

Paediatric Symptoms  
National Guidelines  
Child Protection  
Growth Charts  
Patient Information



✉ [pco@rcpch.ac.uk](mailto:pco@rcpch.ac.uk)

🌐 [www.pcouk.org](http://www.pcouk.org)





## Contact

We'd love to hear from you – get in touch at

[milestones@rcpch.ac.uk](mailto:milestones@rcpch.ac.uk)

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Winter 2019

## Welcome

IT'S BEEN ONE of those years in which taking a breath has proved rather difficult. But despite a frenetic 12 months, we made important progress on several fronts. I'm particularly proud of the new careers campaign that we launched in October (page 18). Our approach, according to those who understand marketing, was a bit unusual. We made a deliberate decision to talk openly and honestly about what life is really like in paediatrics.

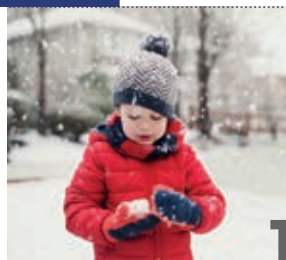
We wanted to show our incredible profession at its best, of course, but I was eager to start a real conversation about what life is like at the frontline of a stressed-out system. I think we mostly hit the right balance, and I am incredibly grateful to everyone who gave their time, energy and thoughts to making the campaign happen. It is hard to recruit at a time when retention is such a challenge, but it is possible and essential to tackle these two priorities together – and in a way that feels true to our specialty.

I hope to see some of you between now and the end of the year. In the meantime, I hope you enjoy the new-look magazine – most of which, I'm happy to say, is written by members.

Best wishes,

**Russell Viner**

[@RCPCHPresident](https://twitter.com/RCPCHPresident)



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## Milestones

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

jamespembroke  
...media

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**KEEP IN TOUCH**

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# Update

The latest news and views

## KEEP IN TOUCH

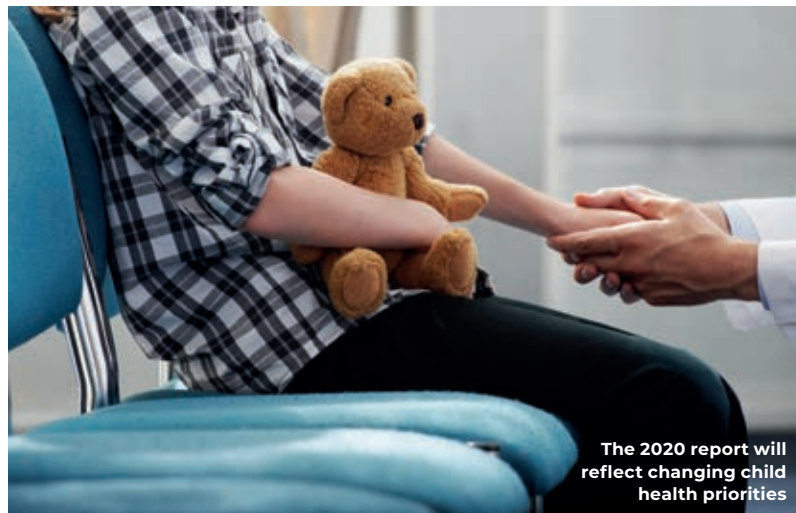
We'd love to hear from you, get in touch through our channels

🐦 Twitter @RCPCHtweets

📘 Facebook @RCPCH

📷 Instagram @RCPCH

🌐 milestones@rcpch.ac.uk



The 2020 report will reflect changing child health priorities

## REPORT

### State of Child Health: New Indicators



**Dr Ronny Cheung**

● Chair of State of Child Health Project Board

🐦 @cheungronny

**IN SPRING 2020**, RCPCH will publish the second edition of its groundbreaking *State of Child Health* report, with updated data for existing measures, and new indicators to reflect changing child health priorities and evolving challenges.

The 2020 report

will focus on new areas that include:

- **Looked After Children:** This group has a long history of disproportionately poor health outcomes.
- **Mental health:** A historic dearth of national data on mental health meant the 2017 report could not provide the focus that this challenging area deserves. This time, we will complement new data with voices of children and young people to

focus directly on the impact as they experience it themselves.

- **Injuries from violence:** We plan to examine the extent to which young people are presenting in emergency departments with injuries inflicted by violence.
  - **Workforce:** Using our census data, we will examine changes to the paediatric workforce population over recent years and outline the case for investment in the child health workforce.
  - **Social determinants:** We will retain the lens of inequality across existing indicators, but will also focus specifically on the relationship between poverty, education, housing and health.
- The report will go live in March 2020 and will be even bolder and broader than its 2017 incarnation – we will be keeping you posted between now and then with all the information you need to become a champion for child health.

## SCREENING

### 50 YEARS OF NEWBORN BLOOD SPOT TESTS

**IN SEPTEMBER 1969**, national guidance was published on screening for phenylketonuria (PKU) using the Guthrie test on heel prick blood samples. This was the first national screening programme in the UK. Very soon, issues familiar to all involved cropped up, including seeking written consent, how long to keep cards, and whether normal results should be notified. Most of the UK now screens for nine conditions using the newborn blood spot. An evaluation of severe combined immunodeficiency screening is now proposed.

Before screening for new conditions, it is important to ensure more harm than good isn't done, so careful assessment is undertaken. Once screening is introduced, strong national oversight is essential to ensure good co-ordination across the NHS. Individual clinicians can provide

information on the child and potential treatment.

The importance of paediatricians in providing this information and the need for systems to capture clinical outcomes cannot be overemphasised.



**Dr Rachel Knowles**

● Senior Clinical Research Fellow, UCL Great Ormond Street Institute of Child Health



## The Rainbow NHS Badge

"As a paediatrician, as a gay man, I wanted to be part of something to make things better"

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### POLICY

## Addressing politics and pressures

**IF WE CAN** be certain about one thing, it's that this year hasn't been normal. No doubt readers will be taking a belt and braces approach to planning for the eventual pressures that come with winter, all whilst navigating a somewhat perplexing period of politics. The policy team have been **monitoring concerns about the impact of our departure from the EU**, specifically around any concerns that may be detrimental to children, young people and health professionals.

Looking forward, we're excited to share a whole range of work with you. We are

**recruiting to the College's Ambassadors programme**, which will establish a network of members to advocate locally for children, young people and the surrounding workforce.

We'll be publishing a position statement on air quality in the UK, acknowledging our responsibility to encourage all staff and members to support action that minimises threats to the environment.

And we are looking forward to introducing you to the **College's Assistant Officer for Mental Health and Wellbeing, Dr Karen Street**, who will be leading the College's work to ensure that mental health and wellbeing for children and young people is embedded within the policies and education needed to support paediatricians across the UK.



We are now recruiting college ambassadors

## INTERNATIONAL RCPCH FACTS



**24%**  
OF COLLEGE  
MEMBERS ARE BASED  
OVERSEAS



**22**  
NUMBER OF  
COUNTRIES WHERE  
THERE IS A SINGLE  
COLLEGE MEMBER



**88**  
NUMBER OF  
COUNTRIES WHERE  
THE COLLEGE HAS  
MEMBERS



THE TOP THREE  
OVERSEAS  
COUNTRIES WITH  
RCPCH  
MEMBERS ARE

1 SAUDI ARABIA  
2 INDIA  
3 MALAYSIA



**4,800**  
CANDIDATES  
(APPROXIMATELY)  
WILL HAVE SAT  
THEIR CLINICAL AND  
THEORY EXAMS  
OVERSEAS BY THE  
END OF 2019

## College news



### REPORT

## 75 YEARS OF FEMALE MEMBERS

**WHEN RCPCH (FORMERLY** the British Paediatric Association, or BPA) was founded in 1928, it had just 60 members and all were male. While membership grew, the gender of members remained constant, despite rising numbers of female doctors.

In 1938, a joint meeting was arranged with the BPA and the Canadian Paediatric Society, which had female members. This meant that the BPA would be welcoming female doctors from Canada while excluding women in Britain.

The meeting was ultimately cancelled but it started discussions, and in 1944 a vote to admit women to the BPA took place. The majority were in favour and the first female members were admitted in 1945.



## THE GIRFT NEONATOLOGY WORKSTREAM

NEONATOLOGY IS ONE of the latest clinical specialties to become part of the Getting It Right First Time (GIRFT) quality improvement initiative. The ambition of GIRFT is to identify areas of unwarranted variation with the goal of improving the quality of patient care across the specialty.

Neonatology datapacks are being developed that benchmark a large number of clinical metrics. In addition, GIRFT questionnaires will be sent to neonatal networks, transport services and neonatal units in England over the next few weeks. GIRFT will be visiting all neonatal units and networks in England to discuss the data, support development and implementation of local action plans, and to report nationally on themes.

As part of this work, GIRFT joined forces with the College in a UK-wide medical workforce snapshot survey covering neonatology and general paediatrics.

Our plan is to use these findings to make further recommendations to support our workforce and improve patient care.



**Dr Eleri Adams**

● Consultant Neonatologist, Oxford University Hospitals NHS Foundation Trust

● @NHSGIRFT



New key initiatives are enhancing Child Protection services



**Dr Alison Steele**

● Officer for Child Protection

## CHILD PROTECTION

# Safeguarding is everybody's business

**I HAVE BEEN** the Officer for Child Protection for nearly 18 months now and it has been a busy time. I wanted to take the opportunity to let you all know about some of the key initiatives that we have been working on.

## Education

The fourth edition of the intercollegiate safeguarding competencies document was launched earlier this year, published this time by the Royal College of Nursing. Due to the document's increasing complexity we have been working on a complementary document to more simply outline the knowledge and skills that paediatricians require to obtain their safeguarding competencies.

## Influence

Workforce remains high on my agenda, and a short report is due later this year making policy recommendations across the vulnerable children and families workforce. We are already working with national service delivery partners to address current issues, including the child sexual assault workforce. Separately, we have been supporting

the Family Court to address problems with the availability of paediatricians willing and able to give expert evidence to these courts.

## Advocacy

We are aware that members are having difficulties in managing perplexing presentations and children where there is concern about possible fabricated and induced illness. Having conducted a survey, we are currently writing an updated guidance document. Separately in our advocacy work we have been working with a group of trainees to raise the profile of current migrant healthcare issues.

## Evidence

The College continues to update the systematic reviews of best evidence for child protection practice, using the outputs to regularly update our Child Protection Companion, which is freely available to all members via Paediatric Care Online.

► Visit [www.rcpch.ac.uk/child-protection](http://www.rcpch.ac.uk/child-protection)



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## Winter is coming

We need your advice on managing and alleviating winter pressures when caring for children



## Staff Spotlight

**Robert Okunnu**

● Director of Policy and External Affairs

🐦 @ROkunnu

**I JOINED THE** College in March this year at a rollercoaster time in the wider political and policy environment. I arrived having spent most of my career in policy and communications at the BMA and other membership bodies, plus a spell in the corporate world.

Working closely with the College's President and officers, I lead the Policy and External Affairs team made up of experts in policy, public affairs, media, campaigns, digital and our national offices – all working hard to deliver influence and impact for the College.

We aren't unique in having to cope with the unpredictable environment. Any organisation seeking the attention of governments and the NHS must know when and how to engage effectively.

As I reflect on the past few months, I can see that the College recognises the

importance of keeping on top of how politics and policy evolves. We have a voice and are using it, but the challenge is making sure we continually cut through the noisy external environment, so we are heard in all the right places.

Making progress on improved recruitment and better retention of the paediatric workforce, ensuring that the NHS delivers services that children and young people deserve relies on ongoing conversation with government departments, ministers and NHS leaders.

We have a powerful story to tell and we must tell it in engaging ways to grab and hold the attention of decision makers. An exciting opportunity I'm relishing, as that means also thinking about new ways to use our website, social media, video, podcasts and other channels as part of our storytelling for maximum impact.



## DIGITAL

### PRESCRIBING APPS FOR PATIENTS

**NOWADAYS, THERE IS** a health app for everything, from migraine tracking to carb counting. It's worth being aware of useful apps to recommend to patients and parents, because they can act as a repository of information and support that lasts well beyond the encounter we have with them.

The difficulty is often in the choosing. There are some great apps out there, but there is currently considerable difficulty regulating the quality of healthcare apps.

Particularly worrying and cynical products have been identified, such as an app which claimed to read a person's blood sugar as they tapped the screen. As a result, several companies such as Orcha and the NHS Digital App Library project have attempted to rate, classify and recommend health apps.

Amazon recently announced its partnership with the NHS to provide voice-activated health advice using the Alexa app. The repercussions of large technology companies

partnering up to deliver healthcare are enormous, with data and clinical safety issues.

As clinicians we need to be aware of these developments – big ethical issues are at stake. Meanwhile, we must help our patients navigate the app landscape to get the best for their health.



**Dr Lydia Yarlott**

● ST2 Paediatric Trainee, The Royal London Hospital

Do you know which hospital in the UK has the most paediatric trainees? Turn to page 23 to find out



# RCPCH in the news

## REGULATION

### TARGETING HIGH-SUGAR FOODS

Child health has been at the top of the news agenda over the last couple of months, with stories relating to gender identity, nutrition and diabetes, among others, hitting the headlines.

Most recently, the College's Prevention Vision, a bold concept that outlines priorities for the Government's green paper on the prevention of ill health, was reported widely. In a move that would transform the health and wellbeing of children and young people in the UK, the College proposed mandatory limits on the amount of free sugar used in baby foods, banning advertising for all formula milks (babies under one) and placing a "moratorium" on Government-imposed public health funding cuts. The College's Assistant Officer for Health Promotion, Professor Mary Fewtrell, was widely quoted across key outlets including BBC News, the *Daily Mail*, *The Guardian*, *The Scotsman*, the *Belfast Telegraph* and *The Sun*.

#### Read more

Discover details of our latest campaigns and successes online at [www.rcpch.ac.uk](http://www.rcpch.ac.uk)

## DEBATE

### PUSHING OUT OPINION

When the Government eventually published its prevention green paper, we expressed our concern over the lack of commitment in a number of cross-cutting areas such as workforce and the reversal of public health funding cuts.

Elsewhere, the *Daily Express*, among others, referenced data from the College's National Paediatric Diabetes Audit (NPDA). And *The Times* and Mail Online referenced the College and its proposed discussions into the use of puberty blockers to treat gender dysphoria.

## PROMOTION

### KEEPING RCPCH IN THE HEADLINES

With the College working hard to improve the health of children and young people, we hope the future news agenda continues to remain child health focused. As a College, we will be doing all we can to publicise the work that goes on at RCPCH HQ.

## JOURNAL

### BMJ PAEDIATRICS OPEN



**Imti Choonara**

● *BMJ Paediatrics Open*  
Editor-in-Chief

Twitter: @BMJ\_PO

**WE CAN TELL** from Twitter activity that the papers receiving the most tweets are usually tweeted by members of the public. With increasing concerns around misinformation online, we have an opportunity to provide the public with accurate information that has gone through a peer-review process.

The benefit of the public reading scientific papers is that hopefully it will reduce stigma to certain diseases and conditions, and encourage academics to write their papers in language appropriate for non-specialists.

We have added a new section entitled *Young Voices* where young people can describe their experience of health care or raise concerns about general issues. We have also involved parents who have described their view on neonatal outcomes.

## JOURNAL

### ADC JOURNAL UPDATE



**Nick Brown**

● *Archives of Disease in Childhood*  
Editor-in-Chief

Twitter: @ADC\_BMJ

**ONE OF THE** many privileges of my job is to watch the evolution of multiple projects. There are currently too many to fully list, let alone do justice to, but each aims to inform, challenge dogma and provoke debate. The developments that are really getting my pulse racing are...

● **Global health.** Papers that range from editorials to trials, the global section is free access specifically in order to be both accessible and practice-changing to readers in low- and middle-income countries.

● **The 'Voices' series.** Looks at children and parents, literature and building a momentum in the history of paediatrics.

● **Viewpoint pieces.** Punchy pieces on hot topics that will take the place of leading articles.

● **Spotlight podcasts.** Based broadly on advocacy issues, Rachel Agbeko's interviews with authors of published papers range from global health to rights to ethics in research.





A standardised  
paediatric PEWS will  
initially launch in 2020



**Dr Damian  
Roland**

● Clinical Lead for  
National PEWS  
programme board

🐦 @damian\_roland

## PATIENT SAFETY

# A National Paediatric Early Warning System

**A CORNERSTONE OF** paediatric practice has been the ability to 'Spot the Sick Child', however multiple reports, case reviews, and the UK's relatively poor childhood mortality statistics compared to other European nations, demonstrate this is an issue that still needs attention.

A number of initiatives have been utilised to aid healthcare professionals recognise children and young people who are deteriorating in inpatient settings and need focused interventions. For a couple of decades the term Paediatric Early Warning Score has been used to describe a system of amalgamating vital signs and other observations into a composite value that highlights the acuity of any given patient.

## A safe environment

Without standardisation, or even a validated underpinning theory as to why they might be effective, different PEWScore developed in an ad hoc fashion throughout the UK. Reviews of their performance consistently highlighted heterogeneity both in quality of research, and the outcomes measured, and they rarely demonstrated clear tangible benefits. The term PEWS came

to represent Paediatric Early Warning SYSTEM as it was realised that the score is only one part of a chain of events needed to provide a safe environment in which children would be looked after.

In adult practice large data sets provided evidence to support a national NHS early warning score. Children and young people are not little adults and there have previously been many voices stating such a national approach would not work for paediatrics. These arguments tend to underplay the evidence on standardisation and the repeated finding that variation in response is a cause of harm.

In the summer of 2018 a group of health care professionals – brought together by the College, NHS England, RCN, RCEM and RCGP – met to discuss the potential for a National PEWS as a priority in England. They will propose a standardised PEWS underpinned by a common score for inpatient paediatric units, which will be launched in 2020.

► Find out more at [www.rcpch.ac.uk/pews](http://www.rcpch.ac.uk/pews)

## PAEDIATRIC TWEETS

Receiving photos of kids  
you've treated doing  
better and growing up is  
always a high  
No one says it will be easy,  
but it will always be worth  
it. #Choosepaediatrics  
@DrSama\_A

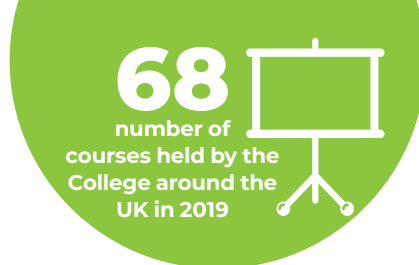
Can't believe I've finished  
my Paediatrics placement  
already, fastest 4 weeks of  
my life, I felt like I'd barely  
started! Going to have  
to drag me kicking and  
screaming back to adults  
#Choosepaediatrics  
@Purple\_Owl

Today in clinic, my  
colleague Andrea  
(paediatrician) sang  
his way through a  
Bayleys developmental  
assessment, keeping a  
tired 2 yr old engaged &  
the rest of us enchanted.  
Clinical skills take many  
forms! #paedsrock  
#playatwork  
@Anne8G

Surreal feeling bumping  
into a family that  
remembered how I  
looked after their baby  
after those years. That I  
made a difference in their  
experience in NICU. That's  
why I #Choosepaediatrics  
@philipp\_kerstin

## FEEDBACK

Get in touch about the  
magazine! Tweet  
🐦 @RCPCHtweets using  
#RCPCHMilestones



**Read more**

Find more dates at  
[www.rcpch.ac.uk/courses](http://www.rcpch.ac.uk/courses)  
[www.rcpch.ac.uk/events](http://www.rcpch.ac.uk/events)

# Diary Dates

Courses and events taking place in the coming months to aid professional development

## COURSES AND EVENTS

**05 DECEMBER 2019**  
**● COURSE**  
**Effective Educational Supervision**  
*Liverpool*

**06 DECEMBER 2019**  
**● COURSE**  
**Progressing Paediatrics: Neonatal Cardiology**  
*London*

**13 DECEMBER 2019**  
**● COURSE** How to Manage: Paediatric Sepsis  
*Newcastle-upon-Tyne*

**16 DECEMBER 2019**  
**● COURSE** MRCPCH Clinical Exam

**Preparation** *London*

**17 JANUARY 2020**  
**● COURSE**  
**Paediatric Clinical Leads Development Programme Module 5: influencing improvement in child health services**  
*London*

**17 JANUARY 2020**  
**● EVENT** National Paediatric Diabetes Audit Annual Conference 2020  
*London*

**30 JANUARY 2020**  
**● COURSE** Progressing

**Paediatrics: Improving Asthma Care**  
*London*

**04 FEBRUARY 2020**  
**● COURSE**  
**Effective Educational Supervision**  
*Newcastle-upon-Tyne*

**10 FEBRUARY 2020**  
**● COURSE** How to Manage: Paediatric Allergy Training (PAT 1)  
*Newcastle-upon-Tyne*

**09 MARCH 2020**  
**● COURSE**  
**Effective Educational Supervision**  
*London*

## Promoting education

Ben McNaughten updates us on the Paediatric Educators Special Interest Group



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## WEBINARS

### ● RECORDED WEBINAR

**Putting children's oral health on everyone's agenda.** For health professionals who may need to provide advice for families.

### ● RECORDED WEBINAR

**Mentoring peer support.** How to set up and deliver a successful mentoring programme for paediatricians.

### ● RECORDED WEBINAR: Time to 'Think Kawasaki Disease'.

A comprehensive update and recent research findings.

### ● RECORDED WEBINAR

**Enhancing Wellbeing and Resilience.** The importance of understanding our own wellbeing and resilience.



## See more

Free and accessible educational updates  
[www.rcpch.ac.uk/webinars](http://www.rcpch.ac.uk/webinars)

## The RCPCH Christmas Celebration

7pm Tuesday, 03 December 2019

St John's Hyde Park, Hyde Park Crescent, London W2 2QD

Join friends and family for a festive evening of inspiring readings and musical performances, showcasing the work of the College. This year, we even have a rap group from Haverstock school!

All proceeds will support our children and young people's initiatives. Tickets are just £10 for adults and £5 for children.

Further info and to book at:  
[www.rcpch.ac.uk/christmas](http://www.rcpch.ac.uk/christmas)



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

2,218

children, young people  
and families shared their  
views and ideas through  
RCPCH &Us sessions  
2018/2019



# Work experience

Career Ready Interns **Raheema** and **Afsana** tell us  
about their recent internships at the College

**WORKING AT THE** College was one of the most rewarding and enjoyable experiences I have had. There was so much to learn and create, and it gave me a huge appreciation of the work that the staff do.

Initially I assumed there were going to be children running around as well as doctors frantically rushing to their jobs. To my surprise it was nothing like that. Not being used to an office-based environment, I realised the deeply professional way of working in how people behaved and acted.

There were a lot of things I got the opportunity to do, such as travelling to Manchester to help teach diabetes teams about participation and engagement. I was able to express my creativity and intelligence, looking at how we use Instagram, how we explain children's rights and supporting the asthma and epilepsy audit work.

Staff members were incredibly supportive and encouraged me to embrace challenges. I co-delivered a training session to consultant paediatricians at the medical education faculty day, which was really nerve-wracking to start with. This made me grow as a person and improved my confidence.

● **Raheema (17) Career Ready Intern with the RCPCH &Us network, part of the Children and Young People's Engagement Team in 2019**



Raheema and Afsana both enjoyed their time at the College

social media to see how other Royal Colleges share information about their work and specialties.

I also attended the BPSU Rare Disease Tea Party in July. I was completely blindsided by how many people are diagnosed with a rare disease every day. It was definitely an eye-opener for me and highlighted the importance of not disregarding 'minor' symptoms because they seem to be just a small problem.

I found out that children and young people are truly at the heart of the College, which works like a bridge between paediatricians, children and young people.

Working at the College has helped me to become more confident when talking to people I don't know. Through contributing in meetings and interviewing the directors of different divisions, I was able to develop my networking skills. This experience was definitely different, but I enjoyed it so much!

● **Afsana (17) Career Ready Intern with the Digital and Creative Media Team in 2019**

► [www.rcpch.ac.uk/and-us](http://www.rcpch.ac.uk/and-us)

## 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

**KEEP IN TOUCH** @RCPCHTweets @RCPCH f @RCPCH milestones@rcpch.ac.uk





## BEST PRACTICE

SEASONAL SURGES ARE CHALLENGING, SO WE ARE KEEN TO HEAR ABOUT YOUR DEPARTMENT'S SOLUTIONS



**Dr Dani Hall**

● Consultant in Paediatric Emergency Medicine at Evelina London, Children's Hospital

🐦@danihalltweets



**Dr Michelle Jacobs**

● Consultant in Emergency and Paediatric Medicine, Watford General Hospital

# WINTER IS COMING

Illustration: Adam Gale

**E**ARLIER THIS YEAR, the phrase “Winter is coming” sparked excitement as *Game of Thrones* fans waited to discover who would be the ultimate ruler of the Seven Kingdoms. But for clinicians in paediatric emergency departments (EDs), this phrase means something else entirely: extremely busy waiting rooms, and doctors and nurses run ragged as they treat the large numbers of children presenting to the ED.

The Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings, an expert advisory group on the emergency care of children, has made advocating for children in winter pressure plans one of its top priorities, to support

clinicians and service managers in preparing for winter.

A College survey in 2018 showed that winter pressures in EDs caring for children are not an isolated problem but part of endemic, whole-system challenges. Rises in attendances and acuity impedes flow, resulting in overcrowding in the ED, challenging teams to deliver safe, quality care.

The survey also showed that sadly, in some departments, resource and space is reallocated to address adult ED winter surges, putting pressure on an already stretched children's ED. Over a third of responses reported staffing problems contributing significantly to winter pressures. It was explicitly clear that health professionals caring for children in the emergency care setting are under pressure, leading to burnout, fatigue and sickness.

## CASE STUDIES


### Meeting the challenge

Finding solutions to these issues can be challenging. Respondents to our survey highlighted more staff, more space and whole-system change as the top three measures that would help to alleviate the pressure. Following the survey, the committee released recommendations for Trusts and Health Boards emphasising the need for children to be explicitly considered and included in hospital and community winter pressures plans. We advised that service planners and health organisations must have a dedicated lead for children at executive or board level so that the needs of children are included in strategic decision making and that resources within children's EDs should be excluded from adult surge policies.

### Sharing solutions

At the College's Annual Conference this year, we ran a workshop on tackling winter pressures. Delegates heard about initiatives such as winter pressure GPs and reconfiguration of space to develop a children's ambulatory unit, helping to improve departmental flow, safety and staff morale.

We are hosting best practice examples as a resource for clinicians and managers on the College website. We are keen to hear more examples from you of how winter pressures have been alleviated so that we can include these to show what has worked well.

The Committee remains focused on this issue. We want trusts and health boards to take a whole-system view when planning and managing winter pressures, ensuring that the standard of care offered to children is not compromised. 

► **Find out more and share your best practice examples at [www.rcpch.ac.uk/winter-pressures](http://www.rcpch.ac.uk/winter-pressures)**

### SHEFFIELD CHILDREN'S HOSPITAL ED

Dr Michael McCarron • Paediatric Emergency Medicine Grid Registrar (ST8)

#### THE CHALLENGES

We are one of a few dedicated children's hospital trusts in the UK and a paediatric major trauma centre, providing paediatric services to children across South Yorkshire. Over the last five years, there has been a 2.3% average yearly increase in attendances to the emergency department. In a 12 month period, 12.7% of our attendances meet primary care triage criteria, this rises to 15.2% in winter months.

#### WHAT WE DID

We introduced a GP streaming model to meet rising patient demand and staffing challenges. On arrival, patients register at the ED reception, then are seen by a triage nurse who decides if they are appropriate for primary care. The service employed one GP and a health care assistant. Primary care patients who saw the GP spent 44 minutes less time in ED than those seen by ED staff.

#### RECIPE FOR SUCCESS

The key to our success has been the collaborative approach at all stages from the initial service development to the shared approach to clinical governance, with clearly defined lines of accountability. Collaboration between primary and secondary care providers also provides a unique opportunity for shared learning, with the added benefit of improving the standard of care children receive in both settings.

### EAST AND NORTH HERTFORDSHIRE NHS TRUST

Dr Amitabh Gite • Clinical Director for Paediatrics, Lead for CAU and Ambulatory Care

#### THE CHALLENGES

During the winter months, having only one registrar to cover both the paediatrics department and the NICU overnight can be a real challenge, especially with increased attendance rates to the children's emergency department and poor patient flow throughout the department. This led to patient safety concerns as well as poor staff morale.

#### WHAT WE DID

We introduced a 'winter pressure registrar'. Eight-hour locum shifts were available every night from October to March. The rota was managed by a consultant and middle grade trainee, allowing a direct clinical point of contact for locums. We also set up a paediatric decision unit with extra nursing staff and converted the 'minors' area into three new cubicles.

#### RECIPE FOR SUCCESS

Team working, planning and strong leadership were our keys to success! We spent time analysing data and engaging with service managers to build a strong business case. We embraced social media and messaging applications to generate links with former trainees and locums, and to build clinical links and a personal touch when filling rotas.

## Ideas from the editorial board on dealing with winter pressures

- Winter pressures affect patients **and** staff. Look after your colleagues, take adequate breaks and **remember to say thank you** to each other.
- Consider identifying a specific '**winter pressures champion**' to advocate for children and young people at executive level when trusts are in escalation.
- **Flow is everything.** Prioritise your teams' work to ensure prompt discharge from ward areas and facilitate movement of patients from acute areas. Consider how your teams can be used flexibly to meet pressure. **Multidisciplinary team board rounds/huddles can help in doing this.**
- Try to **anticipate rota gaps and staff shortages**. Think about your department's strategy to maintain safe staffing levels, whilst maintaining training opportunities and support for junior colleagues.



**EXPERIENCE**

# GROWING UP LGBT+

**DR MICHAEL FARQUHAR, THE RECIPIENT OF THE 2019 RCPCH & US CHILDREN'S AND YOUNG PEOPLE'S VOICE CHAMPION, ON WHY HE'S PROUD TO WEAR HIS RAINBOW NHS BADGE**



**Dr Michael Farquhar**

● Consultant in sleep medicine, Evelina London Children's Hospital

🐦 @DrMikeFarquhar

**ONE OF THE most important privileges, and responsibilities, of being a paediatrician is helping children and young people (CYP) to be heard at**

**every level, and using our voices to advocate for them when they cannot do it for themselves.**

I was hugely privileged to be awarded the 2019 RCPCH Voice Champion Award for work done as part of the Rainbow NHS Badge project.

I'm a gay man, one of the estimated 5% of lesbian, gay, bisexual and transgender people in the UK. That figure is probably an underestimate. Looked at another way, more than 10% of young adults aged 16-25 in the UK don't identify as 'straight'. How we think about sexuality and gender identity is increasingly

nuanced, and those differences represent the wide spectrum of 'normal' – as Lady Gaga says, we were born this way.

I grew up in Scotland in the 80s, when 75% of British adults agreed with the statement "homosexual activity is always or mostly wrong". I knew I was gay from a young age, very aware of the message being sent, from the Prime Minister down, that being gay was a "bad" thing for a child to be. The UK Government passed legislation, Section 28, specifically banning schools from teaching positively about homosexuality, and spoke of it as being "a pretend family relationship". The media reinforced and amplified, with headlines associating gay men, in particular, with HIV, "the gay plague", and implied associations between homosexuality and paedophilia.



**“The badge sends the message that the wearer is someone LGBT+ people can be confident is a good person to talk to”**



### **“I had no one to talk to”**

Growing up in that social climate, you become convinced something is wrong with you, that you are broken, that feeling like this must be hidden, denied, buried away. When young people feel like that, their mental health in particular becomes hugely vulnerable. Harm was caused to entire generations of LGBT+ young people by these attitudes.

Over time, things have got better, much better. Attitudes have shifted, and LGBT+ people are rightly considered no less normal than ‘straight’ people. Section 28 was repealed and new laws passed leading to equal marriage for LGBT+ people in most (but not yet all!) of Britain. TV and film feature LGBT+ characters in a much more positive and mainstream way than in the 80s, with films such as *Love, Simon* normalising the lived experience of being an LGBT+ teenager.

Things are far from perfect though. LGBT+ young people today – especially trans CYP – are still much more likely to have secondary health problems, particularly affecting mental health. LGBT+ CYP are significantly more likely to be bullied, to become depressed or anxious, to self-harm, to attempt suicide. Most still feel

that they do not have an adult they can confidently talk to about their sexuality or gender identity. Their voice too often remains unheard, and in doing so, harm is caused.

As a paediatrician, as a gay man, I wanted to be part of something to make things better – and the Rainbow NHS Badge project was born. The badge sends the message that the wearer is someone LGBT+ people can be confident is a good person to talk to about sexuality or gender identity, and they will support and advocate for them if needed.

I try to be the sort of person that the younger version of me needed when I was growing up; an ear, an ally, an advocate, someone who could have helped make things better for me. Wearing the badge helps give LGBT+ young people the confidence to start that conversation with me – so I can help them find their voice. You can too! 🗨️

► For more, visit [www.rcpch.ac.uk/rainbow-youth-supporter](http://www.rcpch.ac.uk/rainbow-youth-supporter) and [www.evelinalondon.nhs.uk/rainbowbadges](http://www.evelinalondon.nhs.uk/rainbowbadges)

### **How you can help**

**DOCTORS, ESPECIALLY PAEDIATRICIANS should be good people for any child or young person to talk to, but one in seven LGBT+ people don’t feel they trust healthcare providers because they are worried about attitudes towards them.**

Our Rainbow NHS Badge is intended to be a small part of a solution, helping both to raise NHS staff awareness of the issues LGBT+ people face, and at the same time signalling support to LGBT+ patients and families.

We emphasise that wearing a badge is a responsibility and an opportunity, to understand why something like this is needed, to be part of trying to make that better. A badge alone is far from enough, but we hope it can help to start conversations.

The pilot project was developed at Evelina London with the help of children and young people from RCPCH &Us.

We did lots of focus group work with children and young people, but this was the key message: “What do you think seeing this badge would mean to you?” “Included!”



**Top left:** LGBT+ young people today are still more likely to have mental health problems

**Above:** Mike (left) and colleagues (right) from the Evelina London Children’s Hospital with their badges

## EXPERIENCE



# EBOLA IN LIBERIA

PAEDIATRIC TRAINEE **DR NATHALIE MACDERMOTT**  
SHARES HER EXPERIENCES OF WORKING ON THE  
FRONTLINE TO HELP EBOLA PATIENTS IN LIBERIA

**N JULY 2014 I received the phone call enquiring about my ability to respond to the Ebola epidemic in Liberia. I had just submitted a Clinical Research Training Fellowship application to the Wellcome Trust. The organisation that I volunteer with, Samaritan's Purse International Relief, arranged for me to leave on 14 July. I didn't give it too much thought until the day before I left, when I signed a form acknowledging that were I to contract Ebola while in Liberia it would not be possible to evacuate me for medical care. Only then did the implications dawn on me.**

The morning after I arrived in the capital, Monrovia, I met the medical director of the ELWA Ebola treatment facility, Dr Kent Brantly. He introduced me to the five bed isolation facility, housed in the ELWA mission hospital chapel. That afternoon I put on personal protective equipment for the first time. Four of us had the gruesome task of decontaminating three dead bodies and carrying them to the morgue. They



**Dr Nathalie MacDermott**

● *Currently an ST7 grid trainee in paediatric infectious diseases at Southampton Children's Hospital and has been appointed to an Academic Clinical Lecturer post at King's College London starting in December*

had all died that morning; one was my age and nine months pregnant.

So began a whirlwind two weeks of attempting to care for more and more Ebola patients. At the end of my first week, we transferred the patients from our facility and the government isolation facility in Monrovia into a newly constructed isolation facility (ELWA2), leaving us almost immediately over our bed capacity. The following day Kent asked if I would lead the clinical team, so he could undertake administrative work.

## Escalating challenges

That day, I made decisions I never thought I would have to make. The next day I received news that Kent had a fever and had isolated himself. Overnight I had become the clinical lead for the only Ebola treatment facility in Monrovia. That week, community fear escalated into violence with riots outside our compound. By the end of the week, we were knocking through walls to try and expand the number of patients we could accommodate, our morgue was overflowing due to a lack of burial teams, and Kent, as well as another colleague, were confirmed to have Ebola.

I left Monrovia the day after their diagnoses to return to the UK, the remainder of the team were evacuated a short while later due to escalating violence and an inability to continue without international



**Right:** The first mobile rapid response to Gelensiasu, Gbarpolou county. With the medical team in front of the mobile treatment facility just prior to opening  
**Left:** Colleague Nancy Writbol helps Nathalie to put on personal protective equipment



support. On my return to the UK I was isolated at home for three weeks due to the uncertainty of how my colleagues became infected.

## Returning to Liberia

I returned to clinical work six weeks after my initial departure, by which time the international community and media had become much more engaged with the response. I soon requested six months out of programme to return to Liberia and am grateful to my Head of School for Paediatrics in Wales and my supervisors for granting me this time. I left on 10 October 2014, just a few days after discovering my application for a Clinical Research Training Fellowship was unsuccessful.


My work as the clinical programme manager for the Samaritan's Purse Ebola response in Liberia included constructing treatment facilities in rural areas, training health care workers, providing clinical oversight for patient care and developing/operating rapid responses to rural cluster outbreaks. While there, I discussed undertaking Ebola research with Prof Levin. In November, I secured one year of research funding and successfully interviewed for a grid post in paediatric infectious diseases in the UK. I returned to the UK in March 2015 and began my PhD at Imperial College, determined to understand the discrepancies in disease outcome for Ebola infection. In December 2015 I was awarded a Wellcome Clinical Research Training Fellowship to investigate host genetic susceptibility to Ebola virus disease. My PhD took me to Sierra Leone for a prolonged period of fieldwork, recruiting over 2,500 participants from Ebola affected communities. The scale of this fieldwork, in a setting with limited research infrastructure, was a huge challenge, and I am grateful to the University of Makeni for their support. During my PhD there have been countless challenges, from labs being struck by lightning, absent power and damaged laboratory equipment, to unforeseen duty charges of £17,000, road traffic accidents and airport strikes. Most significant was the impact

**"I had wondered about those left behind; now I came face to face with the people behind the numbers"**

of approaching communities devastated by this horrific epidemic. Hearing their stories was heart wrenching. As I watched so many of my patients die in 2014 I had wondered about those left behind; now I came face to face with the people behind the numbers.

## The aftermath

In December 2015 I was diagnosed with post-traumatic stress disorder from my initial time in Liberia. I knew when I returned to Liberia in October 2014 that I had some symptoms of post-traumatic stress, but thought this was an understandable reaction to the situation. I believed things would settle down in time. Having responded to several international disaster situations, I was familiar with the period of adjustment that followed any return home. Unfortunately, this time I didn't adjust as well. Over time the memories of that summer did not

fade; they became clearer and more vivid as I wrestled with the guilt of not being able to save my patients. With the gentle prodding of friends, I eventually sought help. My GP directed me to the Practitioner Health Programme, a confidential service for doctors with mental health problems. I am very grateful to the team there for helping to put me back together. Now, just over five years from the day I travelled to Liberia, I have completed my PhD, am training in paediatric infectious diseases and about to commence an academic clinical lecturer post. 

**► Find out more about the Practitioner Health Programme at [php.nhs.uk](http://php.nhs.uk)**

## Ebola in West Africa

The 2014 outbreak of Ebola in West Africa has been described by the World Health Organisation as "the largest, most severe and most complex Ebola epidemic in the nearly four-decade history of the disease". More than 28,000 people were infected and 11,000 people died from the disease between 2014 and 2016. Most of the cases in this outbreak occurred in Liberia, Guinea and Sierra Leone.

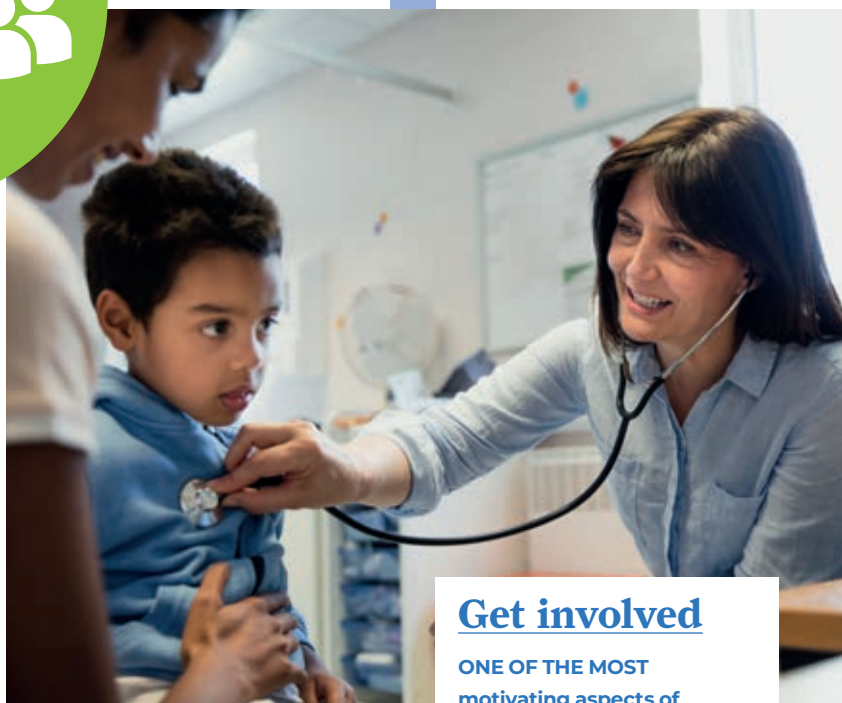




## CAMPAIGN

# #Choose Paediatrics Campaign

We've launched a new digital campaign to recruit the next generation of paediatricians



**IN SEPTEMBER WE** launched our new careers campaign. Like other specialties, we need more trainees to choose us in an environment that's becoming more competitive.

It's not just about recruitment. It's getting more difficult to retain paediatricians at all levels who've already chosen paediatrics as their specialty. That's why recruitment and retention is a major strategic focus for the College over the next three years.

Medical students and foundation doctors tell us they often get just a brief glimpse of paediatrics, which can come late in the cycle. This means, by the time they get to us, many will have already set their hearts on another specialty. This is a big challenge and we need to get better at helping students gain more exposure to paediatrics at an earlier stage.

## Surviving and thriving

Retention will continue to be a core part of our work. VP for Education and Professional Development Camilla Kingdon and Chair of the Trainees Committee Hannah Jacob share their thoughts on what the College is doing for members when it comes to retention:


- **Practical help:** Our resources cover everything from career development and mentoring to wellbeing and less than full-time training support.
- **Lifelong learning:** We provide a comprehensive programme of learning and development

through our courses and online learning provision.

- **Connecting with peers:** Our Stepping Up programme, careers advice network and mentoring support service provide peer support.
- **Lobbying government:** We used census data to successfully campaign for an increase in paediatric training places in Scotland. We also successfully campaigned to get paediatrics included on the Shortage Occupation List.

## Digital campaign

Over the summer, we ran surveys and held focus groups with paediatricians to find out what made them choose paediatrics, what it's like on the tough days, and how we should be talking to the next generation of trainees. Using their feedback, we developed a digital campaign designed to show people the best of our specialty while also publishing features and resources about how we're working to tackle challenges such as rota gaps, resources and burnout.

This feels like the right balance: we need to recruit more trainees, but we need to be real about what an average day looks like in a stressed system. Our job is to help inspire the next generation, support members who've already made the choice, and campaign to change policies and practices that make members' lives harder. 

► Find out more at [www.rcpch.ac.uk/choose-paediatrics-campaign](http://www.rcpch.ac.uk/choose-paediatrics-campaign) or get in touch at [careers.campaign@rcpch.ac.uk](mailto:careers.campaign@rcpch.ac.uk)

## Get involved

ONE OF THE MOST motivating aspects of life as a paediatrician is inspiring the next cohort of doctors – and there are things you can do to get involved. Officer for Recruitment Simon Broughton and Trainee Recruitment Rep Emma Coombe wrote a blog including some of the following tips:

- 1 Engage medical students in your hospital.** Give students the opportunity to shadow the team or help with an audit.
- 2 Represent your specialty at a careers event.** We're on the lookout for members who'd like to talk to the next generation.
- 3 Organise a taster week.** This offers a few days to give a flavour of what paediatrics is like.
- 4 Volunteer to host a paediatrics careers day.** We can support you with content and resources.

WORKFORCE

# Be more Lego!

Why multi-professional working benefits everyone in paediatrics

Dr Nic Jay is part of a team of multi-disciplinary professionals



**“We now need to embrace other professions to ensure children are seen by people who want to look after them”**



**Dr Nic Jay**

● Officer  
Workforce &  
Service Planning  
🐦 @sheffkids65

**C**HILDREN ARE THE future and we need to ensure for all that we maximise their potential. Delivery of healthcare is part of this and to ensure all children have equitable access to quality services we need a viable workforce in all parts of the country. I work at Sheffield Children's

**Hospital, established in 1876 and providing healthcare within the NHS since its inception.**

We function as a district general hospital for our local population as well as providing specialised services regionally and super specialised services nationally. Sheffield is multicultural: 20% of the population add diversity to our city by being from a non-white ethnicity. We are part of South Yorkshire which means we are proud Yorkshire folk, and we also provide a space for those who may be displaced for many reasons.

## The challenges

Across South Yorkshire, there are many unmet health needs. Over 100,000 children live in poverty (a fifth of those under 16 years), 70,000 have a chronic illness and 30,000 have a disability.

Recently, I had a 12-year-old with severe recalcitrant eczema

and multiple allergies who was in a mess. He told me that his family don't have a bath and he has to travel to an uncle's house to bathe, one of the main reliefs for his skin. He said, "Please just help me." But he didn't need me, he needed a clean environment, a bath and a healthcare assistant to spend hours applying creams (he awaits Dupilumab). I am just one part of his care pathway.

## Problem-solving

Our multi-professional allergy team is comprised of doctors, specialist nurses, advanced practice providers, dieticians and team co-ordinators. It is the only way we can get through the workload. If we have a problem, we reflect on who has the competencies to 'sort this'. We know from

other countries that defining competencies in paediatrics allows a team approach to delivering care. As a junior doctor, I spent hours taking bloods; we now have phlebotomists. Tasks can be done by whoever is competent to perform them.

Multidisciplinary teams can improve quality and outcomes by having permanent members embed knowledge to ensure stability, whilst others rotate to provide medical input and gain knowledge. Organisations that contain more functional teams report better outcomes for patients and, as a consultant, I am part of the leadership responsible for empowering individuals to work at the top of their capabilities. Paediatrics has always been the first to consider how to change; we were among the first to support nurses in developing advanced skills because they can and should. We now need to embrace other professions to ensure children are seen by people who want to look after them.

This also makes doctors' lives better. Junior doctors can attend training as we have others to share the work. I know if my clinic is overbooked and there is one of our advanced team free, they will support me. If a child needs my skills then I have the time to deliver that care. In the words of the Lego legends:

"Everything is awesome, everything is cool when you're part of a team; Everything is awesome, when you're living out a dream!" 🌟

► Find out more at [www.rcpch.ac.uk/workforce](http://www.rcpch.ac.uk/workforce)



Being 'more Lego' means being part of a team



# PEDSIG

**22%**  
of the College's  
members are  
trainees

## Paediatric Educators Special Interest Group: who we are, what we do and why you should join



**Dr Ben McNaughten**  
● ST7 Paediatric Trainee in Antrim Area Hospital  
Twitter: Ben McNaughten @pedsig



### I AM PASSIONATE

about paediatric medical education. I have been actively involved in medical education as both an undergraduate and postgraduate. In 2016, I undertook a one-year fellowship in medical education and simulation. I have recently completed a Masters in clinical education.

My first encounter with PEDSIG, which is affiliated with RCPCH, came at the College's Annual Conference

in 2018. I was impressed with the work it was doing to support those involved in paediatric medical education.

PEDSIG is all about promoting paediatric education (undergraduate and postgraduate). They are keen to support those involved in paediatric education through meetings, social media, written resources and by building a network of paediatricians who want to inspire through great teaching and education. Through their link with the College, they aim to influence



and contribute to the wider paediatric education agenda. They also promote educational research and scholarship in paediatrics through their conferences, grants and mentorship network.

In September 2018, I joined the committee and took on the role of social media/promotion secretary. To date, my time with the team has been hugely rewarding. It has been great to share ideas and learn from others who share my passion for paediatric medical education. I have been involved in organising and delivering courses and meetings. I had the chance to chair a session of the joint PEDSIG and Young People's Health Special Interest Group (YPHSIG) meeting at the College's Annual Conference this year. I have also

had the opportunity to develop my skills in website management and to learn more about the work of the College and how we can collaborate with other organisations.

We are keen to expand our membership base and would like to invite all those who are interested in paediatric medical education to join us. Membership is open to all including undergraduates,

postgraduates and medics, nurses and allied health professionals. As a member you will have the opportunity to apply for small grants for education-related courses or projects. You will also become part of a dynamic group working to support and promote education among paediatricians and allied health professionals.

We plan to create a quarterly newsletter to provide members with an update on our work and information about upcoming events. We are also in the process of developing a mentorship scheme for members. Our next event is our annual winter meeting, in Birmingham Children's Hospital on 29 November. 📍

► Find out more at [www.pedsig.co.uk](http://www.pedsig.co.uk)

**★ RCPCH Conference and exhibition**  
28–30 April 2020, ACC Liverpool

Innovating  
for child  
health

Join members and leading figures in child health at the 2020 RCPCH Conference and exhibition.

Find out more and book your discounted early bird place at [www.rcpch.ac.uk/conference](http://www.rcpch.ac.uk/conference)





# Button battery ingestion

Button batteries are commonplace in children's lives, but can cause harm



**Dr Bob Basu**

● Principal Investigator on the button battery ingestion study with the British Paediatric Surveillance Unit (BPSU)

🐦 @bobmd9

## BUTTON BATTERIES

**OR** disc batteries have been around since the 1950s. With the need for portable devices to be powered for extremely long periods of time, their use soon became ubiquitous.

Apparently originally conceived by the Union Carbide chemical company for the American watch makers at Hamilton to power

wrist watches, the potential for these power cells was realised by numerous other sectors. Indeed, it might be fair to say that many modern-day inventions that we depend upon would not be possible without them. Before the era of smart phones, scientific calculators were required in schools to be able to calculate trigonometry. Most modern day cars are reliant on button batteries to power their keys to enable us to remotely lock and unlock the doors as well as to start them without the need to turn an ignition switch. Button batteries then have their place for us to all function in our modern-day lives.

With every advance there is always an unintended consequence. Over the past several years there has been rising



Button batteries are used in many everyday objects

concern around cases of children who have swallowed these batteries and have subsequently come to serious harm. This has been reported through North America and Europe down to Australia and New Zealand. Numerous case reports have been published both in the mainstream media around the world as well as in distinguished medical literature about children who have come to harm after ingesting a button battery.

## Act fast

Button batteries cause harm when they become lodged in between two areas of mucosa. This could be part of the airway or the gastrointestinal system. Once there, an electrochemical reaction takes place and can even occur after the battery has apparently run out. Erosion of the mucosa can occur within minutes as has been shown in dramatic demonstrations using two slices of ham or bacon. If lodged batteries are not recovered in a timely fashion, there can be long-term harm

in the form of fistulas or worse. Lodged batteries have been known to erode through into major blood vessels leading to not only disability but also death.

In view of this, there is always a certain amount of trepidation should a child present, usually to an accident and emergency department, with a history of coming into contact with a button battery. Most ingestions are not witnessed, and children can present with vague signs such as excessive mucosal discharge mimicking a viral illness. Metal detectors can be useful but do not always pick them up so a chest or abdominal radiograph is almost always required to confirm its presence, unless it is lodged in the nose or ear canal where it can clearly be seen. Once seen on the image a 'halo' sign might be noted (a thin rim near the edge of the battery) which can differentiate it from a coin. Prompt discussion with a paediatric surgeon would then be needed for further advice and even transfer to a unit for retrieval of the battery, especially if it is lodged above the diaphragm.

Manufacturers have taken this matter seriously and must be praised for their involvement with the charitable sector to help to improve matters. Most notable has been the collaboration between the Child Accident Prevention Trust and the British and Irish Portable Battery Association who are the industry organisation representing manufacturers of button batteries.

A recent report from the Health and Safety Investigation Branch has again highlighted the need to make recommendations and put in place strategies to help healthcare professionals diagnose children who may have accidentally swallowed a button battery. 🚑

► Find out more about the BPSU at [www.rcpch.ac.uk/bpsu](http://www.rcpch.ac.uk/bpsu)

**"Most ingestions are not witnessed, and children can present with vague signs such as excessive mucosal discharge mimicking a viral illness"**

# Members

The latest member news and views

## KEEP IN TOUCH

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

🐦 **Twitter @RCPCHTweets**

📘 **Facebook @RCPCH**

📷 **Instagram @RCPCH**

🌐 **milestones@rcpch.ac.uk**

## HONOUR

### OBE FOR PROF JUDITH ELLIS



#### OUR FORMER

Chief Executive Professor Judith Ellis, an Honorary Fellow of the College, has been awarded an OBE

for services to healthcare in the Queen's Birthday Honours. Judith was at the College for four years from 2014. Judith is Chair of Trustees of the Tropical Health and Education Trust and Honorary Professor of Nursing at London South Bank University.

## TRAINEES

### TOOLKIT LAUNCHED

IT CAN BE so daunting as a trainee at any level trying to work out who is responsible for organising which aspects of your training. However, the trainee toolkit is freely available on the College website and has been written by trainees, for trainees, to help navigate different aspects of your training. There is guidance on topics from sleep to rotas, less

than full-time working to educational supervision. It has a summary for each section and signposts to other useful resources.

► [www.rcpch.ac.uk/trainee-toolkit](http://www.rcpch.ac.uk/trainee-toolkit)



Look to the toolkit for all training queries

## TRAINEES

### Top Tips for Clinical Exams

Follow the below guidance to make sure you're up to date with MRCPCH clinical examination



**Dr Anna Mathew**

● Chair of the MRCPCH Clinical Examination

#### WITH THE RECENT

changes, Dr Anna Mathew, Chair of the MRCPCH Clinical Examination, gives you her top tips to help you best prepare for the clinical exams.

#### ● Sign into a webinar.

For candidates who haven't done so already, read

the instructions to candidates on the College website, or consider attending a course before the exam. The College runs a clinical course for the exam six to eight weeks before any diet.

- **Practise examining patients** under timed conditions, and practise presenting your findings in under a minute to allow time for discussion.
- **Work with colleagues** in preparation for the exam so that you can learn

from each other and hone your skills through feedback. Ensure you examine in a structured and systematic manner.

- **If you can**, practise seeing two or three patients one after the other, to get used to moving on as you would in the exam.
  - **Practise** for the development station and get an understanding of what is required of you in this station. Advice on how to use the time within this station is available in candidate guides and webinars.
  - **Make sure** you are aware of current guidelines for the management of common paediatric presentations, both acute and long term.
  - **Remember** that you can use paper and pencil to make notes for many of the stations; you will be guided to leave any notes in the station before leaving.
- [www.rcpch.ac.uk/resources/mrcpch-clinical-examination-candidate-guidance](http://www.rcpch.ac.uk/resources/mrcpch-clinical-examination-candidate-guidance)





## TRAINEES

### TRAINEES COMMITTEE NEWS

**THE TRAINEES COMMITTEE** has been busy with a whole range of projects aimed at improving training and sharing good practice around the country.

In the last year we have developed a number of resources including the Trainee Charter, which outlines what trainees should expect from each training unit. This is complemented by the Trainee Toolkit giving a trainees' perspective on training.

We are also developing a leaving questionnaire for trainees resigning their paediatric training number. This will help to quantify the trainee loss that paediatrics is experiencing, and we hope that it will give national insights into specific challenges our colleagues are facing.

The committee has worked tirelessly to support trainees and trainers in their regions during the transition to the Progress curriculum. We have continually provided feedback from trainees about ePortfolio and have recently agreed important improvements to the trainer's report and the assessment forms.

► Find out more at [www.rcpch.ac.uk/trainees-committee](http://www.rcpch.ac.uk/trainees-committee)

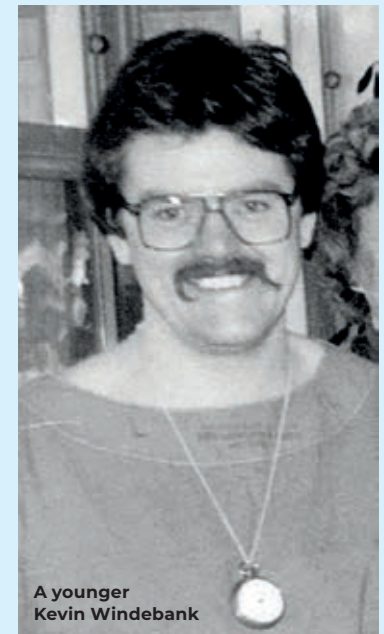
## EXPERIENCE

### Trip Down Memory Lane

**A Consultant Paediatric Oncologist from Newcastle reflects on his long career**

**I BEGAN TRAINING** in paediatrics four decades ago. It was a very busy and self-directed apprenticeship [over 80 hours each week] rather than training as we know it now. Whilst the new Shape of Training pathways are necessary for the modern health service, I remain concerned whether the introduction of run-through training suits the wide spectrum of newly qualified doctors. It certainly took me a few years dallying with neurosurgery and general practice before discovering I was really a paediatrician at heart.

Although assessments and portfolios track progress, I am pleased we still have rigorous theoretical and clinical exams in place to drive learning. As an examiner over many years, I was on



A younger  
Kevin Windebank

occasion taken aback by a candidate's poor demonstration of basic clinical skills. Fortunately, due to the efforts across the Royal Colleges, exams are now fairer. Trained examiners help candidates perform to their best, rather than 'tricking and trapping' them. We must ensure that clinical skills are properly learnt because, despite progress in diagnostic technology, the bad things happen when parents are not listened to and children not examined competently.

### Onwards and upwards

Since I started in the NHS, there have been nearly 30 significant organisational changes, however, the most exciting are happening right now! The internal market is being steadily dismantled. Integrated Care Systems informed by genuine coproduction with our communities, and staff have the potential to revolutionise how we care for and nurture our children and young people in the future.

Do I ever look back and think I should have chosen a different career? Absolutely never.



**Dr Kevin Windebank** • Council  
Representative for Senior Members  
and Fellows



The trainee committee

## BOOK

### GROWING PAINS: MAKING SENSE OF CHILDHOOD. A PSYCHIATRIST'S STORY

by Dr Mike Shooter



**Dr Shilpa Shah**

● Consultant  
Paediatrician,  
Craigavon Area  
Hospital

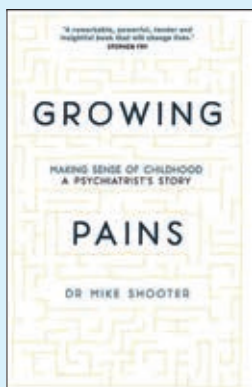
Twitter: @drshilpa  
shah

**MIKE IS A** storyteller. He states that life is not all about successes. Failure, regret and disappointments are an integral part of life and can be an opportunity for growth. His first story is about his own self. He says it took a dying patient to make him realise and stop! He claims perfection is a bad model and chooses the 'good enough' one instead.

Whether it is the empowerment of a 15 year old with dialysis-dependent kidney disease, a repressed 17 year old figuring out her sexual preference, or an eight year old burdened with a misdiagnosis of ADHD, Mike's stories help us look beyond a diagnosis.

Mike describes adolescence as a second shot for parents at the terrible twos! He highlights the evolution of the adolescent brain from primitive tasks to more sophisticated tasks and suggests that parents must take risks with their adolescent offsprings because without experiment they will not develop.

I'd recommend this book to everyone who seeks to understand human behaviour and, through it, their own.



## PODCAST

### TWO PAEDS IN A POD



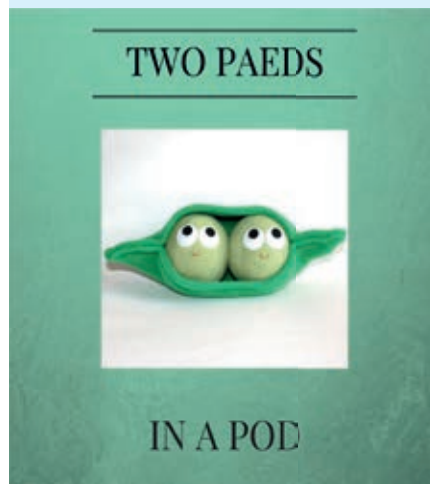
**Dr Ian Lewins**

● Consultant  
in Paediatric  
Emergency  
Medicine, Royal  
Derby Hospital

Twitter: @ianlewins

**THIS PODCAST WAS** created by Derby-based paediatricians Dr Sarah Simons, Dr Geoff Burnhill and Dr Ian Lewins. They wanted to create a resource for those healthcare professionals new to paediatrics or who see children as part of a wider healthcare role. The podcast has gathered a wide listenership among doctors, nurses, advanced clinical practitioners and paramedics, with over 32,000 listeners.

There are 35 episodes to date available for free on Spotify, iTunes and SoundCloud. Each podcast is around 20 minutes long, and so ideal for listening to while commuting, and covers a range of clinical topics, such as the management of common conditions, non-clinical topics including the NHS Rainbow Badges project, and the latest in paediatric research.



**11%**   
of members have  
been with the College  
since it gained royal  
status in 1996





## STARTER FOR TEN

# We put 10 questions to a consultant and a trainee to see what makes them tick

## Dr Seb Gray

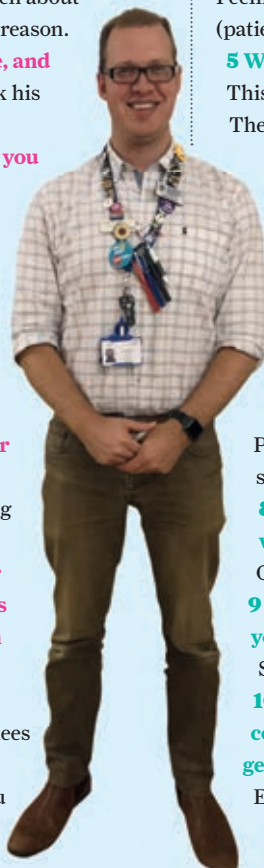
Consultant Paediatrician, Salisbury NHS Foundation Trust, Deputy Regional Lead for Wessex.

@SebJGray

- 1 Describe your job in three words.** Ultimate job satisfaction.
- 2 After a hard day at work, what is your guilty pleasure?** If the kids are asleep, sometimes they 'accidentally' wake up when I pop in for a quick chat. I'm also a sucker for trashy reality TV to properly switch off and unwind.
- 3 What two things do you find particularly challenging?** Saying "no" – there are always so many exciting things to do! Forgetting that not everyone is as honest or trustworthy as I would like.
- 4 What is the best part of your working day?** Working with an incredible multidisciplinary team.
- 5 What is the one piece of advice you wish you could impart to yourself as a junior trainee?** Don't worry so much about an eventual consultant job – things happen for a reason.
- 6 Who is the best fictional character of all time, and why?** The BFG – kind, caring and willing to stick his neck out to help children.
- 7 What three medications would you like with you if you were marooned on a desert island filled with paediatric patients?** Oral rehydration sachets, sun protection cream, antibiotics.
- 8 If you were bitten by a radioactive gerbil, what would you like your superpower to be, and why?** Mind-reading powers – it would be incredible to know what babies are thinking!
- 9 What is the single, most encouraging thing that one of your colleagues can do to make your day?** Smile – happiness is contagious and it's so important to create a joyful environment working with children.



- 10 How do you think you, your colleagues and current trainees can inspire the next generation of paediatricians?** Concentrate on nurturing and looking after current paediatricians and trainees – there's no point trying to fill a bath with more water unless you put a plug in!



## Dr Katie Restall

ST4 Paediatric Trainee at Salisbury NHS Foundation Trust

@ktlour88

- 1 Describe your job in three words.** Busy, challenging, rewarding.
- 2 After a hard day at work, what is your guilty pleasure?** Eating Nutella straight from the jar with a tablespoon!
- 3 What two things do you find particularly challenging?** I like to be organised and plan things in advance, so not being able to plan ahead for something is frustrating for me. Likewise, I don't like uncertainty.
- 4 What is the best part of your working day?** Feeling like I've made a difference to someone's day (patient, relative or colleague).
- 5 What is the best advice you have received as a trainee?** This fits in with my challenges – it's OK not to know something. There'll always be someone else to ask, even when you become a consultant.
- 6 Who is the best fictional character of all time, and why?** Piglet – the most loyal friend to Pooh, who although he is small and quite timid, tries to be brave if it means helping out his friends.
- 7 What three medications would you like with you if you were marooned on a desert island filled with paediatric patients?** Paracetamol, prednisolone (in a liquid preparation not a soluble tablet), ceftriaxone.
- 8 If life, indeed was like a box of chocolates, what flavour would yours be?** Chocolate praline.
- 9 What is the single, most encouraging thing that one of your colleagues can do to make your day?** Smile!
- 10 How do you think you and your colleagues can inspire the next generation of paediatricians?** Encourage each other to look after ourselves as well as our patients.



# RCPCH View from the Nations



## IRELAND

**Dr Ray Nethercott**  
Officer for Ireland

[@RCPCHireland](#)

**A**T THE TIME of writing the distractions of Brexit consuming almost the complete bandwidth of public, media and political attention in Northern Ireland is proving frustrating. However, the positivity of the paediatric community, similar to the children and young people we work with, is reassuringly ever-present.

We have gathering momentum in the formation of our Child Health Partnership, the New Children's Hospital has its foundations and is growing. Work is beginning to bring new clarity of focus to digital child health information, that will support our efforts to more comprehensively describe our population in terms of physical, mental and behavioural health outcomes.

We have enduring hope that we can bring positive changes to our system that will reduce the very real health inequalities that exist here in Northern Ireland. We are determined to improve our outcomes utilising best available evidence for standardising practice, together with better, more accurate and timely information that will give us the agility to change tact when appropriate. But most influential from my observations are the voices of clinicians working together across disciplines and with families to do the right thing for the right reasons.



## WALES

**Dr David Tuthill**  
Officer for Wales

[@RCPCHWales](#)

**A** QUESTION WE OFTEN ask ourselves in advocating for children's health is: "How can we shout loudly enough to cut through the noise?" It's a good question and I'm glad that programmes like the State of Child Health raise the profile of children's health.

Each year it's released with a planned media campaign and has been successful in attracting positive responses from both media and Welsh Government.

Alongside College staff in Wales, paediatricians are working with the Children's Commissioner for Wales to inform thinking on transition from paediatric to adult care; Public Health Wales on updating health information for parents; and Welsh Government on a range of issues from workforce planning, through autism services to obesity.

I'm grateful to colleagues who, usually in their own time, engage with policy and decision makers in commenting on reports, contributing to policy consultations and taking part in programme boards and workshops.

We're often approached by officials to provide paediatric input into policy and service design. If you're interested in getting involved in this kind of work, do consider applying for College committee roles – I'm always happy to have a chat with you too!



## SCOTLAND

**Prof Steve Turner**  
Officer for Scotland

[@RCPCHScotland](#)

**T**HE CHANGING OF the seasons and the weather in our maritime climate is a constant reminder that nothing stays the same. Child health is also constantly changing.

I can't remember when I last saw a child with rotavirus or meningococcus. The College's community needs to keep light on its feet. It is that time of year when the trainee intake for 2020 is set and armed with the 100% complete workforce survey we have been able to show that workforce is changing and necessitating more trainees to maintain the status quo of consultant numbers. Part-time working in both male and female trainees and consultants is on the rise and this needs to be factored in. Lifetime allowance is rearing its head as a potential problem. Sorry but I have to mention the Brexit word, and what its impact may be for the future. In addition to providing an evidence-based case for increasing trainee numbers, the College also hosted a 'Facing the Future' event in September, the aim of which was to engage in blue sky thinking among clinical leaders and about how child health services are going to provide care for children and young people in 2020 and beyond.





# Lifelong learning

**Dr Rabia Hydal-Mohammed** believes education is key to improving child health in Trinidad and Tobago



**Dr Rabia Hydal-Mohammed**

● Registrar at the Paediatric Emergency Department (PED), of the North Central Regional Health Authority



**TRINIDAD AND TOBAGO** is a tropical, twin-island republic state nestled in the southern Caribbean, just off the north-eastern coast of South America. We are a multiethnic, multicultural and religiously diverse country with a population of approximately 1.4 million people.

My name is Dr Rabia Hydal-Mohammed, Registrar at the Paediatric Emergency Department (PED) of the North Central

Regional Health Authority (NCRHA), one of the five Regional Health Authorities in Trinidad and Tobago. In 2003, I attained my Bachelor of Medicine and Bachelor of Surgery (MBBS) from the University of the West Indies, Trinidad and Tobago, and completed the membership examinations from the Royal College of Paediatrics and Child Health in 2013. In 2017, I graduated with a Masters in Health Administration from the University of Trinidad and Tobago.

## An inspiring workforce

Throughout my career, I am fortunate to have been surrounded by a variety of



senior, locally and internationally trained paediatricians, with years of knowledge and expertise. Their code of ethics and approach to paediatrics has moulded me into the paediatrician I am today.

The healthcare system in Trinidad and Tobago comprises both public and private healthcare facilities. Public healthcare is available to all citizens and is free, whereas private healthcare is available at a fee-for-service charge. Most of my paediatric experience has been within the public healthcare system, which affords a vast, diverse paediatric population with a multitude of illnesses to treat and learn from, quickly. Asthma is the most common condition seen in the PED, followed by seizures. Recently, we have also seen an upsurge in patients presenting with anxiety-related issues, recreational drug use and intoxication.

In an effort to reduce these trends, numerous projects to better advocate for the patient have been created. Our Super User Nurses programme, in which a cohort of paediatric nurses were exposed to in-house nurse practitioner training, has improved the skillset of

the paediatric nurses in the department. Our Schools United with NCRHA (SUNreach) programme, in which teachers are empowered with the core competencies to handle common paediatric illnesses, injuries and basic paediatric emergencies while at school, is highly rated. Our SUNreach Resilience Training programme coaches secondary school teachers to recognise the challenges of adolescence and foster improved coping skills in teenagers.

## Challenges to overcome

Recently, at our Back to School Child Wellness Initiative, over 1,200 children were given medical 'check-ups', screened and educated about the importance of maintaining healthy lifestyles in order to prevent the scourge of non-communicable diseases. However, our greatest challenge, despite all these programmes, remains data collection. We lack computerised systems to produce timely, accurate statistics of our patient numbers and trends. Local research is time-consuming as our medical records system is mainly paper-based. Monitoring and evaluating the impact of our initiatives through objective data is limited.

I am a keen advocate of strengthening the healthcare system through effective partnerships, and strongly believe that through education and the empowerment of our people, we can improve the quality of lives of our nation's children. 🌟

**“Recently, we have also seen an upsurge in patients presenting with anxiety-related issues, recreational drug use and intoxication”**



**Above:** Rabia and colleagues at an event, Life was Meant to be Lived **Top:** Rabia at work



# Wellbeing

Support, guidance and reflection

## **SURVIVE AND THRIVE**

### Saying the unthinkable

Balint groups help doctors to explore complex interactions in paediatrics



**Dr Nick Schindler**

● Paediatric Registrar  
ST7, Norfolk and Norwich University Hospitals NHS Foundation Trust  
@drnicktwit

#### **IT WAS A** night shift. Not particularly busy.

The baby had a high fever and was irritable, the genuine kind of irritable where nothing soothes them. The parents were reluctant for the child to have any investigations and they flat-out refused a lumbar puncture. You just about convinced them to accept some blood tests and antibiotics. The cannula took two attempts and they were angry about that as well. "You don't have kids do you?" the mother asked. "You can't possibly understand, then."

The doctor finishes their story and picks up their cup of tea. It isn't easy to relay the facts of an event without an overlay of how it made you feel.

Now is the turn of their colleagues to share thoughts on how the doctor might have felt. The doctor sits and listens while the others discuss the event.

#### **Sharing experiences**

"I think the doctor must have felt pretty angry. If that was me I'd have been really mad. What does being a parent have to do with it? They were just trying to be hurtful."

"I wonder if the doctor felt a bit guilty, for being a cause of worry for the family and doing these things to their baby. They needed a cannula, but we all feel bad when we miss."

"I'd have been scared. I hate it when parents yell at me. Even if you're 100% in the right, you still worry someone will say you should have done something differently. Then you have to explain it all at ARCP (annual review)."

"It's just so frustrating when people won't listen. I always try to explain things clearly to parents, give them time to think and process. They've come to hospital because the

Balint groups allow doctors to share experiences and emotions



child is unwell, why don't they trust us to do our jobs?"

The facilitator redirects the conversation. "OK, we've discussed that the doctor might have felt angry, scared and a bit guilty. How do you think the parent in this situation felt?"

#### **Effective explorations**

Balint groups work by allowing a doctor to share the facts of an experience and then sit back while their peers explore the possible emotional responses to it. The idea is that others are more likely to say the unthinkable things that as professionals we don't typically express. The doctor doesn't have to validate these feelings, they might not all be correct, yet each individual in that group gains an insight into how peers might respond inwardly in a similar situation.

As paediatricians, we are often told that we're the nice ones. We never get angry, we never shout, we always review the child when asked. Balint gives us a space to explore the hypothetical. In a depersonalised way we are allowed to say that "the young person who comes in every weekend with self-harm makes me really angry", without fear of judgement.

Many of us talk at or with our partners or friends after a long day. Many of those confidants are fantastic listeners and yet they might not really understand, or they might get angry and defensive on our behalf, which isn't what we wanted.

Balint groups allow us to say the unthinkable and saying it might help us to process those thoughts into something constructive. They don't come with documentation or assessments. What happens in Balint stays in Balint. 🌀

► For more see [www.rcpch.ac.uk/balint-groups](http://www.rcpch.ac.uk/balint-groups)



## REFLECTION

# How was your day at work?

A consultant explains why sometimes, “Fine” is all you can say when you get home

**THERE IS SCREAMING.** It is very loud. I do my best to comfort the person making the noise, but there is no salve for this pain. Death is coming at the start of life. There is blood everywhere. Between the paediatricians, the surgeons and the nurses, we have battled hard. And it looks like it.

What do we do now? Death is coming. The level of acidosis is overwhelming. The surgery is still on-going, but the heart is inexorably slowing. Do we let the mother in to see the mess? She was not here when it started. She too has just had a general anaesthetic to deliver her baby. She is screaming to see her baby, but she cannot physically get off her bed yet. Every other family on the unit can hear her. I cannot do it. I cannot let her see the current state of the baby.

So, I sit with her, preventing her from falling off the bed in her effort to see her baby, while the

surgeon tidies up and cleans away the blood. It is only seconds, but the desperation of her pleading makes it feel forever.

We go into the room, she cuddles her baby, who is still warm, with a fading pulse, the noise stops abruptly. The monitors are switched off and stop alarming. No other families on the unit are talking. Silence comes and brings death with it.

Some weeks later at the bereavement appointment she thanks me for making sure things were clean and tidy. She cherishes the memory of looking down at her baby wrapped in a fluffy blanket looking whole and at peace. I have a sense of flooding relief that her last memory of her baby is a calm one.

► For help with similar experiences visit [www.rcpch.ac.uk/wellbeing](http://www.rcpch.ac.uk/wellbeing)

## PET THERAPY

### A HELPING PAW

**PIKE THE DOG** is showing how staff and patients can benefit from pet therapy. It's difficult to open a medical journal these days without reading about stress, burnout and mental health. I suppose these issues have always been around, but weren't recognised or had a different name.

I started to bring our dog, Pike, to work. He is an eight-year-old Labradoodle, with a famously healthy appetite. My secretary had mentioned Pets as Therapy, which I had not then heard of. After a brief assessment he was deemed suitable for this role.

The effect on staff and patients has been interesting and informative. He has visited adult ITUs, care of the elderly, regional rehabilitation, the children's ward, and of course, my office.

Wearing his hi-vis jacket, I find that people of all ages, backgrounds and nationalities will come and speak to us (a 'social catalyst', apparently). This includes people I've seen at work for years but had no reason to speak with.

I have no doubt that his visits are good for staff and good for patients.



**Dr Richard Nicholl**

● Consultant Neonatal Paediatrician at Northwick Park Hospital





## A DAY IN THE LIFE

# “Paediatrics provides a supportive environment to work in”

### Dr Claire Salter

Paediatric Registrar, Musgrove Park Hospital, Taunton, Somerset

🐦 @babydrclaire

**I became a Paediatrician because:** I must admit, I'm not sure... I have no medics in my family but my parents say I first said I wanted to be a 'baby doctor' when walking along the beach once as a four-year-old! After that, I learnt all my skills from Saturday nights watching *Casualty*, and was inspired by colleagues in medical school and my early placements to affirm my long-term desire.

**My typical working day/role involves:** It's very varied. As a registrar in training, I spend time in a variety of clinical settings. By day, I work on the General Paediatrics ward and at night I cover NICU/labour ward/postnatal ward and any unwell patients in ED. We see all new admissions and manage the needs of our inpatients. As a registrar, I support juniors in managing the initial presentation and liaise with seniors or other specialties for ongoing support.

My main passion is acute care. I'm fascinated by the range of illness we see; from uncomplicated febrile illnesses and rashes to sepsis and surgical emergencies. Paediatrics is one of the most holistic and multidisciplinary specialities which makes it exceptionally rewarding, and provides a supportive environment to work in. I learn every day and meet some amazing people.

**The most difficult part of my job:** I find it hard to deal with angry, stressed parents, but have to stop and recognise they are often terrified and feel out of control.



**The best part of the job is:** I get to be continually challenged by being presented with illnesses I've not seen before, or critically ill children needing immediate management by various teams. I also

find it rewarding to review more well children, to reassure their parents and educate them about health promotion and prevention. While we can see a lot of sadness, this is rare and the majority of patients we see go from looking dreadful when they arrive to playing on our interactive floor while demolishing a packet of Quavers! When we face tragedy, we face it as a team and make sure we look after each other. Oh, and we can eat jelly at work without being judged.

**My most memorable moment was:** The little things are the most memorable. My favourite letter was from a six-year-old boy finishing his cancer treatment. He wanted to thank me for giving him a high-five whenever we met as it made him feel 'normal'. He had no interest in my medical role, just that I'd been fun and helped his treatment feel more manageable. This is one of the great parts of paediatrics – life is never dull.

**When I'm finished work, I like to:** I'm a Twitter geek and contribute to the social media content of Archives of Disease in Children, alongside sharing my interest in wellbeing and support for all members of NHS staff. 🌟

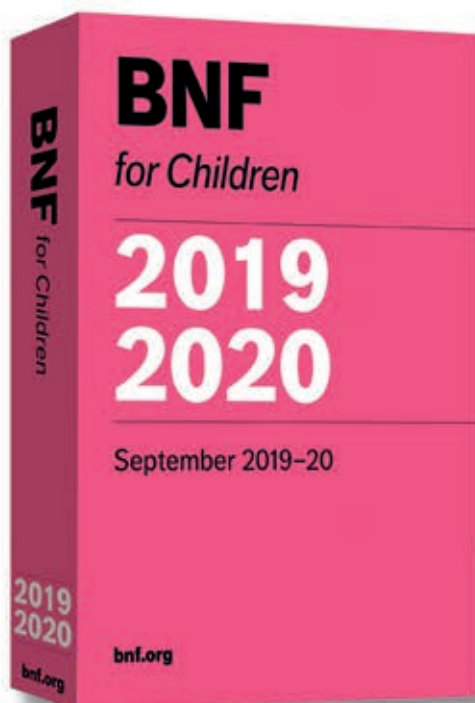
### In my spare time I like to...

**I'm a sports nut so will run, play hockey or five-a-side football, cycle, kayak etc.** I recently got concussed by my other half playing football with a bunch of the medic guys, so am steering clear of that for the time being!



# BNF *for Children* 2019-2020

Guiding health professionals on all  
aspects of paediatric drug therapy



## About the BNF *for Children* (BNFC)

The BNFC provides essential, practical information to all healthcare professionals involved in the prescribing, dispensing, monitoring and administration of medicines to children.

## Significant new content updates to the 2019-2020 edition include:

- **Updated guidance** on diabetic complications, dyslipidaemias, heavy menstrual bleeding, Lyme disease, management of otitis media, oropharyngeal infections, smoking cessation, and prophylaxis of venous thromboembolism.
- **New safety information** about the risk of severe and fatal burns with paraffin-containing and paraffin-free emollients, and the risk of airway obstruction from aspiration of loose objects when using pressurised metered dose inhalers.
- **Significant dose changes** including amoxicillin, azithromycin, ceftriaxone, doxycycline and erythromycin for Lyme disease, dosing schedule of Japanese encephalitis vaccine, *Malarone Paediatric* for prophylaxis of falciparum malaria, and mometasone furoate for prophylaxis and treatment of seasonal allergic or perennial rhinitis.

and more...

ISBN: 978 0 85711 354 2 • September 2019 • 1120pp • 210 x 148mm • £59.95

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**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 less common side effects. **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](mailto:medinfo@flynnpharma.com).

Product	NHS List Price	Pack Size	Marketing Authorisation Number
Slenyto 1mg	£41.20	60 tablets	EU/V/18/1318/001
Slenyto 5mg	£103.00	30 tablets	EU/V/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](mailto:regulatory@neurim.com)

DATE OF REVISION OF PRESCRIBING INFORMATION: March 2019

### Reference:

1. Slenyto® SmPC, March 2019

UK/SLY/0219/0017 Date of Preparation: March 2019

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