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

SPRING 2020

STATE OF CHILD HEALTH
The 2020 update explores the health of UK children
Page 16

INSIDE

Coming of age
Should we extend paediatrics beyond 16?
Page 12

Changing practice
Dr Richard Purvis recounts his 50-year career
Page 14

NHS pensions
Members give their perspectives
Page 21

Happy & healthy
Wellbeing best practice to prevent stress
Page 28
CHILD PROTECTION COMPANION

Your go-to resource on child protection and safeguarding

Covering, child protection processes across the whole range of medical and social interactions

GET IT NOW

www.pcouk.org/companion

RCPCH Publications
www.rcpch.ac.uk/shop-publications
THIS WILL BE AN important year for the College. The launch of the State of Child Health 2020 report looks at more than 20 indicators of health. While there has been some progress, much of the news is concerning and shows how much work there is to do, with the report shaping our public health policy priorities for the next few years.

We’ll use the State of Child Health as an opportunity to engage with key decision makers, not least the new government. The political outlook is more stable than when I introduced the winter edition of Milestones and it seems certain that the new government will serve a full term. We’ve written to ministers calling for action on our manifesto priorities, including urgent investment in public health programmes, the NHS Long Term Plan, and the workforce crisis.

Several other big projects will dominate the College’s workplan for the first part of the year. The 2020 paediatric census is now underway – the results will give us a vital picture of services and staffing across the UK. We’ve also got an exciting agenda for April’s conference, taking place in Liverpool – I look forward to seeing you there.

Best wishes,
Russell Viner
@RCPCHPresident

THIS ISSUE

12 Debate
When do children become adults in the eyes of the NHS?

14 Paediatrics and me
A reflection on a long and varied international career

16 Landmark report
State of Child Health 2020

18 Redthread advice
Youth workers’ guidance on working with young people

19 Development and collaboration
The Children and Young People’s Health Partnership model

20 PIER Network
Best practice in Wessex

21 NHS pensions
Recent survey responses

EVERY ISSUE

4 Update
RCPCH in the news, diary dates social media updates and more

11 RCPCH &Us
The Children and Young People’s Engagement Team

22 Members
News and views from members

27 International
The challenges and rewards of paediatrics in Hong Kong

28 Wellbeing
The benefits of mindfulness; basic ways to prevent burnout

30 A Day in the Life
Paediatric Registrar Dr Rakesh Tailor on his community work
I don’t think you ever get used to seeing a child having an epileptic seizure. Whether it is subtle or dramatic, there is something about a seizure that is always distressing.

What makes it even more difficult is when it is your child, you are not completely sure what it was, why it happened and when and whether it will happen again. It is easy for families and professionals to give vague, incomplete information, to overreact or underreact. However, it is possible, after an appropriate assessment for families, to be given clear, informed, measured information, proportionate safety-netting advice, and also be given clarity about follow-up and where to find good advice in the meantime. The information given can set the tone for the care and pathway that follows.

A group of us, representing several perspectives and experiences, set out to provide an information resource for those assessing children after a first seizure – for example, in an ED or GP setting. We consulted existing materials, undertook an audit examining family’s experience of information after a first seizure, drafted a leaflet, consulted families on its content and then went through a process of consultation and revision. The result is our ‘First seizure, First safety-net’ leaflet for parents and carers. Information covers first epileptic, non-epileptic or uncertain episode where there is no associated fever. It has been endorsed by BACCH, BPNA, RCGP, RCEM, as well as Epilepsy Action and Young Epilepsy. We are now working on a young person-facing version, which we plan to launch later this year.

Download the leaflet at www.rcpch.ac.uk/first-seizure-information

**PATIENT CARE**

**NEW SEIZURE SAFETY NET ADVICE**

**Engagement**

Launch of our Ambassadors Network

**Dr Simon Clark**

VP for Health

**Dr Colin Dunkley**

Consultant Paediatrician Sherwood Forest Hospitals

@drcolindunkley

Integrated Care Systems will facilitate much-needed collaboration

**There is nothing quite like a gathering of the enthusiastic and committed. This is especially true when you are mixing with paediatricians who are an optimistic bunch; working with children makes every day an adventure.**

We are the first of the Royal Colleges to develop a programme of localised engagement. With the policy shift towards integrated working, it is vital that the voices of children and young people are heard. In the push for collaboration providers in England are coming together in Integrated Care Systems. Each system will have a Local Workforce Action Board. Decisions made here will feed into national strategy. Thus, it is crucial that we get paediatricians engaged, otherwise children will continue to fall through the cracks of the health service.

We had a welcome chat from Professor Russell Viner, El Presidente. I followed with some holiday slides from Tonga but did cover the crucial policy elements of the English health service. Dr Nic Jay updated us on the challenges faced by our current workforce. While we have more consultants and more doctors in training, because of the way we are now working, it feels like we have lost staffing numbers.

Dr Lisa Kaufmann educated us on the role of community paediatricians, and why they are ideally placed to help with this more local engagement as much of their work interdigitates with local authorities.

Our Children and Young People’s Engagement team taught us how to canvass the opinion of the youth of today in a meaningful, collaborative manner. Whilst it felt like play, the product at the end was something that could be taken to local, regional and even national policy makers. We also ran an entertaining workshop to practice talking to chief executives, commissioners and others. The message from this was, ask, but have data to back up that ask!

To become an Ambassador, visit www.rcpch.ac.uk/ambassadors

**Download the leaflet at**

www.rcpch.ac.uk/first-seizure-information
“Time to act”

PUBLIC AFFAIRS

WAVES IN WESTMINSTER

YOU DON’T need us to tell you that the previous few years in UK politics have been characterised by uncertainty and instability.

Post-election, the Government has an opportunity to enact a longer-term strategy, and deliver programmes set out in their manifesto and the months before. There have been commitments to address funding, quality of care and workforce pressures. With a majority, the Government now has the bandwidth to make good on its promises.

Over the coming months the College will press Ministers on the urgent delivery of the NHS Long Term Plan, publication of the People Plan in full, and a definitive solution to the pensions issue penalising senior doctors.

While we lost a number of our key parliamentary supporters in the election, State of Child Health 2020 offers us an exciting opportunity and basis upon which to engage and build relationships with newly elected MPs.

A new programme will support children with epilepsy and seizures

PENSION-RELATED TAX BILLS

“I hope the Government will tackle the pension crisis with the same urgency as ‘getting Brexit done’”

NEW PROGRAMME

EQIP pilot success

THE EPILEPSY QUALITY IMPROVEMENT PROGRAMME (EQIP) puts service teams in the driver’s seat of their own local improvement interventions.

Imagine a programme of content that kicks off with a two-day training residential allowing paediatric epilepsy service staff to network and learn tools and techniques while having fun with tennis ball and skittles exercises. Then, as if by magic, each team leaves with an action plan, new sense of drive and team spirit.

We, as a team in Luton, were truly grateful to have the opportunity to participate in the EQIP pilot project. QI is not anything new, but the tools to embed QI within the NHS were new to us. As a team we are eager to improve in areas where we recognise there are difficulties, i.e taking a good seizure history, knowing when it is safe to discharge a child, and how we can ensure that the process is equitable to all children and young people.

I tremendously enjoyed the weekend and left with an understanding about what we can do better for children with epilepsy. We all are responsible for children with seizures and epilepsy and see young people struggling with school, friendships and academics.

We all felt part of a bigger team over the weekend and it was great to network with teams from across the country.

We are in the midst of developing our integrated seizure care pathway and are happy to share our QI initiatives with colleagues. I am hoping that the project will bring us closer to prioritising epilepsy nationally.

> Read more at www.rcpch.ac.uk/eqip

63% COLLEGE MEMBERS BASED IN ENGLAND

3% COLLEGE MEMBERS BASED IN WALES

6% COLLEGE MEMBERS BASED IN SCOTLAND

2% COLLEGE MEMBERS BASED IN NORTHERN IRELAND

TOP 5 UK CITIES WITH MOST COLLEGE MEMBERS

1) LONDON
2) BIRMINGHAM
3) GLASGOW
4) SHEFFIELD
5) MANCHESTER

Dr Vandna Gandhi
Consultant Paediatrician, Luton and Dunstable University Hospital

Milestones SPRING 2020 05
HOW DO I provide excellent perinatal care to the babies and families in my unit? Having spent three days at the British Association of Perinatal Medicine (BAPM) and Evidence-Based Neonatology (EBNEO) conference, I’m inspired, informed and invigorated.

The conference kicked off with a thought-provoking presentation by Professor Harish Kirpalani on sustained inflation, followed by a taster of the 2018 National Neonatal Audit Programme (NNAP) highlighting for the first time huge variation in mortality and morbidity among our national networks. Another internationally respected researcher, Professor Barbara Schmidt, helped us place these figures into perspective with an eloquent lecture on the use of the ‘number needed to treat’ and the importance of remembering the baseline risk of each disease within individual populations.

Innovation was celebrated in sessions describing pioneering work in artificial gestation, human genome mapping and understanding the infant microbiome. Established practices were challenged on transfusion of platelets in neonates, and in the Founder’s lecture surprising data was uncovered within ‘normal’ neonatal blood sugars. A clarion call to extend duty of candour to the world of academia was delivered by Professor Martin Elliott. The long-lasting implications of prematurity upon both infant and family were also explored, and echoed by a free paper on the TIGAR project monitoring impact of gestational age on childhood hospitalisations.

Workshops throughout the three days helped us develop our research and critical appraisal skills. Simply reading the papers isn’t enough, we all need to appraise, criticise, disseminate and discuss in national and international sessions facilitated by modern connectivity and social media. It seemed as if every attendee was tweeting on each session!

I can’t wait until next June when BAPM will join forces with the Neonatal Society and British Maternal and Fetal Medicine Society in London at Perinatal 2020. I’ll be booking my place ASAP!

For more information, visit www.bapm.org
I’ve been at the College for two years, and last year I stepped up into the Workforce team lead role. Our aim is to ensure that every unwell child is seen by the right person, in the right place at the right time.

I previously worked at Public Health England researching how EU nations could collaborate to stockpile vaccines in case of an epidemic. I handed in my report to the European Commission just a week before the referendum! Prior to that I completed my PhD in experimental psychology.

Workforce is the defining issue for the College, the NHS and politicians. My team collects data that feed into a wide array of work. For example, we are currently conducting modelling to look at the impact of Shape of Training on the trainee pathway. As well as that, we inform State of Child Health, Paediatrics 2040, the #ChoosePaediatrics campaign and the recent pensions issue.

There is no quick fix to the crisis we’re currently facing, so we need to be creative. Luckily, paediatrics has always been at the forefront of multidisciplinary working, forward thinking and collaboration. People are the foundation of paediatrics, it’s really just about making things better for healthcare professionals.

In my own time, I love to read (preferably feminist) sci-fi. I find cooking meditative and I consider Salt Fat Acid Heat (by Samin Nosrat) my bible.

See the College’s latest resources on workforce and service design [www.rcpch.ac.uk/workforce](http://www.rcpch.ac.uk/workforce)

---

**CATCH-uS AS WE FALL: TRANSITION FOR YOUNG PEOPLE WITH ADHD**

**RESEARCH**

IDEAL TRANSITIONAL care from services aimed at children to those aimed at adults should be a planned process that supports the medical, psychological and educational or vocational needs of the young person.

Young people who have ADHD experience huge difficulties in controlling impulses and emotions, focusing attention and organising themselves. Some will find medication helps, while others would like psychological support to help them cope better. About two thirds will still experience difficulties related to ADHD in adulthood.

Working with the British Paediatric Surveillance Unit (BPSU) and the Child and Adolescent Psychiatry Surveillance Service, I led a team that studied transition in young people with ADHD called CATCH-uS.

We measured how many young people with ADHD, who needed and wanted to continue their medication but were within six months of the age at which the reporting consultant’s service would have to stop seeing them. This work suggests that two thirds were accepted by adult mental health services, but only one fifth attended their first appointment and 6% experienced optimal transition.

We then interviewed young people before and after transition, as well as parents, carers and practitioners working in child or adult services. This work suggests that while transition was supported by a good handover, there were gaps in care as many patients thought ADHD medication was only needed for school, and GPs were left to fill gaps in care. Many services are focussed around medication so stopping medication often means losing health service support.

The final strand of work was to produce a map of ADHD services for adults.

[For more information about the study see medicine.exeter.ac.uk/catchus](http://medicine.exeter.ac.uk/catchus)
RCPCH in the news

CLIMATE

AIR POLLUTION
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.

NEONATAL CARE

NATIONAL NEONATAL AUDIT PROGRAMME
Our neonatal audit report revealed a stark regional variation in mortality rates for sick newborns. The report found almost 70% of nursing shifts did not have enough qualified nurses, while more than a third of shifts lacked enough general nurses to meet NHS England’s guidelines.

NEOBIRTH

WHO REPORT
We were widely quoted for our response to a World Health Organisation report that warned of a ‘global epidemic of childhood obesity’. We said children who are more active have better health and wellbeing and generally do better in school. Our response was covered by the BBC and in The Guardian, The Telegraph, and The Daily Mail.

ADC JOURNAL UPDATE

THE RANGE of article types available makes it hard to know where to start, but, in the spirit of sparking discussion and change, I recommend you look out for the following:

- **Podcasts:** Traditional broths and antimalarial properties; racial disparities in preterm birth; parents’ views on brain tumour follow-up MRIs.
- **Articles:** ‘Votes for a better future’ – Neena Modi; ‘Complexities and challenges...’ for us all as paediatricians – Hilary Cass.
- **Original research and policy:** Medical devices: loopholes in EU law and over the counter pharmacy; Should family members be present at resuscitation?; Vitamin K deficiency bleeding in Australia.
- **Global:** Intimate partner violence and child health in Cambodia; TB in China; Anthropometry in low birth weight detection in Ethiopia.

In 2019 there were 200 online articles about the State of Child Health

ALONGSIDE ORIGINAL research articles, we are now publishing research letters, with abstracts of 100 words, they are useful for PubMed, and allow researchers and readers to scan the contents. Child health in Scotland and the contrasting approaches of the British and Scottish Governments are highlighted in an editorial by Professor Steve Turner and Dr Samir Ahmed. The Scottish Government appears to take a more holistic view of child health and wellbeing eg banning smacking and promoting healthy behaviours. BMJ Paediatrics Open continues to make progress and is now recognised as a welcome addition to the list of paediatric journals with its inclusion in PubMed Central, Scopus and Embase as well as Google Scholar.
I recently had a really tough experience with a preterm baby that for a little while made me consider what I was doing with my future. Today, the mum sought me out and thanked me for my role at that time. I honestly nearly cried. Occasional reminders of why we do the job are.

@ccdaniels65

The Patients’ Choice award gives patients the opportunity to nominate the individual they think is exceptional. This year’s winner is Dr Dennis Grigoratos in paediatrics

#KingsStars
@KingsCollegeNHS

Why do I love my job? I asked a seven-year-old which sticker he wanted. He picked one and gave it to his sister. I let him pick another for being so kind and he gave it to me!

#neverwanttogrowup
@lucnahabedian

pediatrician: I need help ortho: of course peds: I have a super-cute little girl with a forearm fracture ortho: I need a better description peds: she’s got pigtails and a wonder woman cape ortho: peds: I mean can you stand it?!

@DocAroundThClok

As well as a paediatric intensivist, I’m also fortunate enough to be an NHS Clinical Entrepreneurship Fellow. Sure, it’s hard to pronounce (and to spell!) but what actually is it?

The programme was developed to make it easier for clinicians to grow their ideas into businesses without having to sacrifice their clinical careers. It is open to all kinds of health professionals with all kinds of different innovative ideas, ranging from artificial intelligence apps to physical devices and podcasts.

All you need to get in is the drive to innovate and a few ideas as to how you might want to do that. Each year there is an application process in which you pitch your idea (and, more importantly, yourself!) to the team in the form of an online application and an interview. I pitched a few tech solutions I’d knocked together, smiled enthusiastically, and it seemed to do the trick!

Once you’re in you get the prestigious title of NHS Clinical Entrepreneurship Fellow, which you can stick on your Bumble profiles (disclaimer: this doesn’t help) but the real value is in the support and teaching you receive. The cornerstone of the programme is the ‘pit-stops’ – regular get-togethers where you mingle with likeminded healthcare workers, investors, NHS stakeholders, government officials and well, you name it… At these events there is also dedicated teaching on ‘businessy’ topics as well as insightful talks from previous fellows. Plus, there are opportunities to meet the health secretary, tour massive companies or travel the world.

As for me, it’s allowed me to form a medical analytics start-up, which is helping to join together and integrate health and social care data across whole geographical areas (yup, that stuff is actually coming – watch this space!). If innovation is your kind of thing, I can’t recommend it more.

For more information, visit www.england.nhs.uk/clinical-entrepreneur
Diary Dates
Courses and events taking place in the coming months to aid professional development

COURSES

09 MARCH
Effective Educational Supervision
London

13 MARCH
DCH Clinical exam preparation course
London

26 MARCH
Disability Matters Relaunch Event
London

3 APRIL
Effective Educational Supervision
London

22 APRIL
Statement and Report Writing (Safeguarding Level 3)
Edinburgh

21 MAY
Effective Educational Supervision
Birmingham

04 MAY
How to Manage: Gastroenterology
London

22 MAY
Effective Educational Supervision Plus: Supervised Learning Events
Birmingham

05 MAY
MRCPCH Clinical Exam preparation course (two days)
London

15 MAY
Progressing Paediatrics: Childhood epilepsies
London

09 JUNE
How to Manage: Recognising neuromuscular disorders
London

11 JUNE
Mentoring Skills
Stirling

WEBINARS

● RECORDED WEBINAR
Transitional care for young adults with ADHD
Presenting results of the first in-depth study of the transition of UK ADHD patients from child to adult.

● RECORDED WEBINAR
Mentoring peer support
Set up and deliver a mentoring programme for paediatricians.

● RECORDED WEBINAR
Returning to paediatric training series
Essentials to ensure a successful return to work following a break from clinical practice.

● RECORDED WEBINAR
Facing the Future: Paediatric Standards
Introducing a suite of service standards and highlighting best practice examples.

Meeting room and venue hire
Meeting facilities in the heart of London
Based at the home of the Royal College of Paediatrics and Child Health, in the heart of London, our range of versatile meeting rooms offer access to facilities including integrated audio-visual technology and an array of catering options.

How can we help you?
We can be flexible to your needs and would be pleased to discuss your requirements. To get in touch with our venues team call us on 020 7092 6027 or email room.bookings@rcpch.ac.uk.

Royal College of Paediatrics and Child Health
5-11 Theobalds Road, London WC1X 8SH
www.rcpch.ac.uk/venue-hire

Redthread
“We use the ‘teachable moment’ in the aftermath of a health crisis to help improve their lives”

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

Free and accessible educational updates
@www.rcpch.ac.uk/webinars

In a typical classroom of 30, 9 children are living in poverty
We’re different but that’s OK!

Following a national survey, the ICYP Engagement Committee got a group of young people together to talk about... rights

THE UNITED NATIONS Convention on the Rights of the Child (UNCRC) article 12 is about respecting the views of the child in decision making. In autumn 2019, 1,791 children and young people from across the UK took part in a survey to voice their thoughts on what makes the best health service. Of these, 77% identified three priorities for helping them to keep ‘healthy, happy and well’. Think about how you can use their views to influence your decision making.

1. We need help to be healthy, happy and well. Tell us about things like sleep, diet, exercise and where to get help and advice.
2. Increase our awareness of health conditions. Tell us about diabetes, epilepsy, asthma and other conditions so we can help our friends and siblings.
3. Create youth-friendly and youth-aware services. Think about different groups of children and young people and what they might need when they see you.

Following the survey, 17 young people, plus carers, and parents met for the Infants Children & Young People (ICYP) Engagement Committee. We talked about why voice and rights matter and looked at what the RCPCH &Us members had said. They used their article 12 right to help us understand what help they need when it comes to health. You can use their responses to inform your services.

- Brought to you by Phoebe, Nicola, Michael, Lynn, Carmen, Ali, McKenzie, Adam, Demi, Camilla, Laura, Tiffany, Viv, Ishaan, Rosie and Mac
- Read more at our page www.rcpch.ac.uk/rightsmatter

499 said we need help to stay healthy, happy and well

407 said we need youth-friendly and youth-aware services

464 said we need help to find out more about conditions our friends and siblings might have

Young people said...
- Being you is your superpower
- We’re not defined by our conditions
- Believe in yourself
- I have a life outside the consultation room
- Coz I’m different, don’t judge me
- I will continue to fight
- Still normal and still me
- See me not my illness

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.

Keep in touch: @RCPCH_and_Us 📩 rcpch_and_us f@RCPCHandUs 📧 and_us@rcpch.ac.uk

1,791 children and young people were consulted for the State of Child Health 2020 report
THE HEART MAY say “Yes, the upper age of paediatrics should be higher than 16 years”. Fine, but how high should the age ceiling be? Are we talking about 18 years old? Or 25? Here are four reasons why my head says, “We cannot safely change from 16 years old in the near future”.

Firstly, we do not currently have the staff to provide care for individuals aged 16 years old and over. You may have noticed that our workforce struggles to provide emergency and scheduled care for the population aged under 16 years. Most centres fail to meet the College’s Facing the Future standards. How can we accommodate more patients? There is a perception that there would only be a small increase in workload by increasing the age limit of paediatrics by a few years. This is wrong. Young people have a considerable healthcare demand. For example, there are more hospital admissions for 10–19 year olds than 1–9 year olds. Any increase in age limit must consider the required expansion in the multidisciplinary workforce required to provide high-class healthcare. It takes at least three years to train a nurse and seven years to train a consultant (on average more than 10 years).

A further consideration is, would our colleagues in adult specialties who currently care for the over 15 year olds be happy to lose staff in light of their falling workload?

Secondly, our current workforce is not trained in providing care for many conditions in individuals aged over 16 years old. One obvious example of a novel clinical context is providing ‘medical’ care during pregnancy. Would we take over management of a sexually transmitted disease? Even a simple condition such as asthma can be different in an 18 year old compared to a 14 year old, since different aetiologies, eg occupational exposures, become important. There is a long list of adult chronic conditions, which paediatricians sometimes glimpse in 14 and 15 year olds before handing on to adult physicians. Our wonderful colleagues in adult medical, surgical and obstetric specialties provide a perfectly efficient service for individuals aged over 15 years. Why do we think we can do better?

Thirdly, we currently do not have the accommodation to provide scheduled and unscheduled care for patients over 15 years. Our ward and outpatient spaces are already often full to capacity. We often have boys and girls in small four-bedded wards, but this would not be acceptable in the context of over 16 year olds. We are still a long way from providing a teenage-friendly environment in our hospitals. Can we do it better with more teenagers to care for? Have I mentioned the small question of office accommodation for the additional front line and support staff required to look after an expanded paediatric population?

Finally, and most importantly, has anyone asked children and young people what they want? My experience is that 15 year olds feel very uncomfortable in the paediatric inpatient setting. A move to expanding the upper age limit to 18, 21 or 25 years (or even beyond) has some attractions but would require a whole system rethink. Any change must be patient centred, and ideally be community-facing. I embrace change, but there are some inconvenient practical obstacles to increasing the upper age limit. Let’s get it better in the 0–15 year olds first.
WHAT IS MAGICAL about the age of 16? Does something happen the day a 15 year old turns 16 that logically supports a paediatric referral being redverted to adult medicine? There are areas in the UK where 16 and 17 year olds fall outside paediatric criteria but not yet into adult criteria hence they fall into a gap and do not receive specialist healthcare.

Changes occur during adolescence and young adulthood (AYA) that vary in timing and duration between individuals and are poorly related to age. At 16, these changes are all ongoing! The pre-frontal cortex so integral to complex thought and planning, will not mature until the mid-twenties. It is not just about their brains. Their different social environments with multiple transitions (social, vocational and health) influence the decisions, risks and opportunities young people actually take.

The law is of no help. It is not static and varies over time and across geographical and political boundaries. Just take the laws on purchasing alcohol, medical use of cannabis, sale of tobacco, the right to vote and the age of consent. The law will be guided by society. Having a strict cut-off at 16 in healthcare makes no sense!

Medical advances have meant a lot for young people with childhood onset disease, having increased survival and therefore need transfer to adult services. What better way for adult services to become familiar with such conditions than to collaborate with their paediatric colleagues. Similarly, young people develop adult conditions, eg mental health disorders and cancer, and again will benefit from such shared expertise.

We wholly agree with the lifecourse approach being called for in the NHS Long Term Plan, which acknowledges the different life stages. We have to acknowledge that there are many more young people aged 10 to 24 years old (now 18% of the population) than the limited traditional paediatric 10–15 years old age group.

Investing in the health of young people has a triple dividend of better health for them, better adult health, and better health of their children – the young people of tomorrow. How can we let such an investment opportunity be passed by?

You could argue that the focus on transitional care in recent years explains the limited progress in universal implementation of developmentally appropriate healthcare (DAH) provision. DAH by definition is focussed on young people’s development. It is in the less-studied third phase of health transition, which takes place in adult settings after transfer, when at least half of health management skills are acquired.

Let’s look at research. It has identified that the older the young person when transfer takes place, the better the health outcomes. Not just that, a later transfer is developmentally appropriate but needs to be coordinated with the other life transitions during this life-stage eg vocational.

Training gaps continue in both paediatrics and adult medicine, and this will have an effect on delivery. We need to gain momentum and invest in expertise that already exists. We propose truly meaningful support is extended at organisational and national levels to paediatricians and adult physicians with an interest in adolescent medicine. This could lead to an adolescent and young adult workforce similar to that being recognised in Australia. While we are at it, the College could lead the way and undergo transition itself by rebranding as the Royal College of Paediatrics and Young People’s Health!

> Find more about resources for transitioning to adult services www.rcpch.ac.uk/transition-adult
had no option but to follow a career in paediatrics after my baptism into children’s medicine in the tropics when I was a student at University College Hospital Ibadan in Nigeria in 1963. The hundreds of children brought there daily revealed such a wide range of conditions, most of which were treatable and eventually preventable, however advanced they seemed when we first saw them. Time spent with these children and their families was exciting and never dull. It also compared favourably with my previous experience of sick children separated from their parents in huge dreary Nightingale wards during a harsh Scottish winter.

My clear intention was to return to Nigeria, after taking the DCH (London) and MRCP (Edinburgh) in 1967. However, this was thwarted by the outbreak of the civil war in Biafra (where starvation was employed as a deliberate tactic of warfare – remember the young children shown around the world with a ‘Biafra belly’?). I soon discovered another adventure in paediatrics when I became the first paediatrician appointed by the International Grenfell Association to organise the services for the children in Northern Newfoundland and Labrador, including the Innuit (Eskimo) and Innu (North American Indian) children in their established communities there. This meant my flying in single-engine planes to the outports where the children lived close to our nursing stations, over vast distances, and always at the mercy of the weather. Making diagnoses and suggesting treatments to our nurses over a crackling radio telephone system provided unique challenges too, especially as these conversations containing such personal intimate details were avidly listened to by many households up and down the Labrador!

Changing challenges
Throughout my career, I’ve seen a lot of changes in paediatrics. A young doctor starting out in a paediatrics career in the 1960s could expect to spend many long hours doing exchange transfusions in the newborn nursery. Each of these procedures for the treatment of rhesus haemolytic disease, was carried out by cannulating the umbilical vein and required hours of concentration by the nurse and doctor team using a “10ml out… 10ml in… slowly…” approach, which could take several hours to complete and was often scheduled into the “wee sma’ oors”. For many of us it showed how
real teamwork could determine the successful outcome of such a major procedure – a lesson learned repeatedly in the years to follow.

Another theme was the active surgical management of spina bifida, which followed the introduction of the Spitz-Holter valve to control the hydrocephalus associated with the Arnold-Chiari malformation. For the doctors this resulted in a whole industry of treating the complications of blocked and infected valves. We often had to resort to daily ventricular taps before the invention of the Rickham reservoir gave us access to the CSF circulation.

All of this had to be carried out against a media background, which cast doubt on our endeavors and concentrated on wild speculation about the causes of spina bifida. The wildest theory reckoned that since this congenital malformation was more frequent in the west side of Scotland and Ireland, that it surely must be due to the mothers eating potatoes affected by blight!

**Managing the media**

In subsequent decades we have become accustomed to this scenario of working to assimilate vital developments in our practice that have grabbed the attention of the media who interpreted them in their own inimitable way. While understandable, this can lead on to the ‘blame game’ where colleagues have been targeted unfairly from time to time.

Examples of these have been the responses to the Thalidomide tragedy (1960), Kempe’s ‘Battered child syndrome’ (1962), and Caffey’s ‘Whiplash shaken infant syndrome’ (1973). On the other hand, it wasn’t easy to unequivocally support our peers when they were involved in scandals such as the Cleveland child sexual abuse scenario (1981) or when it became known that HIV was being transmitted to patients with haemophilia when treated with Factor 8 (1984), or the revelations about excess deaths in neonatal cardiac surgery in Bristol in 1992.

However, there was a much more solid response from our peers to the paper published in *The Lancet* in 1998, which attempted to link the MMR vaccine to the development of autism. Paradoxically, the increased attention it brought to paediatricians and the public alike provided a strong stimulus to our profession to recognise and understand autism spectrum disorders as commonly hindering a child or young person’s healthy progress in life.

Working in paediatrics has never lacked excitement: whether dealing with children individually, or making adaptations to our practices, adopting the many clinical advances that have taken place in the past 50 years – such as ventilating premature newborns, huge advances in laboratory services and the introduction of new scanning techniques. For me the most fascinating development in the last 20 years has been my involvement in delineating the nature and prevalence of children on the autism spectrum, and their integration into normal society.

Richard has published a comprehensive account of his journey through *paediatrics: A History of Dorchester Paediatrics* is available now on eBay.

**Career Highlights**

1. **1960s Nigeria**

Richard found working as a student doctor in Ibadan exciting. Although the volume of patients was large, the conditions were mostly treatable.

2. **Indigenous children**

Richard’s role as the first paediatrician for Inuit and Innu communities in Canada saw him flying in single-engine planes (above) and consulting over crackling radio phone systems.

3. **Service developments**

In West Dorset Richard led the development of a comprehensive, self-managed, child health directorate involving all the professionals who worked with children in the NHS Trust.

4. **Autism research**

The publication of a paper attempting to link autism with the MMR vaccine brought paediatricians’ attention to autism. Richard’s most fascinating work has been helping to make children with autism’s integration into society easier.
E ARE PUBLISHING an updated edition of our ground-breaking State of Child Health report, three years on from its original publication in 2017. The report provides a snapshot of infant, children and young people’s health in 2020, pulling together available data across the UK.

It covers physical and mental health, alongside wider determinants of health, such as the relationship between poverty, housing, education and child health. The 2020 edition includes new areas – looked-after children, mental health, youth violence, young carers and the CYP workforce – to reflect the changing trends, priorities and evolving challenges faced by paediatricians.

Overall, the report demonstrates considerable progress made in child health over the past 30 years. Although, worryingly, positive trends have stalled in many key areas since 2017 and, in some areas, things are getting worse for children and young people. We are particularly concerned by negative trends in infant mortality (which has risen for the first time in England since 1999) and immunisations (the UK lost our WHO ‘measles free’ status in 2019). Additionally, we know that mental health concerns are seen repeatedly in practice by paediatricians and the data confirms...
“Children from deprived backgrounds are more likely to have worse health outcomes than wealthier counterparts”

that prevalence is rising; young men are three times as likely to commit suicide than women. We hope that shining a light on these areas will prove a focus for decision-makers to help drive improvements in outcomes for CYP.

It’s not all bad news, as the report celebrates positive trends for long-term conditions, as A&E attendance for CYP with diabetes and epilepsy is decreasing year on year, suggesting that there is improved self-management and care in the community. We hope these positive trends will continue through delivery and recommendations from both the National Paediatric Diabetes Audit (NPDA) and Epilepsy12 audit programmes.

The changing context
Importantly, the report highlights the impact of poverty on child health – across the board, children from deprived backgrounds are more likely to have worse health outcomes than their wealthier counterparts. It is projected that by 2022, 5.2 million children will be living in relative poverty, marking a record high for child poverty rates in the UK.

Since 2017, the political landscape across the UK has changed considerably, which has impacted upon the way care for CYP can be delivered by paediatricians and the wider child health workforce. It is important for State of Child Health to recognise and respond to these changes. Within England, the NHS Long Term Plan provides a clear vision for future care, recognising a shift towards integrated and community care. Services are increasingly provided outside of the NHS, within Local Authority remit, which has been impacted by funding cuts. In Scotland and Wales, there has been increased devolved power over health matters, while the Executive in Northern Ireland has only recently resumed following a three-year suspension. And of course, there is the unknown impact of our departure from the European Union. Workforce continues to be a challenge across the UK and, by bringing this indicator into State of Child Health, we hope to demonstrate that wholesale improvements in child health cannot be improved without resourcing the workforce and empowering them to provide health promotion advice.

ACTION POINTS

WHAT CAN YOU DO?

WHILE THE REPORT will retain the focus on influencing national policy as successfully as before, we really want this report to be just as relevant to practising paediatricians just like us. For each indicator, there will be practical advice, guidance and resources that individuals or teams can take. We want to

1 Making every contact count
Children and young people may see an encounter with a trusted health professional as an opportunity to discuss issues beyond their immediate, physical complaint. Professionals should actively explore other issues with which the child, young person or family may be struggling (whether relating to other physical or mental health problems, or with their social and family circumstances).

2 Signpost disadvantaged children, young people and their families to sources of support
Our focus may be on health, but we know the health of children and young people is affected by factors beyond healthcare alone. Make it your responsibility to know what local services exist for your disadvantaged children and young people, and direct them to access the support that they are entitled to.

3 Advocate for local children, young people and their families
Use available data (including the State of Child Health report) to articulate the needs of your local population, and make sure you give them a voice by advocating for their wellbeing to local decision makers and commissioners / service planners.

4 Take an active role in supporting child health research and data collection
Without high quality data, it is impossible to know how healthy your local population is nor persuasively argue for resources for children and young people in your area. Professionals should remember that taking a full and active role in research and improving local data is a vital part of their work. The more clinicians use data, the better the data quality becomes too.

5 Make child health a joyful place to work
There are simply not enough doctors, nurses or other professionals in the child health workforce to deliver high quality, equitable healthcare for all children and young people in the UK. When we are all under increasing pressure to deliver more with less, it is easy to forget that each of us has a critical role to play in recruiting and retaining much-needed colleagues to work in child health services – by creating an atmosphere in our workplace, every day, that celebrates the joy of working in child health.

For more information on the State of Child Health 2020 visit www.rcpch.ac.uk/state-of-child-health
FEATURE

YOUTH WORK

Redthread

Working with young people: practical advice from health-based youth workers

"We use the ‘teachable moment’ in the immediate aftermath of a health crisis to help improve their lives”

John Poyton
CEO of Youth Work Charity Redthread
@Redthread_youth

We all know adolescence is a vulnerable transition, but tailored approaches for this cohort are still an emerging field.

At Redthread, we specialise in working with this group. Our youth workers support people aged 11 to 25, alongside clinicians in emergency departments, on the wards and in GP surgeries. The majority of those we work with have experienced violence or exploitation, and we use the ‘teachable moment’ in the immediate aftermath of a health crisis to help improve their lives. Every day our staff see what social intervention of the most vulnerable young patients in hospitals need to recover.

Stay trauma-informed

For clinicians, the word trauma probably brings to mind a severe injury. But at Redthread, although we’re often there during or immediately after this work, the trauma we’re primarily concerned with has deeper roots and longer lasting impact. Although the incident that brought them to hospital may well have been traumatic, we often see young people who’ve experienced multiple and cumulative emotional trauma throughout their childhood. Remember that if a young person comes in as a result of violence, medical interventions may feel like a continuation of the trauma they’ve just experienced.

Explaining everything that’s happening is even more important than usual. Behaviour is communication – what are they telling you?

Consider adverse childhood experiences (ACEs)

Being informed about trauma isn’t just about considering the incident that brought a patient to hospital, and unfortunately lots of the young people we all see have experienced numerous traumas or ACEs throughout their young lives. Recognised ACEs include having a parent in prison, witnessing domestic abuse or being the victim of abuse or neglect. These experiences have a significant impact on their ability to think, interact with others and on learning.

Be careful not to label

When dealing with youth violence, victim and perpetrator aren’t phrases that are easily applicable or helpful – the beauty of working within a healthcare setting is that we get to meet people as they present and without judgement. Remember that exploitation is often at play and those who are committing violence are likely to have been victims of it themselves at another time.

Remember looks can be deceiving

Just because a young person is behaving in an adult way, needs an adult dosage and looks like an adult, doesn’t mean they are. We see patients as young as 14 ‘aged up’ and treated like adults, when after a short conversation it becomes very apparent that they’re actually a very scared child.

Accepted research around brain development now recognises full brain maturity doesn’t happen until around the age of 25, far beyond the 16-18 transition to adult services. We simply can’t make assumptions about a young person’s abilities.

Be curious, always

One thing every young person deserves from professionals they come into contact with is curiosity. We owe it to adolescents to be curious about the causes of their injuries, the reality of their lives and about what they might need support with. Though we may be trained to deal only with the presenting complaint and not open up Pandora’s box, we need to ‘make every contact count’ and ensure we explore the wider needs of young people during this vulnerable period.

Find out more about the work Redthread do at www.redthread.org.uk

Young people are vulnerable and deserve our curiosity
BEST PRACTICE

Health for the whole child: practising paediatrics

Development is key to improving the UK’s child health outcomes

Any of the most worrying child health outcomes are related to poverty, and the social, political, environmental, and commercial determinants of health. Every day we see the effect of poverty in the children we provide care for. What can we do as paediatricians to provide care for the whole child?

In South London, based at Evelina London Children’s Hospital, Children and Young People’s Health Partnership (CYPHP) is testing new ways of delivering better care for the whole child. Our health system strengthening programme has developed a new model of care with several important attributes: early intervention, biopsychosocial care, and health promotion with supported self-management. We have built a Population Health Management system that enables case finding to detect early intervention and improves equity of access to care for children with long term conditions. We’ve found that 60% of children with asthma in the community have poorly controlled symptoms that are above the threshold for needing care, so picking them up early is especially important. And around a third also have high levels of mental health needs. Self-referral through a patient portal also helps improve access and empower parents.

A biopsychosocial pre-assessment, completed online through the portal, enables us to deliver tailored care for body, mind, and social context.

Joined-up care
A multidisciplinary team provides joined-up care around the child. Our teams include GPs, children’s nurses, general paediatricians, and mental health workers linked to the emerging primary care networks, and working closely with local authorities. Each local area has a linked paediatrician working closely with GPs delivering care together, forming close supportive working relationships, and holding lunch-and-learn sessions together.

Early results show encouraging impact: improved health outcomes, better quality of care, and reduced emergency department contacts and admissions that save enough for the service to pay for itself and deliver moderate savings too. We’re achieving these results by looking after the whole child, and not just their disease. Our approach is reaching children most in need, helping to reduce inequalities in care.

What have we learned?
Child health can be improved by strengthening health systems. Our clinical-academic partnership effectively combines NHS system transformation and quality improvement with research to build the evidence base for children’s health. A population approach to biopsychosocial care can improve early intervention and care for children, and thereby improve health and equity.

Dr Ingrid Wolfe
Consultant Paediatric Population Medicine, Evelina London Children’s Hospital
@ingridjohanna66

Many children with long term conditions have poorly managed symptoms, often accompanied by anxiety and other problems. We need to look at the whole child and family

Can the CYPHP approach be replicated?
One of the most important reasons we’re evaluating so carefully and thoroughly is to ensure we can reliably share learning. We will soon be making available our Evelina London CYPHP manual for health system strengthening, telling you all about implementing and delivering a population health and health systems approach to improving services for children. We hope that others will benefit from the evidence we’ve generated, and adopt a population-approach to improving healthcare for children. And in the meantime, we’re always happy to share ongoing learning, so do get in touch.

Find out more about CYPHP’s work and those involved in the partnership at www.cyphp.org

“Many children with long term conditions have poorly managed symptoms, often accompanied by anxiety and other problems. We need to look at the whole child and family”
PIER Network
Multidisciplinary health professionals working to improve the care of children and young people

Who wouldn't want to be part of a vibrant network of child health professionals working collaboratively to improve outcomes for children and young people? The Paediatric Innovation Education & Research (PIER) network in Wessex aims to do just that.

The initial spark was the use of a quality improvement approach to improve outcomes for children and young people in the region suffering severe trauma. This utilised multi-professional team-based education and standardisation of approaches, which resulted in impressive outcomes. Following this, there was a desire to bring educational opportunities together to maximise improvements and support sustainability. The idea of PIER was born!

It was proposed that if child health departments around the region shared skills, knowledge and experience in innovation, education and research, this would lead to a reduction in variation and avoid duplication of work contributing to improved health outcomes for children and young people. Trainees were enthusiastic and had plenty of energy! Their initial request was for standardisation of guidelines. Trainees were frustrated with being asked to create guidelines – devoting significant time and energy, taking almost the whole length of a training post (if they were lucky?) for the guideline to be agreed and go through governance – only for them to move to the next training post in a different hospital and be asked to start all over again. Surely there was a more joined-up approach?

A lead clinician, nurse or allied health professional from each trust across the region came together for an initial meeting. They were asked what they wanted from the network. This refreshing approach was gladly received, as most had assumed they were going to be told what to do. Since this initial meeting in 2014 the network has flourished. PIER’s ethos is that everyone involved in child health should be empowered to realise the value of their contribution to healthcare teams. We challenge traditional ways of training and promote a culture of continuous improvement. We work with specialty networks, the clinical research network and the Wessex and Thames Valley operational delivery networks in paediatric critical care, cardiac, neurosciences and neonatal care.

Connecting teams
The PIER conference has become a highly successful annual two-day event that brings together professionals to learn and build communities. It is truly multi-professional and innovative in its delivery, with tickets kept at low prices to enable the whole team to attend.

PIER is essentially multi-professional in everything it does, transcending boundaries between healthcare professions, hospitals and specialties. Involving everyone in all key activities ensures they feel valued and committed to the projects. We believe that through inspiring and supporting staff to contribute and develop their ideas into practice PIER has helped to see Wessex rated as the best place to train in England! 🇬🇧

Visit www.piernetwork.org

PIER Network outcomes
- Multi-professional educational programmes across paediatric specialties.
- The development of over 67 regionally agreed guidelines and tools.
- The UK’s first regionally delivered neonatal and child health nurse preceptorship programmes.
- Wessex ranked second-highest nationally for recruitment to research studies in 2018-19.
- A Child Health Information & Leaflet Directory facilitating easy access to up-to-date resources for clinicians, patients and families.

Dr Kate Pryde
- PIER Innovation Lead, Consultant Paediatrician, Southampton Children’s Hospital
- @pier_network

The PIER team: Dr James Edelman (Education) Dr Kate Pryde (Innovation) Dr Katrina Cathie (Research)
LIKE MANY OF us, I had never worried too much about my NHS pension. I believed the pension scheme was reasonable, I was contributing and that was it. However, the last few months have seen the rise of an unexpected pension crisis. Consultants across the country have been struck with staggeringly large tax bills following changes to pension rules.

More senior colleagues are considering early retirement and the College's pension survey reflects this trend across the UK.

Here is a summary of what I learnt: We have a £40,000 per year tax-free allowance for our pension. This is averaged over three years. We also have a lifetime allowance of around £1 million. If your total annual income crosses £110,000, the annual limit is tapered until only £10,000 is left. In addition to your monthly contribution plus the NHS contribution, an additional amount is added to your pension pot based on growth from previous years. Currently, there are limited options to predict this growth and adjust your contributions based on it. You might not be automatically informed if you cross the annual allowance.

In England and Wales the Government has proposed a temporary solution for the 2019/20 tax year. You can ask NHS pensions to pay the bill with the 'scheme pays' option. The promise is that this will be repaid when you retire by the NHS so that you are not out of pocket. I am no expert though. It is best to take financial advice for your individual circumstances as the whole thing is incredibly complicated.

The NHS faces many challenges. The pension crisis has hit morale. A clear manageable system is the first step to a solution. The NHS was a big election issue and I hope the Government will tackle the pension crisis with the same urgency as ‘getting Brexit done’.

I’VE RECENTLY RETIRED, what a relief! I’ve pretty much escaped the issues around pension tax and annual accruals.

Actually, not strictly true, as I’ve returned to work, and am still anxious I may have got my sums wrong and be in for a shock! As someone who worked eight sessions for many years, I thought I would be safe, but after seeing an accountant I find I will have some additional tax to pay for exceeding the lifetime allowance. It’s not easy to understand the finances, especially when you get inaccurate information from the pension agency. I had a letter saying my tax accrual was three times my salary for one year. This was wrong, but it took several phone calls before I got someone to admit it. The responsibility lies with you to get your tax correct.

I’ve just completed job planning for my department; no one wants to do extra work. That includes the additional clinics needed and key lead roles. In fact, three consultants want to make drastic reductions in their job plans due to tax pressures. Although this potentially releases money, it doesn’t fund a full post and getting extra funding from one’s trust is a challenge. Plus, if funding is agreed it may take over a year, and then one needs to find someone to fill the post. Pensions changes have come along at the same time of increasing demand and public expectation and pressures on the consultant workforce are immense, making retirement or working part-time the only sane options to staying healthy and having life outside of work.

The solution is to reverse the tax changes before too many experienced doctors are lost. If we don’t, the staffing crisis we already face will widen further and we will see departments becoming unsafe and unattractive to recruit to.

Read about the key findings from the College’s survey www.rcpch.ac.uk/nhs-pensions
Guidance

Tips for MRCPCH Theory Exams

Seeing these exams as a learning opportunity can help you remain calm and focussed.

The Theory examinations are a useful and reliable test of knowledge. For many paediatricians, they are a significant high point in their learning. Here are some tips for candidates that I hope can help.

1. Look at the sample papers.
2. Use the recommended resources. These include the ‘Clinical Cases’ series and The Science of Paediatrics textbook.
3. Form a study group. Write questions for each other.
4. Plan your revision and stick to it. The theory examinations will require 600-700 hours of personal study for the average candidate. Some will need to devote more time to a particular exam.
5. Keep calm in the exam. The questions and answer stems will be given in a random order. Try to resist the urge to read the answer options before reading the question. This introduces bias and reduces your chance of success.
6. Seek advice from your supervisor and College tutor. This is particularly important if you are undertaking a particular examination for the third (or more) time.
7. If you are finding the Theory and Science examination difficult, consider attending the MRCPCH Theory and Science taught course, or accessing the online content.
8. Do not despair. I have worked with brilliant paediatricians who have found the theory examinations a hurdle. Most have failed one or more parts.

Find out more at www.rcpch.ac.uk/theory-exams
**FROZEN II**

**IT’S THE BLOCKBUSTER**

film release we’ve all been waiting for. Frozen has been distracting hot, snotty children in waiting rooms across the country since 2013 – it’s impossible to be a paediatrician and know nothing about it. If you’re not keen to sit through the whole two hours of Frozen II, here’s a summary to help you fool any 5 year old with your knowledge of Anna and Elsa’s latest adventures:

- Elsa is queen and can still turn anything to ice and snow with a sassy sweep of her hand.
- The Kingdom of Arendelle is under threat, and it’s up to Elsa and Anna to save it.
- The whole crew – including snowman Olaf, loyal and lovable reindeer Sven, and good looking but gormless ice hacker Kristoff – enter the ‘enchanted forest’ to confront four creepy spirits and unearth previously hidden family secrets. (Spoiler alert!) Not all of them leave the forest, leaving countless parents shocked and surprising themselves by sobbing into their popcorn.
- There are 80s rock ballads, a proposal, feminist girl power, climate change references and tears.
- But, it’s mostly a happy ever after, although not in the standard Disney way.

---

**Trainees Committee News**

Dr Hannah Jacob explains the role of the Trainees Committee and reveals what’s on the agenda this year

**BEFORE I JOINED** the Trainees Committee, I didn’t really have much of an idea about what it did. So, in case you were wondering, it’s made up of elected representatives from each region in the UK and a handful of subject representatives. We’re all trainees and meet three to four times a year with plenty of messaging in between.

We are focused on all issues related to training, including exams, curriculum, recruitment and trainee wellbeing. We’re keen to involve more trainees, and so this year there will be an opportunity for up to three trainee observers to attend each meeting. Do get in touch with your regional rep if you would like to join us for a fun day out full of topical trainee discussions!

**Future plans**

We’ll be continuing to proactively work with the College on the #ChoosePaediatrics campaign, particularly supporting foundation doctor events, and are always on the lookout for enthusiastic trainees to help out and promote paediatrics. And, of course, we’re all looking forward to the annual Conference this year, where regional winners will be put forward for the national PAFTAs. See you there!

[www.rcpch.ac.uk/trainees-committee](http://www.rcpch.ac.uk/trainees-committee)
**THIS IS GOING TO HURT**
by Adam Kay

**THIS BOOK IS** hilarious. I caught myself chuckling throughout, mostly to my own dismay! The exquisite use of medical jargon with witty footnotes is pure genius! But that’s as far as I can praise.

Adam uses ludicrously unprofessional reflections as a junior doctor for the sole purpose of misrepresenting the NHS. His general idea is that the health service disregards junior doctors who are the most underpaid and overworked individuals. Authors are entitled to a licence, but when he compares the celibacy and toil of Shaolin Grandmasters to the existence of junior doctors in the NHS, it stretches the licence.

Agreed, the NHS is far from perfect, and I get that he is having a dig at politicians and managers, but I’m unsure of his methods. There is immense kindness and support for peers, juniors and seniors alike, and I continue to be amazed by the wonderful people who make the NHS what it is today. Anyway I would rather believe someone who remains within and fights than without and moans.

So dear Adam, If I am ever looking for a laugh I will read your book and pay to watch your show. In turn, if you are unwell, do come to us. We will look after you. Free of cost.

---

**ADMISSIONS: A Life in Brain Surgery**
by Henry Marsh

**ADMISSIONS IS THE** follow up to 2014’s Do No Harm – Stories of Life, Death and Brain Surgery. While the latter recounted the day-to-day work of a neurosurgeon in thrilling detail, Admissions takes a more philosophical retrospective view of his incredible life. Having spent a career battling against death, he realises time is running out for him as he approaches retirement and the unknowns of what old age will bring.

He revisits some of the memorable cases that he has dealt with over his career, both in the UK, Nepal and the Ukraine carrying out humanitarian work. The descriptions of the surgery will have you on the edge of your seat. Interlaced among these accounts, he describes his attempts to renovate a lock-keeper’s cottage against the ravages of time, which acts as a fitting metaphor for where he is in his own life.

This book is written with scalpel-sharp precision. It is both an unsentimental love letter to the NHS, which he has witnessed being gradually dismantled over the latter part of his career, but also a moving treatise on the transience and fragility of life.

---

**DON’T FORGET THE BUBBLES** (DFTB) began life in 2013 as a blog run by four friends, and has rapidly grown into one of the world’s leading websites for paediatric Free Open Access Medical Education (FOAMED) and knowledge translation. The back catalogue of podcasts, available for free on iTunes and Spotify, initially consisted of recordings of talks given at the three annual DFTB Conferences in Brisbane, Melbourne and London. In late 2019, we launched a new podcast bringing original content from a collaborative of podcasters based in the UK. Original episodes are released fortnightly. Subjects range from conversations with published authors about their original research, to discussing clinical topics with experts in their field and exploring non-clinical aspects of paediatric life, such as Schwartz Rounds and wellness programmes. Future episodes will also focus on global health issues, such as the recent measles outbreak in Samoa. The aim is to create pioneering, evidence-based, community-focused, collaborative educational materials in keeping with the DFTB ethos.
We put 10 questions to a ST7 paediatrician and a consultant to see what makes them tick

Dr Rebecca Broomfield
ST7 Paediatric Emergency Medicine
GRID, University Hospital Southampton
@RCBroomfield

1 Describe your job in three words.
Challenging, enjoyable and fulfilling.

2 After a hard day at work, what is your guilty pleasure?
Watching truly awful romantic comedies.

3 What two things do you find particularly challenging?
Not knowing the answer; you don’t always have all the pieces of the jigsaw puzzle, which can be frustrating. Rotas also make it difficult to balance a young family.

4 What is the best part of your working day?
The variety – you have to be able to switch from playing with a toddler singing Baby Shark to reassuring parents.

5 What is the best advice you have received as a trainee?
You are never alone, it’s OK to not know all the answers. One of the most reassuring things ever said to me by a consultant was that they actually didn’t know.

6 Who is the best fictional character of all time, and why?
Princess Tiana – she gets to be a princess, but she had to work hard for her dreams.

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

8 If you were bitten by a radioactive gerbil, what would you like your superpower to be, and why?
The ability to see into the future. It would make offering safety netting advice a whole lot easier.

9 What is the single, most encouraging thing that one of your colleagues can do to make your day?
How do you think you and your colleagues can inspire the next generation of paediatricians?

Dr David James
Consultant Paediatric Emergency Medicine,
University Hospital Southampton
@DrDaveJames

1 Describe your job in three words.
Tough, but rewarding.

2 After a hard day at work, what is your guilty pleasure?
No pleasure should ever be guilty after a hard day!

3 What two things do you find particularly challenging?
Balancing the need to deliver a great service and great training. Running out of coffee.

4 What is the best part of your working day?
Seeing the relief of parents when you tell them their child is OK.

5 What is the one piece of advice you wish you could impart to yourself as a junior trainee?
Take your time. It’s not always about the destination, enjoy the journey and do more fun stuff!

6 Who is the best fictional character of all time, and why?
Skipper the penguin leader from Madagascar – we could all learn from his leadership style.

7 What three medications would you like with you if you were marooned on a desert island filled with paediatric patients?
Paracetamol, wound glue and lots of ketamine.

8 If you were bitten by a radioactive gerbil, what would you like your superpower to be, and why?
The ability to see into the future. It would make offering safety netting advice a whole lot easier.

9 What is the single, most encouraging thing that one of your colleagues can do to make your day?
Put the kettle on!

10 How do you think you and your colleagues can inspire the next generation of paediatricians?
We can always aspire to be the colleague that we want to have.
BEST PRACTICE

Learning from Excellence

A different approach to studying could unlock a wealth of insight

ALMOST ALL OF our attention in patient safety is focused on failures, such as error and harm, yet the majority of our work is successful. If we could learn how to identify and study successful work, we may be able to tap a wealth of insight. This is the idea behind Learning from Excellence (LfE). LfE is a strengths-based philosophy and practice, intended to complement the prevailing deficit-based approach to patient safety. At its core, LfE is a reporting system, designed to recognise and appreciate excellence in the workplace. The idea that we could learn from excellence occurred to me after an episode of serious illness.

Thinking differently
In 2010, not long after taking up a post as a new consultant, I was admitted to hospital with pneumonia. During my hospital admission, I realised that I had started actively looking for what was working. Initially, my motivation was to seek reassurance that the system was safe, but after a while, I realised that I was choosing to notice and appreciate the good work I was witnessing – good work that is usually taken for granted.

Many of the staff were displaying excellence in non-technical skills. I noticed that if I drew my attention to these non-technical skills (such as compassion and kindness), I started to feel safer. I also noticed that these excellent, non-technical skills were almost always accompanied by excellence in competence, and started to wonder if we could learn from these interactions.

During my recovery, I wrote a letter of thanks to the hospital staff, describing the excellence I had witnessed. My intention was to pass on my gratitude and provide positive feedback to the staff. I later discovered this letter had not been received by the staff members for whom it was intended.

The power of positivity
It occurred to me that positive feedback is not given the same status as negative feedback: a complaint results in a mandated investigation and response. My letter of thanks, on the other hand, was ignored.

After returning to work, I continued to choose to view the work of the NHS through an appreciative lens. I started to feel increasingly uncomfortable with the unilateral negative approach to patient safety. It seemed to me that our sole effort to make our system safer is to recognise and mitigate error, despite the prevalent success in our work.

While this is important, there are two obvious negative consequences of this unilateral, deficit-based approach:
1. Only a very small part of our system is examined (failure is comparatively rare compared with success).
2. Staff may perceive patient safety as an exclusively negative initiative, concerned only with mistakes and poor performance.

In order to address this, we created a positive reporting system, which sits alongside the adverse incident reporting. We named this system Learning from Excellence and made it available to all staff in our trust. Staff are invited to report witnessed excellence, however they define it, using a very simple online form. The contents of these forms are rapidly forwarded to the cited individuals (or teams), thus providing a formal positive feedback loop. Selected reports are investigated in more detail using a structured conversation based on Appreciative Inquiry.

After implementation, we learned that other centres were beginning to do the same type of work, and we discovered a huge demand to implement this system across the NHS (and beyond). Thus, we created an open access website with resources and blogs, and a community of practice has developed across the NHS, and overseas.

Learn more about the initiative www.learningfromexcellence.com
I graduated from the University of Hong Kong and obtained my MBBS in 2011. During my internship, I came to realise that I am particularly drawn to paediatric patients. From witnessing premature infants striving through their first months of life, to listening to the joyous laughter of the toddlers who regained their strength, these real-life encounters attracted me. Subsequently, I went through specialist training in Paediatrics and Adolescent Medicine in a regional hospital and became a fellow in 2018.

Hong Kong is a diverse, multi-ethnic and vibrant city. Several regional hospitals that I work in serve many people from mainland China and ethnic minorities. Many of them are less privileged and rely on public health care. Cultural and language barriers are challenges that frontline doctors face every day.

In a world of protective medicine with increasing patient expectation, the demand from doctors is ever growing. With some regional hospitals located in the city centre in close proximity to residential areas, the most frequent admissions we encounter are the common cold, flu and pneumonia. It is common to find patients and families who strongly believe symptomatic treatment for upper respiratory tract infection are crucial to their recovery.

Some families seek advice from Traditional Chinese Medicine practitioners, whose principles of practice are very different from ours. It takes patience and experience to earn the trust of these families and develop mutual respect and understanding in order to develop a good doctor-patient relationship.

Growing trends
Patients with psychological issues seem to be a rising trend too. There are a number of challenges young people face in Hong Kong. The education system is highly competitive. It is common to see Tiger Parents hovering above their children, anxious about their academic achievements and prospects. Children are faced with parents who have high expectations. It is not surprising to find children with sleep and mood issues early in life. It takes a multidisciplinary team of paediatricians, psychiatrists, psychologists and social workers to tackle complex psychiatric and behavioural problems.

Land shortage is another big problem faced by the Hong Kong population. City-dwellers are living in increasingly costly and crowded conditions. Many families in the lower socio-economic class can only afford to live in tiny rooms. Children in these families are therefore faced with crowded living environments and a lack of outdoor space to use for fun.

Working together
On-call hours are long during paediatric residency, but my colleagues and I share memories of fighting together in the middle of the night for kids who are seriously ill. We enjoy hanging out after a night call too, despite the sleepy faces. After all, it is the encouragement and supervision from our mentors, comradeship of our colleagues and the happy children we treat that keep us going.

I never regret my decision eight years ago to become a paediatrician, especially when I see the smiling faces of the children we treat every day.

“Children are faced with parents with high expectations. It is not surprising to find children with sleep and mood issues early in life.”
Wellbeing
Support, guidance and reflection

Mindfulness at work and in life

Learning how to practice mindfulness can help us deal with stress

A FEW YEARS AGO I came across a reply from our clinical psychologist to whom I had referred a child with anxiety-related symptoms. She had suggested mindfulness as one of the interventions. Mindfulness? I had some idea what this was but was unaware of the evidence base. I reviewed the literature and was amazed to find the wealth of scientific evidence for this secular practice, which has its roots in ancient Buddhist teachings going back 2,500 years. The evidence mainly relates to stress management, anxiety, depression and chronic pain. More recently, its benefits in wellbeing are becoming apparent.

Mindfulness is paying attention on purpose in the present moment, nonjudgmentally with kindness and curiosity. Sounds straightforward, but it is not easy. The mind is habituated to wandering. It has been likened to a monkey that swings from branch to branch – feeding on sorrow, regret and guilt of the past and dreams, expectations and anxieties of the future. Trying to keep this monkey mind in the present moment is a challenge that needs practice.

One of the ways in which this can be achieved is by practising awareness of the breath and the body. These practices of awareness are called meditation. Meditation is not intuitive and needs rehearsing. Over time, the mind develops the ability to stay present with whatever arises – good, bad or ugly – the so-called choiceless awareness.

We spend most of our lives on automatic pilot. Mindfulness is about noticing moments and staying present. We can do this with almost any daily activity, such as noticing the small things – the roadside flowers, the lopsided shop sign, the darkening clouds. Just for the sake of it. Because it is there. Because it brings us into the moment.

Managing stress

Stress is reinforced by our patterns of thinking. When we are stressed, it can be helpful to separate out facts from our thoughts about the facts. Facts are usually quite straightforward. Somebody sends us an email which we perceive as unpleasant. That is a fact. There is an immediate physiological reaction in the body. The heart may beat faster, the muscles tense or the breathing changes. That is another fact. The reactive thinking that follows is not always factual.

Let’s say there has been a medical error. We are likely to feel guilt, remorse and regret. We then project into the future and are filled with fear – imagining the worst – catastrophising – our thoughts may go like this: “I will be disciplined”; “I will lose my job”; “I will be reported to the GMC”. These thoughts arise from perfectly natural feelings, but they dominate our thinking.

Mindfulness is a way of life and meditation is a way of developing this skill. I have found it of great benefit at work and in life. Not only do I manage to deal with stress better but also find that I feel able to fully embrace what life has to offer.

I am now training to be a mindfulness teacher with Bangor University. I’ve really enjoyed leading two-hour mindfulness taster sessions for trust staff and am looking forward to delivering a breakfast session at the College’s annual Conference this year in Liverpool.

Book your place at this year’s Conference and attend Sanjay’s mindfulness session on Tuesday 28 April www.rcpch.ac.uk/conf2020
Promote wellbeing

Research shows that too many doctors are suffering from burnout, affecting their ability to work well. Here are some ideas to tackle the issue.

I'VE BEEN THINKING a lot about wellbeing. A recent GMC survey made sobering reading. One third of doctors state they experience high or very high levels of emotionally exhausting work. One sixth of us state we “never have energy at the weekend”. One quarter of us feel burned out. And yet the NHS, with 1.4million staff, is an ‘anchor institution’ – it influences the health and wellbeing of those it employs, as well as those it serves.

Burnout, an occupational phenomenon, leads to medical errors, poorer quality of care, and reduced patient satisfaction. Healthcare staff fall victim to ‘caring neglect’ whereby human interactions become depersonalised. People feel disengaged and ineffective in their jobs; this is compassion fatigue. Yet many may take on extra work, to keep up appearances. The facade can only be maintained for so long; the mask will drop. Is burnout an early warning system, but for staff?

Different strategies will work for different people, but we will all benefit from working together across disciplines and throughout all echelons of the NHS to foster an inclusive, open, and positive culture. This short piece scratches the surface of what departments could be doing, so let’s bring joy to our work!

The workplace

My own very informal survey of friends, colleagues, and the internet identifies the following as good starting points for promoting system change:

Environment

- Access to affordable, healthy and tasty food throughout the day and the night shifts.
- Somewhere to rest – for night shifts, or afterwards, before the drive home.
- Encouragement of active travel – were you shown showers and lockers in your induction?

Culture

- Communication and transparency throughout the NHS hierarchy. What happens to the feedback we give? Feeling listened to makes you feel valued – some organisations have senior executive “drop-in” sessions in the canteen at lunch time.
- Consider staff as people first: one chief executive asked my colleague about her cat’s trip to the vets!

The people

My same rigorous research methodology identified some suggestions for what we can do as individuals:

Ourselves

- Look up the RCPCH and BMA guidance on wellbeing.
- Read The Baker’s Dozen of Mental Toughness toolkit.
- Try CALM or Headspace apps.
- Manage negative thoughts.
- Remember HALT. If you are hungry, angry, late or tired, address that first, if you are able to, before you go and see your patient.
- Get your diary out and block out time for you. Recharge your compassion battery. Make friends. See your friends. Prioritise your support network.

Each other

- The Swedes have fi ka, the social phenomenon of spending time together over a coffee (and ideally a cinnamon roll!). Can we start something similar?
- Look out for your friends. Signpost people to available resources – be that a helpful consultant, occupational health, the Professional Support Unit, or a GP.
- Find out what’s going on where – what’s happening in your hospital, or in other paediatric departments? Can you share initiatives and co-ordinate? Successful initiatives include the buddy system or peer-to-peer coaching, lunchtime mindfulness, nutritional projects, and training on stress management.

For further resources on wellbeing visit

www.rcpch.ac.uk/wellbeing
I decided to become a paediatrician after watching ER. Dr Doug Ross was easily the coolest guy on the show, and he happened to be a paediatrician. I knew then that I wanted to do paediatrics! Community paediatrics was also an easy choice, offering a true teamwork approach to holistic medical care with a better work-life balance. (Now that I am greying my wife says I look like Dr Doug Ross too.)

My typical working day involves getting into the office by 9am, and over an espresso catching up on work emails and patient letters. In my clinics I will see four to five patients in the morning. Each appointment ranges from 30 to 60 minutes, depending on whether they are follow-up or new patients. The afternoons are usually set aside to dictate letters and I also, on occasion, go on home visits with our community nurse. I run special school clinics once weekly where I see children with disabilities in their school setting. Some community paediatric departments have a safeguarding on-call rota where your role is to attend strategy meetings and perform child protection medicals. I’m generally heading home by 6pm after I’ve completed my admin for the day.

The most difficult part of my job is being unable to deliver the care that I would like to. For example, families with severely disabled children in the area that I serve have had their funding for in-house and respite care cut. I often get asked to write letters to the local authorities to help, but this is usually out of our control and down to local, and ultimately, central government. This can be really frustrating.

The best part of the job is that I enjoy having the chance to work closely with different professionals, such as teachers, audiologists and social workers. I have plenty of time for appointments, which allows me to listen more and build a strong doctor-patient relationship with both them and their parents. This is vital in community paediatrics as you will often meet your patients in infancy and continue to see them until they are 19 years old – you get to know your patients very well!

My most memorable moment was last year when I presented some new research on the association of autism with ethnicity in Tbilisi, Georgia at the European Academy of Childhood Disability’s international conference. It was great to share my findings amongst academic rock stars and get some great feedback. I was also amazed to witness how in the post-Soviet era, with comparatively little funding, Georgia had set up a state service to reach out to children with disabilities and social communication disorders with fantastic results. Their motto ‘together we are stronger’ just summed up the teamwork ethic in community paediatrics.

When I’m finished work I like to...
...spend time with my family and go to the theatre. I have a passion for medical history so love to read about this in my spare time. I try to get down to the Emirates as much as I can (when not on-call) to watch the Arsenal, although this just gives me stress and is becoming less and less enjoyable these days! Playing football once a week gets me running around a bit – but mostly I enjoy the social aspect after the match.
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

PRINT: Order your print copy now at www.pharmpress.com/bnf
ONLINE: For pricing information contact our sales team at pharmpress@rpharms.com

www.bnf.org
RCPCH Conference and exhibition
28-30 April 2020, ACC Liverpool

Innovating for child health

The RCPCH Conference and exhibition offers a fantastic chance to come together with the paediatric community to explore the latest developments in child health, discover how we can harness new techniques and technologies, and what a positive vision for the future looks like.

What to expect at this year’s event
- Outstanding keynote talks
- High-quality clinical workshops
- Unique networking opportunities
- A selection of invigorating and calming wellbeing activities

Find out more and book your place at www.rcpch.ac.uk/conf2020

© RCPCH is a registered charity in England and Wales (1057744) and in Scotland (SC038299)