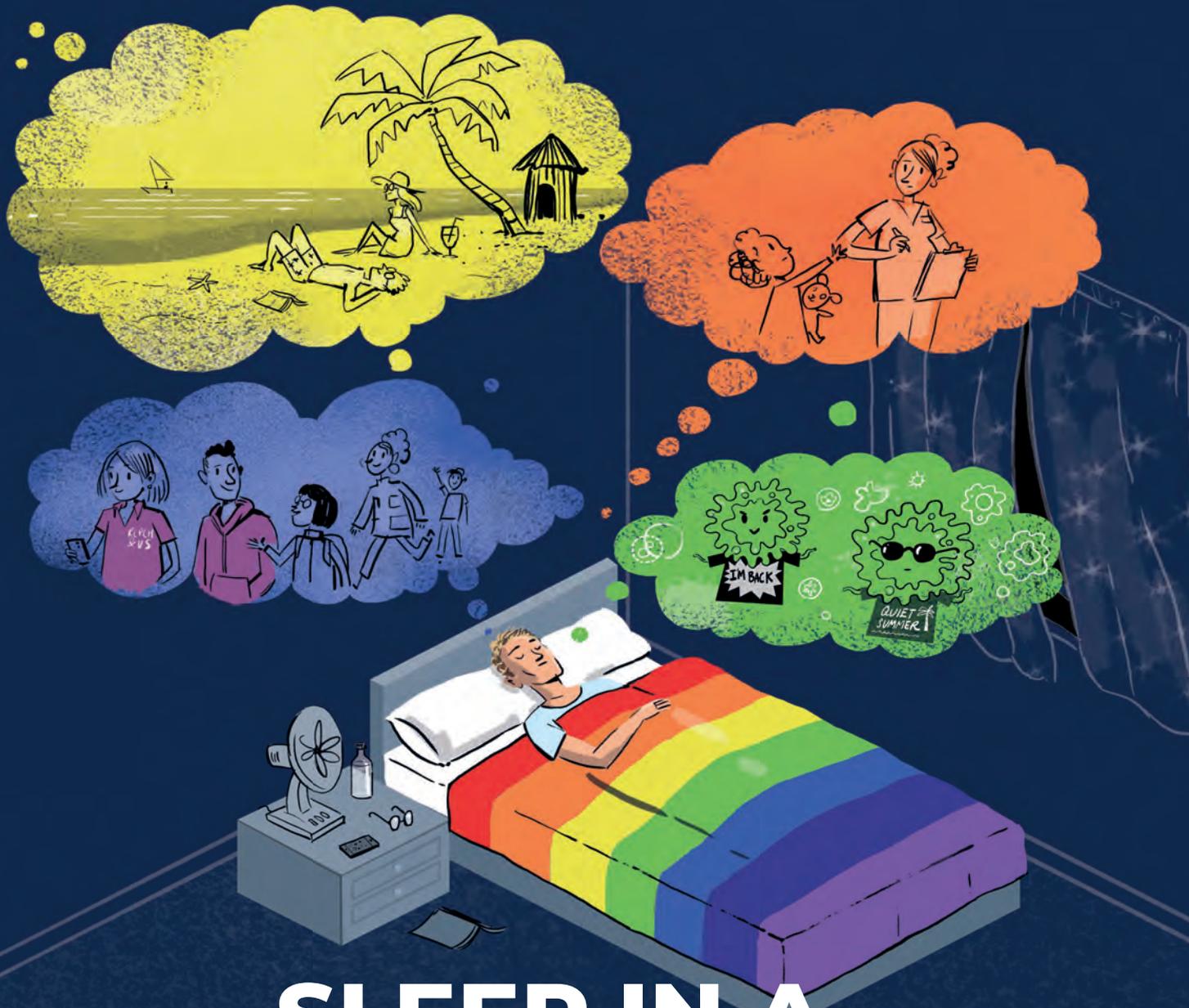


# RCPCH Milestones

The magazine of the Royal College of Paediatrics and Child Health



## SLEEP IN A TIME OF COVID

### Open to all

Accessibility and inclusion in health

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### Soft Landing

The scheme to help IMGs find their feet

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### Bronchiolitis

How we can be best prepared for a surge

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### Women at work

A woman's experience in paediatrics

Page 16

# ✦ RCPCH Child Protection Portal

## Child Protection and Safeguarding in the UK

Major concerns have arisen as a result of the COVID-19 pandemic. Since the first lockdown began, there has been a dramatic surge in child protection referrals as councils report rises in mental health issues. Now more than ever it is important for paediatricians and the wider child health team to be prepared to be equipped with the best child protection and safeguarding skills and knowledge.

The Child Protection Portal offers access to six vital sections including the Child Protection Companion – your essential resource to help clinical practice and child protection procedures, along with an expert insight into legislation and the legal system.

The Child Protection Portal offers access to six vital sections:



**Child Protection Companion**



**Evidence & Reviews**



**Standards & Resources**



**Safeguarding Legislation**



**Child Protection Advocacy**



**Educational Opportunities**

Find out more: [childprotection.rcpch.ac.uk](http://childprotection.rcpch.ac.uk)



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



### 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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Autumn 2021

## Welcome

It gives me great pleasure to welcome you to the autumn edition of *Milestones*. It's been another crazy year when it comes to holiday planning and if you're like me and plan holidays months in advance – I share your pain but I trust you got some relaxation and family time over the summer.

There was a time when paediatricians looked to the summer for an opportunity to catch up on CPD, invest in team building activities and enjoy a few months of slightly less frantic working. 2021 will not be one of those years. Many colleagues have been heard to say, "Winter started in June – what will November/December/January be like?". It has been a very unusual few months but I am really proud of how everyone has risen to the occasion and worked with colleagues in primary care to do their very best to support our patients and their parents with the very large number of viral infections. This bodes well for the winter months when we doubtless will need to dig deep into our reserves of goodwill.

My best wishes – and take care.

**Camilla**

**RCPCH President**

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



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## EDITOR'S PICKS



Myself and the rest of the editorial team really hope you enjoy our latest offering! Thank you, as always, to all that have contributed. Difficult to pick my highlights this edition as there are many! As well as our usual features (and suspects) we have a timely article from Sanjay Patel sharing some thoughtful reflections on the impending RSV surge, wise Demi from RCPCH &Us gives us three simple tips to use when thinking about accessibility and the brilliant Mike Farquhar discusses some of the factors that have impacted on the sleep/wellbeing of paediatricians. On that note, stay well and look after each other!

**Dr Hannah Baynes**

## Milestones

Our history, your future  
**25 RCPCH**

**jamespembroke**  
media

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## DIVERSITY

# One year on from *Putting Ladders Down*



**Dr Bhanu Williams**

● Consultant Paediatrician

● London North West Hospitals NHS Trust

🐦 @BhanuWilliams

**IT HAS BEEN** a year since the release of the RCPCH Equality, Diversity and Inclusion (EDI) Report *Putting Ladders Down*.

Our *One Year On* report examines our progress against our initial findings and recommendations.

*Putting Ladders Down* was commissioned to focus on EDI with regards to our member involvement in voluntary roles and the *One Year On* report focuses on progress around this issue. We have made good progress in terms of data collection, embedding EDI at the heart of the College and communicating with our members, made roles more accessible by removing the requirement to be a fellow from many roles and invested in IT to allow appropriate evolution of ways of working. There has been a continual focus on best practice in use of language in sensitive areas of EDI. We recognise we won't always get things right, but we



are committed to listening and learning as practice evolves.

Working with colleagues on EDI has been a pleasure. Camilla Kingdon as President and Rob Okunnu as senior staff lead have both provided energy and wisdom to our endeavours and Natasha Neill (Chief of Staff) and Carlota Navarro Esperse (EDI lead) have worked tremendously hard to drive our progress forward.

I am delighted with the member engagement with the EDI work, both within the member reference group and more widely. The conversations have always been interesting, educational and full of constructive challenges for

**"The conversations [about EDI] have always been interesting, educational and full of constructive challenges for us to do better"**

us to do better. A particular highlight for me has been working with Segn Nedd, our EDI representative on the Trainees' Committee on plans for reciprocal mentoring – a scheme where more junior members of our College from traditionally under-represented backgrounds, work with senior officers to share experiences and improve engagement. As ever, the young people we work with lead the way in educating us; I found the CYP session on experiences of trans teenagers seeking healthcare at the Annual Conference to be very thought provoking and it has impacted positively on my practice.

I'll end with two requests to my colleagues. Please fill in the new diversity monitoring form, available on the website. And please continue to be in dialogue with us on all areas of EDI that impact on your working lives and on the health outcomes of the children and young people for whom we care.

► For more information on the College's EDI work [www.rcpch.ac.uk/edi](http://www.rcpch.ac.uk/edi)



**Rest is best**

Dr Mike Farquhar on the importance of good quality sleep (see his quick sleep tips through these pages)

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# Staff Spotlight



**Carlota Navarro Espere**

● Equality Diversity and Inclusion (EDI) Project Officer

**I JOINED THE COLLEGE** in February this year. My role is to support the development of the EDI work at the College by working very closely with Natasha Neill (Chief of Staff), as well as liaising with the EDI Staff Working Group, the Oversight Group and the EDI Member Reference Group.

I am very passionate about the work I do as I believe EDI is essential towards achieving a more equitable society, by creating advancements and programmes to ensure that everyone has access to equal opportunities. Our report *Working for Change* sets out the College's current key areas of EDI work. These reports are centred around the working lives of paediatricians, health outcomes for children and young people, College volunteering and awards, and our College as an organisation.

Outside of work I am part of a volunteering programme run by Chance UK which involves mentoring and working with children and their carers to create a brighter future through a solution-focused and trauma-informed approach. We support children and help them identify their strengths, as well as express their feelings, to enable them to imagine their preferred future.

**DIVERSITY FACTS**

**2030**  
BY 2030 VOLUNTEERS ACROSS THE COLLEGE WILL REFLECT THE DIVERSITY OF OUR MEMBERSHIP



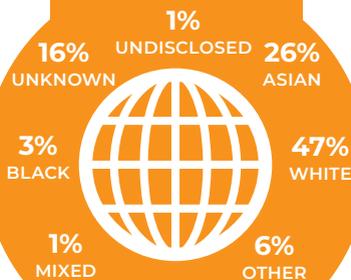
**64%**  
OF OUR MEMBERS ARE WOMEN

**32%**  
OF OUR MEMBERS ARE UNDER 35



**1%**  
UNDER 1% OF MEMBERS DISCLOSED A DISABILITY OF ANY KIND (COMPARED WITH 21% OF ALL UK CITIZENS)

**ETHNICITY AT RCPCH**



**SCREENING**

**EVALUATION OF SCREENING FOR SEVERE COMBINED IMMUNODEFICIENCY**

**IN SEPTEMBER 2021**, it is planned to start an evaluation of newborn screening for Severe Combined Immunodeficiency (SCID). This will cover approximately two thirds of babies born in England. Each year, approximately 14 babies are born in England with SCID. There is now a substantial body of evidence that early detection, by newborn screening, and timely treatment, before babies contract infection, makes a substantial difference to mortality and morbidity, such that most patients lead a normal life, free of medication.

In the UK, the blood spot, collected at five days old, is used to detect nine conditions, including sickle cell disorders, cystic fibrosis, congenital hypothyroidism and six metabolic disorders. From 6 September this year all initial bloodspot samples received in laboratories covering about two thirds of births in England will be tested for SCID. Any babies with abnormal results will be referred urgently to their local immunology specialist for diagnostic assessment and management. The evaluation will run for two years, after which a report will be submitted to the National Screening Committee, so that it can make an appropriate recommendation to the Ministers of Health for all four nations.



**Dr David Elliman**

● Clinical Lead for the Newborn Blood Spot Screening Programme  
● Public Health England



Limit caffeine use. Too much caffeine later in the day can affect sleep quality

See page 28

# College news



## ROYAL COLLEGES COLLABORATING



**Jo Revill**  
● RCPCH CEO  
● @8jorev

**THERE ARE TIMES** when we come together with other Medical Royal Colleges that demonstrate how powerfully doctors can use their voice on the right issues.

We saw that happen this summer. With GP and emergency medicine colleagues, we warned that a very high number of babies and young children were being brought into emergency departments, many with mild fevers and symptoms that would be better treated at home. We produced advice

for parents and carers, explained what to look out for and conveyed the impact on services of such high demand. Above all, it was about trying to help parents make the right decision for their child at a time of real concern for them.

Colleges collaborate every day on a great raft of projects, guidance and urgent national issues that cut across the specialities, but I don't think this is always seen from the outside. Perhaps we need to improve the way in which we demonstrate that collaboration. Webinars and virtual events featuring other areas of work are a smart way to do this ensuring that, as Colleges, we showcase each other's impact on patient care.

This summer, we turned 25 years old and celebrated the extraordinary way in which paediatrics and child health has developed over the years with stories from members and from young people. From the first 60 members of the British Paediatric Association to more than 20,000 today, the granting of that Royal Charter in 1996 enabled the profession to do so much more. In the same week, we had our busiest ever – and remote – Annual Conference, with topics ranging from the climate change emergency to thoughts about paediatric leadership. More than 1,700 attendees joined from 44 countries across the world – a feat that remote technology allows us. Next year, we are back 'in real life', we hope, but will hold onto the best parts of this innovation.

► **Read the advice for parents and carers on fever in children** [www.rcpch.ac.uk/ed-dramatic-rise](http://www.rcpch.ac.uk/ed-dramatic-rise)

## STUDY

# BPSU study on FGM



**Dr Deborah Hodes**

● Consultant Community Paediatrician  
● The Lighthouse, UCLH

**IN 2014, THE** first and still only clinic for children and young people who have undergone or are at risk of FGM was opened at University College London Hospital by me and Professor Sarah Creighton – Paediatric Gynaecologist. Mindful of the importance of supporting the physical and psychological impact of FGM, the clinic is multidisciplinary including psychotherapists and a clinical nurse specialist.

In the BPSU study, only 103 girls were reported over two years. This and other research suggest that there may well be a change in the attitude of the diaspora for girls whose mothers have been cut. However, we need to be alert to the possibility that it does take place. In 2019 there was a successful prosecution in London after a three year old presented to Whipps Cross Hospital.

It is important to have the confidence when taking a family history to include FGM. It is also important to remember that taking a good family history includes knowing the country of origin of the parents and asking about relevant conditions which includes FGM. So, having asked about illnesses to introduce the topic, I will then ask about FGM. Questions could include, "You may have read about FGM, traditional cutting of women and could I ask if you come from a practising community?". If the answer is yes then the next question to the mother would be, "Have you been cut?" and lastly "What do you feel about your daughters?".

Given how families feel so stigmatised by the way they are often treated by police and social care services, it is important that paediatricians are sympathetic independently of whether the girls have been cut.

Importantly if you do see a case and you're not sure, do not hesitate to send the video image for a second opinion to the UCLH clinic and if necessary the child can always be seen; it is better to be certain of your findings before possible prosecution.

► Visit [www.rcpch.ac.uk/bpsu/fgm](http://www.rcpch.ac.uk/bpsu/fgm)



## Welcoming IMGs

Find out how the Soft Landing scheme is easing the transition to working for the NHS for doctors new to the UK

P12



## MIKE'S SLEEP TIPS

Restrict your use of electronic screen devices in the hour before bedtime

See page 28



### Dr Emily Payne

- Community Paediatric Consultant
- Cwm Taf Morgannwg University Health Board



## CLIMATE

### Taking action on climate change

I'M THE CHAIR of the Support for Members workstream of the Climate Change Working Group (CCWG) in the College. I volunteered for this role as we have abused and overused our habitat and now need to nurture it to health so our children have a healthy future. I was also finding that although I have a relatively 'green' lifestyle at home, it feels like I'm walking into another century coming to work sometimes!

The College has set up the CCWG to help deliver its climate change strategy. There are five workstreams supporting this:

- Advocating for Change
- Research into Climate Change and Impact on CYP
- Toward Sustainable Buildings and Resources
- International
- Support for Members

There's now a website dedicated to the CCWG which will continue to be developed and will likely form the platform on which much 'support for members' can be found. You'll

also have seen sustainability and climate change were given more prominence at the College's Annual Conference (and hopefully in your own specialty conferences and departmental meetings!).

The aims of our workstreams are:

- To identify the needs of members with regards to climate change.
- To provide support to address these needs.
- To determine the needs of trainees and update the curriculum to reflect this.

If you have questions or would like to share examples of good practice in sustainable healthcare, please use [ccwg@rcpch.ac.uk](mailto:ccwg@rcpch.ac.uk) to contact us. As a starter, here are three suggested changes you can make right now:

- 1 Approach the executive board of your health board/ trust to get climate change on their agenda.
- 2 Avoid taking flights wherever possible.
- 3 Prescribe tablets over liquid and dry powder inhalers over MDI inhalers where safe to do so.

► Find out more about the College's work on climate change [www.rcpch.ac.uk/climate-change](http://www.rcpch.ac.uk/climate-change)

## AWARDS

### MEDICAL STUDENT ANNUAL PRIZE AWARD 2021

EVEN BEFORE STARTING medical school, I had a keen interest in paediatrics. Having volunteered on a paediatric ward whilst at sixth form, I was always amazed by the work that the paediatricians did and the difference they made to the lives of so many children. This interest continued into my university placements, and I have recently completed my elective in paediatric emergency medicine and community child health. I was also the Vice-President of my university's Paediatric Society.

I am absolutely thrilled to have won one of the RCPCH Medical Student Prize Awards. As part of the prize, I was fortunate enough to attend the RCPCH Annual Conference. I attended all three days, and even though it was virtual I still really enjoyed it. Some particular highlights included the 'Social Determinants of Children and Young People's Health' breakout session which raised a lot of important discussions, as well as the 'RCPCH & Us Engagement Workshop' where I enjoyed learning about inspiring projects involving young people. I also found the talk from the UK Aspiring Paediatricians Society really useful as it gave a lot of helpful tips regarding careers in paediatrics. There was a virtual social event organised in the evening for medical student prize winners, which was a great ending to a wonderful conference!



### Emily Davis

- Final year medical student
- Cardiff University
- @emilydavis0701

I am early on in my career, but I am already really passionate about paediatrics and so to receive this award is such a wonderful ending to my time at university. I'm looking forward to the future, and hopefully joining the world of paediatrics!



**ANNIVERSARY**

# 15 years of Medicines for Children: where we've come from and where we're going



**Dr Helen Sammons**

● Consultant Paediatrician and Paediatric Lead  
 ● Northern Devon Healthcare NHS Trust  
 @MedsForChildren

**WHEN MEDICINES FOR CHILDREN**

was launched in 2006, the aim was to develop a trusted and accessible source of free information on paediatric medicines for parents and carers. Today, Medicines for Children hosts paediatric-specific

information on more than 220 medicines, with over four million downloads a year. The website also includes information on broader topics, such as the use of unlicensed medicines in children, and videos demonstrating how to administer medicines by various routes.

The medicines information has been developed by an army of paediatricians and pharmacists, using a combination of standard phrases (e.g. for dosing) and tailored information and images. All medical jargon is avoided. The medicines information is reviewed every three years or when new information emerges. The information covers concerns that parents told us they often face when giving medicines at home, such as: What if I forget to give it? Which side-effects must I do something about? What if my child is sick?

We continue to work with families through our partner WellChild to understand what they need. In September 2021 we are launching a new-look website with improved functionality, and a free mobile app is being developed to help parents/carers keep track of their children's medicines.

Medicines for Children offers a readily available source of reliable information that clinicians can share with families. The project board is proud of our achievements to date and would like to thank the many people who have helped get us here. We hope Medicines for Children will continue to grow as a valuable resource, in collaboration with our partners WellChild and the Neonatal and Paediatric Pharmacists Group (NPPG).



► Visit Medicines for Children  
[www.medicinesforchildren.org.uk](http://www.medicinesforchildren.org.uk)

**JOURNAL**

## BMJ PAEDIATRICS OPEN



**Imti Choonara**

● BMJ Paediatrics Open Editor-in-Chief  
 @BMJ\_PO

**HITTING CHILDREN IS WRONG** is the title of an editorial highlighting the progress in countries legislating against violence towards children. It is one of our most read papers. It highlights how England lags behind Scotland and Wales in protecting children. What is surprising is that England and Northern Ireland are behind Albania, the Congo, Honduras, Nepal and Turkmenistan. The latter are among the 59 countries that have passed legislation recognising that hitting children is wrong.

Sweden was the first country in the world to ban hitting children in 1979 and the editorial highlights the publicity aimed at parents explaining why hitting children was counterproductive. Surveys have shown that the attitudes of Swedish parents have changed with practically all now recognising that violence to children is wrong. Paediatricians can play a positive role in changing attitudes, in England, Northern Ireland and the other countries, where legislation (and education) is still needed.

**JOURNAL**

## ADC JOURNAL UPDATE



**Nick Brown**

● Archives of Disease in Childhood Editor-in-Chief  
 @ADC\_BMJ

**AS I WRITE**, the gates of Wimbledon are re-open, two years after the last serving of strawberries and cream and clumsy, tabloid punnery rife as the tournament approaches its denouement. So, this must be summer, the season where one can take feet off the gas for a few weeks, right? Not any more. We know from the Australian experience of RSV (the 'classic November infection'), that a fourth COVID wave, despite the easing of restrictions, and that priority group vaccine uncertainty are all lurking menacingly stage left. If we'd wanted routine jobs, though, we'd never have signed up for paediatrics.

After sifting through a jaw droppingly high quality shortlist for our new Trainee Associate Editor positions, a joint journal and RCPCH initiative, we've just appointed two new Trainee Associate Editor positions each to both the ADC and Fetal and Neonatal editions. So, congratulations to Hadeel Hassan, Sunitha Vimalasvaran, Shiraz Badurdeen and Michelle Fernandez. Exciting on many levels, not least the new 'energy' they will bring.

**AWARD**



**Professor Henry Halliday**

- Retired Neonatologist
- Belfast

## James Spence Medallist

**IT WAS A GREAT HONOUR** to receive the James Spence Medal for 2021, an award not just for me but for those with whom I had worked during the past 50 years. I have been very fortunate in having wonderful colleagues and mentors, first in Belfast and then in Cleveland and San Francisco, people who gave me an exceptional grounding in neonatology and research. I was also lucky to meet so many good colleagues, scientists and clinicians with similar research interests in Europe and worldwide. Colin Morley from Cambridge gave me great advice about continuing our research into surfactant replacement for RDS when he suggested

I visit Bengt Robertson's laboratory in Stockholm 37 years ago. The European research networks that we subsequently developed in the 1980s allowed testing in randomised trials of pulmonary surfactant which is now indispensable in the care of preterm infants.

Since I retired from clinical practice, I have been kept busy chairing many committees involving a veritable alphabet soup of clinical trials, trial steering, data monitoring, and research ethics committees in many countries. I have also enjoyed being joint Editor-in-Chief of the journal *Neonatology* for the past 18 years with my good friend Christian Speer from Wurzburg.

What am I most proud of? That is easy – my wife and family who have supported me through thick and thin. Marjorie and I have three children and four grandchildren whom we love dearly. I am proud to say that our children followed us into the caring professions – we have a Consultant in Intensive Care and Acute Medicine, a Consultant Paediatric Oncologist and a Cardiologist. Hopefully we will be well looked after in our dotage.

I was honoured to accept the James Spence Medal for 2021 and join a list of most distinguished paediatricians and others who have contributed to improving child health worldwide.

**AWARD**



**Dr Mike Linney**

- Retired Paediatrician
- University Hospitals Sussex NHS Foundation Trust
- Past RCPCH Registrar
- @linney\_mike

## RCPCH &Us Voice Champion Award

**I WAS DELIGHTED** to receive the 2021 RCPCH &Us Voice Champion Award. The achievements by the other nominees were awe-inspiring and all would have thoroughly deserved the award.

Chairing (I use that term loosely!), our RCPCH Engagement Committee taught me to listen, respect and follow the young person's voice. I was able to meet and talk to many young people engaged with healthcare, listening to their stories and achievements, both as individuals and collectively. This helped when I met senior healthcare decision-makers, making me a better advocate for children.

Leading from all this, I saw the value for youth workers in helping young people engage in their

individual health service, seeking their voice. We successfully employed our first youth worker in our non-specialist hospital this year, able to link in with support in the community, take individual referrals, seek out those on wards who were struggling to get their voice heard and engaging with young people to develop a better service.

Finally being able to help write a book chapter on children's healthcare engagement from these experiences and supporting RCPCH &Us through all their COVID work (for example the 'book club' on children's experience during COVID) was hugely rewarding and something I remain very proud of.

Thank you again for the award.

**AWARDS**

## HONORARY FELLOWS 2021

**Lord Victor Adebawale**

- Chair of the NHS Confederation

**Prof Zulfiqar Bhutta**

- Chair of Global Child Health at Hospital for Sick Children, Toronto and Director of the Centre of Excellence in Women and Child Health, Aga Khan University

**Dr Fiona Campbell**

- Consultant Paediatric Diabetologist / Associate Medical Director (Children's Services), Leeds Teaching Hospitals NHS Trust

**Dr Helen Goodyear**

- Consultant Paediatrician, Birmingham Heartlands Hospital

**Dr Jenny Harries**

- Deputy Chief Medical Officer for England

**Prof Aye Aye Khaing**

- Professor of Paediatric Oncology, Yangon Children's Hospital, Myanmar

**Prof Kyaw Linn**

- Professor of Paediatric Neurology, Yangon Children's Hospital, Myanmar

**Dr Robert Scott-Jupp**

- Retired Consultant Paediatrician, Salisbury NHS Foundation Trust

**Dr David Vickers**

- Medical Director & Consultant Paediatrician, Cambridgeshire Community Services NHS Trust



**MIKE'S SLEEP TIPS**  
 A small amount of alcohol can help some people to relax, but closer to bedtime it can negatively affect sleep quality  
 See page 28

**Simply the breast?**

Three doctors explain how their own experiences helped them support breastfeeding mothers



p18

**EVENT RECORDINGS**

● **Managing RSV and other respiratory viruses in 2021**

This webinar looks at how to manage patient flow, 'keeping patients safe and pathways open', covered recognition, management and discharge, and signposting to resources for parents.

● **BPSU-PHE Symposia series: COVID-19 from a Paediatric Perspective**

Discussions cover the impact of COVID-19 on pregnancy, neonates and general paediatric populations and the rare syndrome, PIMS, as well as the wider impact of the pandemic on child health.



**See more**

Free online event recordings

[www.rcpch.ac.uk/live-event-recordings](http://www.rcpch.ac.uk/live-event-recordings)

**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

Here is a selection of our online and eLearning courses. More courses will be confirmed in the next few weeks so keep an eye on our website for further updates

● **MRCPCH Theory & science exam preparation course**  
 3 Sep

● **MRCPCH/DCH Foundation of practice exam preparation**  
 8 Sep

● **RCPCH-BPSU Webinar: Lead toxicity in children – a continuing problem**  
 8 Sep

● **MRCPCH Clinical exam preparation**  
 13 Sep

● **Webinar: Childhood obesity – medical management**  
 16 Sep

● **How to Manage: Paediatric Allergy Training PAT 3**  
 22 Sep

● **Webinar: Childhood obesity – surgical management**  
 23 Sep

● **How to Manage: Eating disorders**  
 6 Oct

● **DCH Clinical exam preparation**  
 3 Nov

● **How to Manage: Paediatric sepsis**  
 4 Nov

● **How to Manage: FASD in community paediatric services**  
 16 Nov

● **How to Manage: Common cardiac problems**  
 19 Jan 2022

The **Paediatric Sepsis** Podcast Real world guides on stopping sepsis

Advice from: - parents.  
 - specialists  
 - junior doctors

[www.rcpch.ac.uk/sepsis-podcasts](http://www.rcpch.ac.uk/sepsis-podcasts)

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

**NHS Health Education England**

**medisense** LEARN DIFFERENT



# Accessibility and inclusion in health

Demi, a member of RCPCH &Us, tells us what accessibility means to her and gives her three-point plan to improve inclusivity



**Demi**  
● Aged 16

## ACCESSIBILITY IS IMPORTANT

to me because I have experienced the frustration of not being able to do something without planning it first.

I know firsthand how it can impact a person and their family's daily life too. My older brother is deaf and has cerebral palsy so it's something I've witnessed on a daily basis. Having to ask questions like, "Is there access via a loop system?" or, "Can he access that with limited mobility?" or, "Can we do it together or independently?" but the answer isn't always yes.

Accessibility has different meanings depending on who you ask. However, I believe that accessibility is inclusion for everyone, always with the adaptations and flexibility being available to all. Communication is another factor of accessibility as well because people have the right to ask questions and be heard, using the language that works for them, whether this is via a translator/communicator, symbols or subtitles, so accessibility has many factors.

For the RCPCH Annual Conference this year, Dr Fizz Izagaren and I met and spoke about accessibility and some of its advantages as well as its flaws. In our interview we spoke honestly about our life experiences and she explained the difficulties she has faced throughout COVID-19 and before with being deaf and having full communication access. I can't

comprehend why it has taken so long to be able to wear clear face masks. This would help patients and health staff not just who are deaf but also who have learning disabilities, English as a second language and other things.

I think everywhere needs to have a three-point plan that they use to check their accessibility, in a project, in a clinic or in other parts of life. This could include:

## Diverse role models in films



**Central Bedfordshire Youth Parliament have selected five diversity films which feature role models from different backgrounds, understanding different cultures and experiences, or having different experiences to others.**

1. *Wonder*
2. *Moana*
3. *Raya and the Last Dragon*
4. *13th*
5. *Coco*

**1** Check their communication needs – do they need a voice over, subtitles, large print, or pictures?

**2** Check their age and stage ability – do they need an easy read version, someone to explain it?

**3** Check their access needs – how can they get to see you in person or online with as much independence and dignity as possible.

Have a think about the three-point plan and see what you can do in your team to make it more accessible to patients, families, and staff. Also look to see young people's ideas for films with diverse role models (left) too! 📌

## 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** 🐦 @RCPCH\_and\_Us 📷 @rcpch\_and\_us 📺 @RCPCHandUs 🌐 and\_us@rcpch.ac.uk

# Soft Landing – supporting paediatricians new to the NHS

The founders of a new organisation run by international medical graduate paediatricians tell us how they will be supporting those from overseas to make the transition a little easier



**Dr Nadia Baasher**

- ST7 Paediatric Trainee
- The Royal London Hospital

**T**he inspiration for Soft Landing came from my own personal experience of moving from the Middle East to come to work at a tertiary neonatal unit in East London. For a long time, I had a real aspiration to achieve the internationally recognised qualification

of UK training in paediatrics.

I met a consultant who was working in London at my hospital overseas, and he encouraged me to consider coming. At that point, I was really settled in my job and my family life in Saudi Arabia, but it was kind of now or never... so I packed up my whole life and my family's life and moved.

I am actually half-Irish and knowing the language and the culture from visiting lots of times, I didn't expect the big adjustments to working in the NHS. The struggles I encountered even in the communication, were not a language issue, but more about the style of education abroad which is quite restrictive – you don't have a chance to express or even discuss. In some countries the health systems have an almost military-like hierarchy, unlike the UK. In spite of this, handover is very informal. Clinically, I had nine years of paediatrics experience, but I struggled at the start.



The Soft Landing team

I was very fortunate that the department I arrived at and my SHO on my first on calls took very good care of me and helped me to thrive. But it is not like that for everyone. It was at that point that I started working with Habab on helping people who were hoping to come and train here. I started to hear about the difficulties people were having in departments who were less lucky. Some of the departments weren't used to international medical graduates (IMGs) and some of the IMGs themselves were not prepared.

It started as an idea on a word document, but we quickly realised we needed to do

something official. It's not just a course but wanting to have a team available to support people who are newly arrived and trying to find their feet.

The team grew quickly. The enthusiasm that came from many quarters, not least Camilla Kingdon's generous encouragement, seemed to suggest that this was something valuable that we could offer to these doctors, at very formative moments in their careers.

I am grateful to work with such an amazing passionate team and I am hoping we can reach out and enable a 'softer landing' for IMGs and a softer reception for the departments they are joining.



**Dr Habab Easa**

● ST4 Paediatric Trainee  
● Oxford University Hospitals

Settling into a new healthcare system and a foreign country comes with many challenges. Without the right support these challenges can have detrimental effects on the personal, social and professional lives

of IMG doctors, resulting in differential attainment, retention issues, even in extreme cases mental health problems.

As IMG doctors, who have gone through some of the hardships ourselves, we think this transition could have been made easier if IMG paediatricians received the right support at the start. Nadia and I had a vision of a supportive network for IMG paediatricians that provides customised training, mentoring, signposting, and peer support, by IMGs who are further established in their UK careers.

The main areas of struggle are not related to clinical skills or knowledge, but interpersonal skills like communication, situational awareness, and knowing how to access the right support channels. A number of challenges were identified from a survey we conducted with over 100 IMG paediatricians. In particular, past experiences of escalating to the consultant were discouraged, you were considered a bad registrar if you get your consultant up at night – of course this is the exact opposite of paediatric working in the UK where it is vital that you keep your consultant up to date. MDT working is also very different. Another thing was the admin – in many overseas settings, doctors do not have to complete the amount of admin that is normal in the UK.

By providing customised support in terms of workshops and webinars exploring the topics that most IMG paediatricians are struggling with due to lack of previous experience, the gap in differential attainment between IMGs and the UK-qualified paediatric doctors could be bridged.

Our pilot workshop took place virtually with a full-day of lectures and Q&A sessions covering a day in the life of an NHS paediatric doctor, surviving your first on-call, understanding the MDT, tips for proper documentation, safeguarding and wellbeing.

During this workshop, we were proud to introduce our very own Soft Landing communication skills videos, filmed using our very own resources and acted by our team members. The contents of those videos were inspired by real work-life scenarios that are usually encountered daily (handover to a colleague, talking to a difficult parent, and escalation to consultants). Crucially the doctors in the videos reflected the varied accents and appearances of many of our audience. All the other sessions highlighted cultural pitfalls that IMGs may run into. The feedback was hugely positive from the candidates and from our peers who kindly attended the workshop as reviewers. We intend to deliver this workshop two or three times a year.

Other interactive sessions so far have included ST1 mock interview sessions, as well as ST3/4 sessions lined up with nearly 90 candidates registered. Our plan is for regular webinars for UK IMGs addressing their specific needs; career progression/CESR, untangling ePortfolio, smashing ARCPs, wellbeing in the workplace and paediatric mental health. We hope to continue with webinars aimed at overseas colleagues who are planning to move to the UK with topics covering GMC registration, NHS job applications and life in the UK.

Our dream for Soft Landing is a national hub, with a mentoring programme and peer support network. The project arose through the good deeds and pure voluntary efforts of our ever-growing team, and it has been truly humbling to see how much can be achieved from the desire to help others. To our fellow paediatricians, we hope to unleash the full potential of this valuable asset within the NHS workforce, for better job satisfaction, and retention of the workforce. ✨

▶ Visit [www.soft-landing.org](http://www.soft-landing.org)

## How you can help IMGs transition to working in the NHS

- Always ask about IMG colleagues' experience and level of familiarity with the NHS system. They could be a paediatric consultant, or this could be their first job in paediatrics!
- Be aware they may have left family and friends to start work in the UK. Isolation can be an issue so invite them for a cup of tea.
- Introduce them to other IMGs who are more established or offer a mentor, in addition to their educational supervisor for more informal troubleshooting.



**@paedsoftlanding**  
**Team.softlanding.com**  
**Soft Landing**





# What can we do to prepare for a bronchiolitis surge?

**DR SANJAY PATEL LOOKS AT THE RISE IN CASES, WHILST PREPARING FOR THE POTENTIAL IMPACT IN THE COMING MONTHS ON PAEDIATRIC SERVICES AND PRIMARY CARE**



**Dr Sanjay Patel**

● Consultant in Paediatric Infectious Diseases and Immunology

● Southampton Children's Hospital

🐦 @doctorsanjay

**Who would have predicted that we'd see almost no infants admitted with bronchiolitis in the UK during winter 20-21? Although it seemed like a blessing at the time, with a large number of paediatric staff being redeployed to support adult services,**

**it appears that viruses may have the last laugh once again. Data from the Southern Hemisphere are obviously concerning – large surges in Respiratory Syncytial Virus (RSV), including children beyond infancy, occurring out of season have put significant pressure on paediatric services.**

Will the same occur in the UK this year? To be honest, we don't really know. Modelling from Public Health England (PHE) suggests anything from a 100% increase in admissions to an actual reduction in cases compared to historical averages. However, in my opinion, it seems likely that as we ease social restrictions as part of the governments' COVID-19 roadmap to recovery, we're probably going to see a significant uplift in transmission of all respiratory viruses. And with pregnant women or children not having

been exposed to respiratory viruses (except SARS-CoV-2) over the past 18 months, we have a large pool of susceptible young children with and without co-morbidities.

In terms of when this rise in cases is likely to occur, there remains considerable uncertainty. Active surveillance data from sentinel sites across the UK are already showing a rise in cases of RSV in the North West of England, mainly in young children and we've just heard that NHS England is suggesting restarting the palivizumab programme for the most vulnerable young children. Whether or not numbers will rise sharply in the next few weeks and whether or not this will be replicated in other regions of the country remains unclear; we know from SARS-CoV-2 that considerable regional variation is possible. In addition, the impact of school summer holidays and whether or not this will make the surge more likely to occur when schools go back in September is also hard to predict, although early data from Scotland, where schools broke up in late June, are encouraging. Irrespective, we as paediatricians need to be prepared to manage a large number of children with bronchiolitis potentially in the coming weeks and months.

Maintaining patient flow between EDs, short stay units, inpatient wards, high dependency units and paediatric intensive care units is paramount in

order to deliver safe care if the number of bronchiolitis admissions increases sharply. However, the ongoing use of the national COVID-19 specific red/amber/green pathways continues to make achieving efficient patient flow extremely challenging in almost all parts of the hospital. However, these pathways were primarily introduced to reduce the nosocomial spread between adult patients in hospital; within a paediatric setting these pathways are now hard to justify when we know that SARS-CoV-2 so rarely causes severe illness in children and most staff members have received two doses of a COVID vaccine. They also take no account of other respiratory viruses that can result in nosocomial transmission to patients and staff.

## Achieving balance

So how much influence do paediatricians really have in implementing pragmatic processes that will allow patient flow to be maintained during a bronchiolitis surge? The delivery of effective IPC relies on carefully balancing the risk of nosocomial spread of infection whilst still being able to safely deliver clinical care to patients. There isn't a one-size-fits-all approach as no two hospitals look the same; conducting a local risk assessment is essential. The good news is that we're hopefully moving away from COVID-specific infection



Cases of bronchiolitis were lower than usual last winter

control pathways to more generic respiratory infection pathways, which will describe good IPC practice whilst making it clear that local teams should have the final say on which systems are put in place. This approach is reflected in the recently updated RCPCH bronchiolitis guidance, which highlights the importance of local risk assessment as well as a more pragmatic approach to PPE use. NHS England is also in the process of cascading this guidance down to infection control teams across the country, many of whom have previously had no involvement in the infection control aspects of children with bronchiolitis. However, the onus is still with us as paediatricians to initiate these discussions with our local IPC teams and operational managers if we want to ensure that we have effective systems in place that allow us to deliver safe care to large numbers of children whilst minimising the risk of nosocomial spread of respiratory viruses between patients and to staff.

Another area that we as paediatricians need to urgently address is ensuring that our patients have access to either point of care PCR testing or laboratory based rapid PCR testing for respiratory viruses. Throughout the pandemic, hospitals have prioritised access to these tests to adults. It is essential that we make our microbiology/virology colleagues

aware that a surge in bronchiolitis is predicted to occur out-of-season this year and that timely access to rapid test results in children is essential in order to maintain patient flow and deliver paediatric services.

### Working with colleagues

Finally, we need to recognise that a surge in bronchiolitis is going to impact our colleagues in primary care as much as us in hospital. We've seen record numbers of children presenting to primary care and ED with self-limiting febrile illnesses over the past few weeks. It appears that reduced rates of infections in children over the past 18 months may have reduced the confidence that parents have in their ability to distinguish severe from mild illness. RCPCH has developed excellent guidance for parents and we should be working with our colleagues in primary care and local authorities to disseminate this. In addition, primary care has moved to a

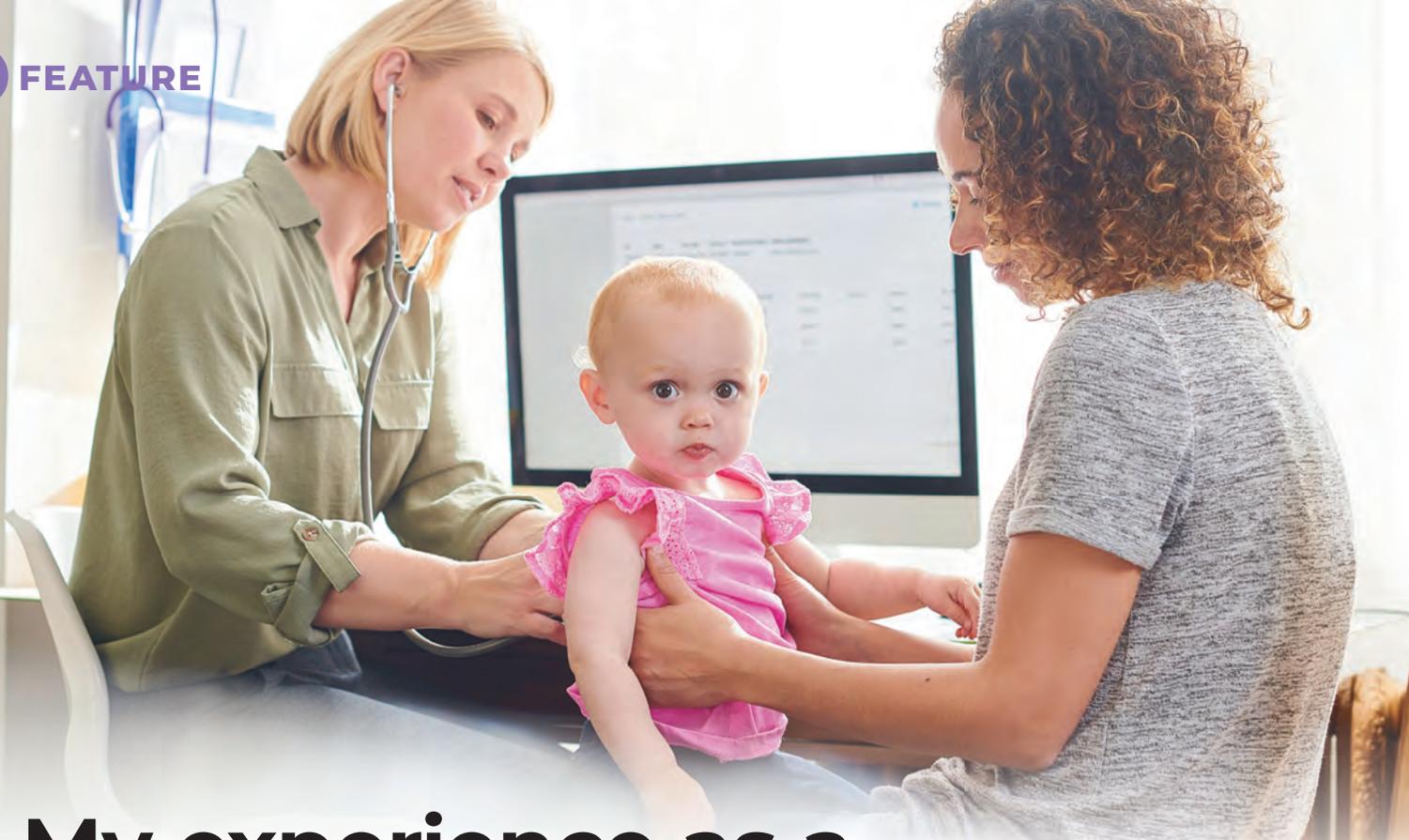
**“We need to recognise that a surge in bronchiolitis is going to impact our colleagues in primary care as much as us in hospital”**

total triage model during the pandemic and their capacity to see large numbers of patients with symptoms consistent with COVID in face-to-face settings remains limited. Clinical pathways and educational resources for the remote assessment of children have been developed for primary care staff and effectively implementing them may allow precious face to face slots to be used more effectively. Ensuring consistent approaches and clinical pathways across the urgent care pathway may also reduce the number of children being referred to hospital during a bronchiolitis surge. We should be promoting collaborative working between primary care and secondary care staff to deliver such integrated models of care.

Being prepared means having systems in place before the bronchiolitis surge begins. I suggest meeting with your local infection control team and conducting a local risk assessment, talking to your local microbiology/virology team to ensure that you can get rapid respiratory virus PCR results on children and collaborating with your primary care colleagues to ensure that a consistent approach is implemented across the urgent care pathway. I can't promise that this will get us through a bronchiolitis surge unscathed but it's a start. 

### Useful Links

-  Bronchiolitis guidance [www.rcpch.ac.uk/bronchiolitis-covid-19](http://www.rcpch.ac.uk/bronchiolitis-covid-19)
-  Advice for parents and young people during coronavirus [www.rcpch.ac.uk/coronavirus-posters](http://www.rcpch.ac.uk/coronavirus-posters)
-  Integrated models of care [www.rcpch.ac.uk/qi-central/integrated-care](http://www.rcpch.ac.uk/qi-central/integrated-care)
-  Managing RSV and other respiratory viruses in 2021 – webinar [www.rcpch.ac.uk/rsv-webinar](http://www.rcpch.ac.uk/rsv-webinar)
-  Clinical pathways – remote assessment [what0-18.nhs.uk/clinical-pathways-remote-assessment](http://what0-18.nhs.uk/clinical-pathways-remote-assessment)



# My experience as a woman in paediatrics

DR LIZZIE WORTLEY SHARES HER PERSONAL EXPERIENCES WORKING AS A WOMAN IN PAEDIATRICS AND ADDRESSES SOME OF THE COMMON ISSUES THAT ARISE



**Dr Lizzie Wortley**

● Paediatric Registrar  
● University College Hospital  
@LizzieWortley

**T**HERE IS a lot to celebrate about being a woman in paediatrics – we make up about 75% of trainees, consultants are about 50:50 and working LTFT is so much easier than in other professions. Discussing inequalities through the lens of a woman's

experience would seem fairly pointless.

A few months ago, I was asked to talk at the RCPCH St David's Day Conference about being a woman in medicine and what it means. With such a huge topic, but only 25 minutes, there had to be some editing on what I spoke about. Even my personal 'incidents'

that I could remember through medical school and beyond reached 4,000 words and I soon gave up. It was too much. I didn't want it to be about one person's experiences, but I wanted it to have a ring of truth to it.

Having many conversations at work and beyond, a lot of the common experiences were not being discussed on a larger scale, and many women spoke about being too scared or ashamed to talk about struggles with colleagues and the difficulties that arose from that.

We all know sexism still exists, and there were plenty of examples of that at all levels. A number of experiences were around significant issues it was felt weren't being heard. Doctors experiencing domestic abuse, but not being believed ("You're too clever to let that happen to you!"). Experiencing things within your family as a child or adult,

that then arise at work for your patients as a safeguarding issue, and the complex web of emotions and thoughts being at work then brings. Being a trans woman. Being a single parent. Periods and menopause – the difference of opinion between using medicines to 'remove the problem', and those that don't or can't. Men at work can feel lost too – these issues can apply to them too, and they may feel even less able to discuss difficulties.

Issues can arise in paediatrics for women, men and families. Difficult areas for paediatrics appear to be:

- Assuming our female colleagues want a family and constantly asking about it – with their abilities questioned if they don't want or have children.
- Struggles with infertility whilst facing other families' 'success' every day at work.
- Pregnant trainees not being supported,



Being a parent and a paediatrician can bring up conflicting experiences

even having miscarriages at work, when we have all cared for babies born sick, too soon or too small.

- Seeing families in ED/postnatal wards struggling in the first few weeks of a newborn's life, whilst our colleagues go off on parental leave with little support but often complex and confused expectations about breastfeeding.
- Returning to an on-call rota in a profession that knows small children sleep badly; mothers may still be breastfeeding; and teaches the lifelong impact of the first 1,000 days contributing to guilt, tiredness and stress.
- Being a parent in CYP centred paediatrics whilst feeling like your own family can't come into the equation.
- All the complexities of life that we see and can be mirrored in our own experiences – complicated pregnancies; problems with feeding; postnatal depression; domestic violence; addiction; mental health; and hiding it for fear of judgment or reprisal.
- Parenting beyond babyhood, especially complex needs and adolescence when all that 'should be sorted out' by now.

There are lots of places where this is a problem – not just paediatrics. The difference for us is this mismatch between



our professional and personal experience. Walking out of a discussion and the thoughts racing through our own heads. Trying to avoid bias without being able to acknowledge to our colleagues the reality of our lives, and the influence that has.

I was overwhelmed by the messages I received when I started talking more about this. Comments around miscarriages at work led to writing a piece about my own as I realised my experience wasn't unique. The response was overwhelming, I couldn't believe how many had negative experiences of having to work during a miscarriage or being too scared to tell anyone.

During the conference there was discussion on staff fertility issues whilst always working with other people's children; working whilst pregnant and having complications; and what

impact deciding to have children has on your career. The range of experiences is so broad there isn't a one-size-fits-all solution.

It does seem particularly hard in paediatrics to feel that building your own family can come with issues in a specialty that is about caring for babies, children and young people. Even women that actively choose not to have children can't escape others' assumptions and judgements, with their age, working abilities and life choices seemingly a reasonable source of work based opinion.

I think the reality is we don't really know what the impact being a woman has on working in paediatrics, because we haven't asked people. I hope in the future we can be more proactive and open in the way we look out for and support people with difficulties that may or may not be related to being a woman.

I am now working with the College to write best practice guidance on pregnancy and miscarriage at work. The College's attitude to making positive change has been really encouraging. This is on top of the work they have already been doing with the phase 1 and phase 2 of their equality, diversity and inclusion reports and recommendations which are vitally important and I wish them every success.

There is room for everyone in paediatrics, and it shouldn't be a zero-sum game. Paediatrics is special because of the different life stories and potential to help make things better. I really hope that in the future far fewer people are scared to talk about the mismatch between what they need in their lives and what work is asking of them. This starts with culture, and a lot of that comes from the top. I love that when I contacted the College about this, they jumped on it, listened and opened up gates to get this heard. I'm really proud to be part of something that has responded like that, and long may it continue! 

We appreciate it would not be possible to represent everyone's experiences in one feature, on what is a complex and sensitive topic. The editorial team would welcome hearing additional viewpoints for future editions. Please email [milestones@rcpch.ac.uk](mailto:milestones@rcpch.ac.uk) 

# SIMPLY THE BREAST?

THREE PAEDIATRICIANS TELL US WHAT THEY HAVE LEARNT AS MOTHERS TO INFLUENCE THEIR PAEDIATRIC PRACTICE AND HELP THEM BETTER SUPPORT BREASTFEEDING



**Dr Jessica Burke**

● Paediatric ST6  
● Wirral Women and Children's Hospital

**M**y breastfeeding experience started promisingly, with antenatal hand expression and my daughter initially latching well. I hadn't previously considered 'oversupply' a potential issue, but by week three my substantial supply led to forceful let-downs.

My daughter now struggled to hold her latch, coughing, spluttering and screaming through unsettled feeds.

My mind jumped to medical diagnoses; reflux, cow's milk protein allergy etc. However, none were the case and with excellent peer support to suggest technique and position changes, share experiences and coping strategies, I persevered. If only all mothers could have this support, as by week six my supply regulated, my daughter found her groove and feeding became much easier.

With peer support for breastfeeding women restricted by the pandemic, paediatricians are even more likely to be an early contact for those experiencing breastfeeding difficulties. The ability to take a good breastfeeding history and support or refer mothers with breastfeeding issues

has never been more important, in addition to our role in recognising infants with medical issues. Whatever our own level of experience, we can utilise experienced colleagues and allied healthcare professionals when suspecting technical breastfeeding difficulties. And please signpost mothers to local infant feeding support groups, many of which have adapted with telephone and online support during the current times.



**Dr Jenny Lemon**

● Paediatric ST6  
● Warrington and Halton Hospitals NHS Trust

**M**y baby latched beautifully and by day five had regained her birth weight – fantastic! But by two weeks she was losing weight, vomiting frequently and at four weeks she virtually stopped latching. Realising I had an under-supply, I spent

the following few weeks on an unsustainable regime of breastfeeding, bottle feeding (mostly formula) and then expressing, leaving little time for anything else. Following a tongue-tie release, she remained frustrated at the breast, so I focused on expressing, supplementing the deficit in my milk production with formula, a regime I sustained until 10 months of age.

Multiple factors contributed to our feeding difficulties. I now respect this delicate supply/demand balance and appreciate the detrimental effect of overzealous top-ups on supply, especially when root causes of the difficulties aren't addressed.

I spent the first months riddled with guilt and tears over my breastfeeding experience. On returning to work I am hyper-aware of the significant emotional impact of breastfeeding difficulties. I now take more time talking to families whose babies present with early feeding problems, carefully considering the mothers' wishes, feelings and support available and working with them to devise a safe and manageable feeding plan.



**Dr Rebecca Clements**

● Paediatric ST4  
● Alder Hey Children's NHS Foundation Trust  
● @doctormumbec

**B**reastfeeding my first didn't come naturally but I was incredibly well supported by my family, friends and community breastfeeding team and I breastfed my daughter for two years, having only aimed for six months! I realised breastfeeding was a massive gap in my

paediatric knowledge base, so I began to research evidence-based lactation resources and trained as a volunteer peer supporter – a role I love. I discovered physiology and management options I'd never heard of! I'm currently breastfeeding my second daughter with much more knowledge on board and far fewer challenges.

Resources which have been invaluable to me include the Hospital Infant Feeding Network website, protocols from the Academy of Breastfeeding Medicine and peer support from the Breastfeeding for Doctors Facebook page.

## Key points

- Recognise the critical early weeks for establishing breastmilk supply.
- Breastfeeding difficulties can present with similar symptoms to medical diagnoses – include a breastfeeding assessment.
- Under supply and poor milk transfer can be treated in the short term by expressing to top-up but support is needed to do this alongside direct feeding.
- Breastfeeding difficulties can be highly emotive. Sensitivity is key.
- With good and timely support, many breastfeeding difficulties can be solved or even avoided.

▶ RCPCH position statement on breastfeeding [www.rcpch.ac.uk/breastfeeding](http://www.rcpch.ac.uk/breastfeeding)

# The Synapse Centre for Neurodevelopment

Dr Ben Marlow talks about the inspiration behind setting up The Synapse Centre and what he hopes to achieve



**Dr Ben Marlow**  
 ● Consultant Paediatrician and Clinical Director  
 ● The Synapse Centre for Neurodevelopment ESNEFT

**T**HE SYNAPSE CENTRE for Neurodevelopment ESNEFT (East Suffolk and North Essex NHS Foundation Trust) is a new research centre based in the East of England looking to translate biomedical research into practical therapies for local children and their families with neurodevelopmental difficulties.

It will harness the collective skills of a range of professionals including clinicians, speech and language therapists, physiotherapists and clinical psychologists. It will look to innovate and draw on new technologies and partnerships in research.

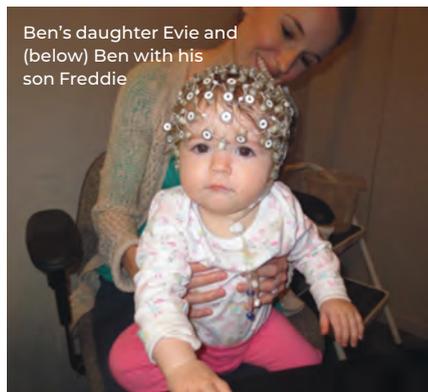
## Inspiration behind the Synapse Centre

Working as a paediatrician in neurodevelopment, I have designed and created the Synapse Centre driven by personal interest and circumstance.

My son Freddie is six years old. He has been diagnosed with severe autism and learning impairment, along with many comorbidities that impair his development. Not sleeping, suffering with abdominal pain, immune problems and sensory processing difficulties means learning and development for him is very difficult.

He is the inspiration for this centre and to raise awareness surrounding the importance of early intervention, collaboration and trying to correlate behavioural and biological impairments to have a more personalised approach to generalised 'umbrella' diagnoses.

My experience as a doctor and parent



Ben's daughter Evie and (below) Ben with his son Freddie



drives this project to better prioritise, fund and research a clinical area that consistently gets pushed to the side. It has taken me approximately three years to set the centre up and establish links with researchers from across the UK and the rest of the world with similar aims and interests. I have been enabled to pursue this interest through support by ESNEFT and a 'Greenshoots Award' awarded through the NIHR to take some time in my week away from clinical medicine.

## The Synapse Centre vision

Database; the centre aims to establish a ground-breaking database that seeks to combine data from a variety of platforms: social care, education, primary care and secondary care. Many children we see have 'umbrella' diagnoses of autism or learning impairment that don't truly reflect the underlying behavioural of biological phenotype.

Addressing comorbidities; many children with neuro-disabling conditions experience a host of medical co-morbidities: gastrointestinal issues, sleep disturbance, seizures and pain. All of these impact on the quality of life of the child and their families, but also their ability to learn and develop. Better recognition of these co-morbidities is central to the work of the centre and how they can be addressed and treated to improve quality of life and life expectancy.

New areas of research; understanding the roles of the microbiome, immune system and genetics in neurodevelopment give the potential to provide exciting breakthroughs in this field over the coming years.

Family lead; the centre has a core focus group of families and children from a variety of neurodisabling conditions. Their lived experience is vital to better understand and dictate themes of research. Monthly meetings will define research objectives and allow families and young people to be part of research decision making.

Education; to transform and invigorate this area of medicine is reliant on the 'up and coming' generation of doctors. Monthly external speakers from the UK and abroad, coupled with monthly journal clubs will raise questions, critically appraise research and combine interests and opinions. 

► **The Synapse Centre is keen to collaborate with anyone who shares our vision.**  
 Visit [www.synapsecentre.co.uk](http://www.synapsecentre.co.uk)

# COVID-19 in Ebola's well-trodden path

We hear from **Dr Bethany Bryant** on her experience of working in Liberia, first during the Ebola crisis, followed by the global pandemic of COVID-19



**Dr Bethany Bryant**

● ST1 Paediatric Trainee  
● Morrision Hospital, Swansea  
● @BBryant6465

**L**ITTLE PREPARES YOU for the helplessness of seeing families choosing to walk away from healthcare, too afraid of the cost. The cost of treatment and cost of a day's work lost. The Elwa Hospital, where I arrived in January 2019, provided the site for the country's first Ebola

treatment centre. Healthcare workers have been operating in a system of constant crises or recovery for decades. Nurses were managing the stresses of trauma from times of war and Ebola whilst having to constantly work in inadequate systems to provide quality patient care.

Attitudes of apathy, I am certain we'd all be susceptible to when faced with burnout. Trying to cope in overstretched systems with increasing demands, staff were losing hope.

May 2019 was the beginning of a pilot programme to address some of the issues and improve access to healthcare for the most vulnerable children in the community. Through training, mentoring and provision of basic medicines, we began to see results.

Then came COVID-19. Having barely taken a breath of recovery following Ebola, worries pounding through everyone's mind, hundreds of memories that haunted them daily. Within

hours, the systems in place from Ebola were reintroduced.

Soon, many healthcare workers were rapidly considered exposed or high risk. Hospitals closed as staff isolated. During Ebola we learnt many deaths resulted from the impact on strained health systems and fear around seeking healthcare. We had to prioritise keeping hospitals open and staffed during the coming weeks.

With few places left to maintain maternity services, Elwa became overwhelmed with mums and babies. Many didn't make it, only to the Emergency Department, too hot from long journeys of the dry season, some cold, still, others jerking, unresponsive to the phenobarbitone, no options for escalation.

Many children couldn't access the malnutrition clinic due to extra strains of their family's life, including increased transport costs to maintain social distancing. Some communities restricted movement of people in and out. Only the sickest children were able to pass through road blocks. The children's ward filled with neonates with respiratory distress, tetanus and severely malnourished children. We considered bringing supplies to the main villages we knew clusters of these patients were, but what if a community became infected following our visit? We did not want to lose trust. After all, we came from the first hospital in Liberia with a COVID-19 positive death and riots followed.

Some weeks passed, the stricter limits

reduced, and a flurry of patients returned, sicker than before. Mums shared their fears learnt from Ebola, a time when loved ones never returned, too scared to take that risk. Some clutched at strands of hair, the story of its protection, carried as charms. People profiting from fears.

Many will be left broken, unable to cope with the work that once revived them. Locally and globally, we admire colleagues, friends and families who will be facing extra challenges with waned strength and limited resources. In Liberia, many have stepped up to work in riskier environments and despite worries, and the harsh rejection they knew they would meet. Some were refused entry into marketplaces, rumours spread, and they survived only through the kindness of strangers. No clap encouraged these workers.



# What's it like to work from home as a shielding trainee?

A trainee and her supervisor share their experiences of the positives and challenges of a remote role



**Dr Sophie Jackson**

- STI Paediatric Trainee
- Community Children's Health Partnership
- @DrSophieJackson

**R**EWIND BACK TO March 2020. Along with 1.5 million others, I received notification of my new status, of Clinically Extremely Vulnerable (CEV) to complications from COVID-19. Government guidance advised shielding with immediate effect. As colleagues were preparing

for the toughest period of their working lives, I was contemplating an indefinite interval spent indoors. From the positives to the challenges, here's what I wish I'd known starting out on this journey.

I focused on education, creating a paediatric emergencies handbook, whilst formalising my teaching competency in a postgraduate certificate in clinical education. I was able to contribute to patient care through managing outstanding inpatient results, updating clinical guidelines and assisting with editing of a patient and parent information pack. I joined the RCPCH Equality, Diversity and Inclusion Member Reference Group, which enabled me to develop leadership and management skills. I wanted to maintain some clinical contact, so with an inclusive and creative consultant team I joined outpatient clinics virtually.

For wellbeing, I found peer support through a senior mentor, colleagues and other shielding doctors invaluable through shared experience. Regular chats and check-ins with friends provided that much needed social interaction.

## FINAL THOUGHTS

If we've learnt anything over the course of this pandemic, it's to live with uncertainty/

unpredictability. In paediatrics there's always going to be a level of risk – children are prone to viruses, particularly pre-schoolers. I think we need to manage the risk by being adaptable, for example when COVID-19 case numbers increase to think about redeployment to more COVID secure areas.

One of the main things I've learnt from shielding is the amount of curriculum that can be covered from remote working, both in terms of non-clinical skills but also doing virtual clinics/ward rounds/handovers. The other thing I've learnt is to volunteer for any projects that your department is undertaking. This is a great way to show enthusiasm and ensure you have a variety of work to keep you busy. In terms of protecting and valuing people with health conditions, hybrid working is an option to consider in future, with face-to-face work alongside remote working time. Doctors who have been shielding have proven that remote working can be productive both through contributing to teams but also individual professional development.



## A SUPERVISOR'S PERSPECTIVE



**Dr Alex Powell**

- Consultant Paediatrician
- Musgrove Park Hospital
- @A\_Powell\_ FRCPC

**THANK HEAVENS FOR** technology!

I could get to know my trainee and we were able to touch base regularly.

This helped with signposting and ensuring they had support for their wellbeing.

There were initial difficulties with accessing various

patient systems/platforms. A trainee wants to feel valued and have a sense of purpose. This, combined with drastically reduced acute work, meant there was little 'useful' for a trainee to do remotely. However, with virtual handovers, the trainee gained exposure to some acute inpatient presentations. We established weekly virtual clinics to join, moving onto joining face-to-face clinics remotely (patients seemed unfazed by having a doctor on screen as well as in the flesh). Remote in-house training enabled daily teaching from home.

Overall, I really enjoyed this supervision. It was a pleasure to see the trainee flourish and to witness how many useful experiences were achievable remotely that could be linked to the curriculum.

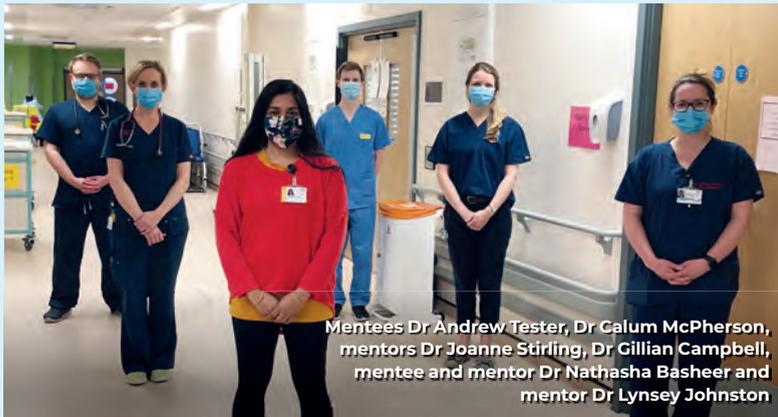
# Members

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



Mentees Dr Andrew Tester, Dr Calum McPherson, mentors Dr Joanne Stirling, Dr Gillian Campbell, mentee and mentor Dr Nathasha Basheer and mentor Dr Lynsey Johnston

## MENTORING

### RCPCH endorsed mentoring programme



**Dr Natalie Bee**  
● Paediatric  
Emergency Medicine  
Consultant  
● Royal Hospital for  
Children, Glasgow

**FOLLOWING THE SUCCESS** of our paediatric mentoring programme in the West of Scotland we have been sharing our journey to encourage other regions to start a similar rewarding initiative. We created a programme inclusive for anyone

in a paediatric post beyond foundation level, with the programme design being underpinned by the RCPCH mentoring standards. Designing your programme around these standards gives the programme a structure.

We created our own training programme for mentors and mentees consisting of online modules, recorded lectures and virtual Q&A sessions. Following completion of the training, mentees were then matched with mentors. Mentors are level 2/3 trainees, associate specialists and consultants.

▶ For further information on mentoring support visit [www.rcpch.ac.uk/mentoring-support](http://www.rcpch.ac.uk/mentoring-support)

We have also designed a CPD programme, with peer-supported learning workshops. Our CPD programme covers important topics including supporting the trainee with difficulties, peer support, wellbeing and human factors. We are delighted to have built a community of over 100 people with 45 mentees matched with mentors.

#### TIPS FOR SUCCESS

- Recruit enthusiastic, motivated and inspiring mentors for your community.
- Engage your target audience from the outset i.e. a survey to potential mentees.
- Produce a robust training programme with additional resources for mentees and mentors to feel empowered.
- Utilise peer supportive learning – learn from each other with group workshops.
- Create a continuous professional development programme for ongoing shared learning.
- Use feedback to adapt and make positive changes to your programme.

## HISTORY

### HISTORY TAKING: DR OTTO WOLFF



**I'D DECIDED TO** reward myself and read *Milestones* outside this summer. A cup of coffee, some of Ash's delicious baked goods and my Zero Day playlist form the perfect backdrop.

Unfortunately, I got distracted. A banging song came on and I belted out the chorus with a mouthful of lemon drizzle. As I picked up my magazine, it struck me that I'd found my tenuous segue into my chosen historical paediatrician instead.

Released in 1982, the song may have been dedicated to the retirement of a giant of the late 20th century paediatric world. Otto Wolff was born in Hamburg to a British GP but came to the UK when he was 16. He studied at Cambridge alongside his brother, graduating in 1943. His 'F2' job was in Italy, guarding a POW camp where he successfully delegated care of sick patients back to their families, which seems like a very good plan on a busy shift.

Back in the UK, he decided paediatrics was for him and trained in Birmingham, starting an academic track that would lead to the discovery of Abetalipoproteinaemia (why not Wolff syndrome?), the identification of the trisomy causing Edwards' syndrome and designed a special diet for babies with Phenylketonuria. All whilst he was in training. Show-off.



**Dr Richard Daniels**

- ST5 Paediatrics/  
Neonatology
- Barnet Hospital
- ▶ @ccdaniels65

He then moved to work at a little cottage hospital in Great Ormond Street, London. Under his guidance, the institution grew slightly and some of you may know it. He retired with a bevy of accolades and awards, but I think his most interesting achievement was creating the first obesity clinic for children.

Which is why he deserved the song, Hungry Like the Wolff.



## MIKE'S SLEEP TIPS

A hot bath or shower just before bedtime can help encourage sleep onset

See page 28

## ASPIRING PAEDIATRICIANS

### TEDDY BEAR HOSPITAL



#### Lily Marrable

- 4th Year Medical Student
- University of Nottingham



**THE TEDDY BEAR HOSPITAL (TBH)** is a community health education project for primary school children run by medical students.

It aims to reduce childhood anxiety about hospitals and doctors and promote healthy living. A secondary aim of the society is to promote the speciality of paediatrics to current

medical students. This led to the creation of TBH Nottingham's first ever paediatric conference.

The programme, hosted virtually, consisted of exciting and informative talks from 10 guest speakers, including consultant paediatricians of various sub-specialties, a paediatric trainee, a speech and language therapist, and three medical students who had completed research in child health. We learnt about paediatrics as a career, global child health and how to communicate with children with Down Syndrome.

We had around 100 delegates from first year medical students to FY1 level. For an online conference starting early on a Saturday morning and lasting over seven hours, we were thrilled with the turnout! We want to continue inspiring the next generation of paediatricians and are already excited to make our next conference bigger and better!

## TRAINEES

### A PAEDIATRICIAN WORKING IN ADULT ITU

**I RECENTLY UNDERTOOK** a placement with the Croydon University Hospital Adult ITU team. Although a steep learning curve, I have learned a significant amount working with this incredible team, and reflect on some differences within adult ITU compared to my previous PICU practice:

- 1** The patients are significantly bigger and heavier! Assisting manually handling and proning patients safely requires due consideration and real physical effort.
- 2** Encountering a greater deal of mortality amongst adults, having frequent discussions around resuscitation status and having to develop a broader understanding of end of life care.
- 3** In light of the pandemic, having increasingly emotionally challenging discussions with patients' families as they cannot physically visit their loved ones in COVID-19 ITU.

- 4** Having to think about typical adult presentations: Ischaemic heart disease! Pulmonary embolism! Decompensated alcoholic liver disease! Hyperosmolar hyperglycaemic



Melanie with her ITU team at the Croydon adult ITU garden

state! Fast Atrial Fibrillation! COVID-19 pneumonitis and its many complications!

- 5** Using unfamiliar drugs that are not used routinely in paediatrics and having to think about anticoagulation considerations for all patients!
- 6** Adult clinicians use point of care ultrasound (POCUS) far more routinely for vascular access, echo and lung assessments and diagnostics.
- 7** Increased requirement for central venous and arterial line placement – also their vessels are much bigger than children.
- 8** The routine placement of percutaneous tracheostomies especially during the COVID-19 era, which are done by the adult ITU team on the unit.

Following this job, I have gained an appreciation for the value of POCUS and will try to weave this into my paediatric practice. I will certainly miss the adults sitting still for cannulas, and even arterial and central lines, not needing singing, bubbles or cartoon distractions! Finally, I really believe as paediatricians, our training can make us versatile clinicians, with solid general medical knowledge, practical and communication skills that can allow us to be valuable within the adult ITU setting.



#### Dr Melanie Ranaweera

- Paediatric Registrar ST5
- Croydon Hospital
- @mellamellaran





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

### Supervisor

#### Dr Madeleine Rooney

Senior Lecturer Queen's University Belfast  
and Consultant in Paediatric and Adolescent  
Rheumatology, Belfast Hospital Trust

 @mmerooney

**1) Describe your job in three words.**

Children, joints, living.

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

A glass of wine.

**3) What two things do you find particularly challenging?**

Childhood chronic pain and waiting lists.

**4) What is the best part of your working day?**

Seeing a child respond to treatment.

**5) What is the one piece of advice you wish you could impart to yourself as a junior trainee?**

You won't have all the answers!

**6) Who is the best fictional character of all time, and why?**

Santa, makes childhood and adulthood magical.

**7) What three medications would you like with you if you were marooned on a desert island filled with paediatric patients?**

Antibiotic, steroid, ibuprofen.

**8) If you were bitten by a radioactive gerbil, what would you like your superpower to be, and why?**

Persistence; it gets you everywhere.

**9) What is the single, most encouraging thing that one of your colleagues can do to make your day?**

Be supportive.

**10) How do you think you, your colleagues and current trainees can inspire the next generation of paediatricians?**

Nothing comes close to watching your patients grow up into healthy, happy and productive young adults.

### Trainee

#### Dr Diarmuid McLaughlin

Paediatric Rheumatology Registrar, Musgrave  
Park Hospital, Belfast  
RCPCCH Trainee Network Northern Ireland  
Representative

 @diarmclaughlin

**1) Describe your job in three words.**

Interesting, challenging, rewarding.

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

Too many crisps to mention.

**3) What two things do you find particularly challenging?**

Confrontation – not something I'm keen on.  
Mastering joint ultrasounds to Dr Rooney's high standards!

**4) What is the best part of your working day?**

Walking away at the end of the day knowing that you've done your very best.

**5) What is the best advice you have received as a trainee?**

Work hard, work as a team and have a laugh.

**6) Who is the best fictional character of all time, and why?**

Paddington Bear – for his determination, bravery and good taste (marmalade).

**7) What three medications would you like with you if you were marooned on a desert island filled with paediatric patients?**

Ibuprofen, prednisolone and co-amoxiclav.

**8) If you were bitten by a radioactive gerbil, what would you like your superpower to be, and why?**

Pause time – for all those great life events.

**9) What is the single, most encouraging thing that one of your colleagues can do to make your day?**

Take the time to teach by motivating and encouraging learning. It can really make a difference.

**10) How do you think you and your colleagues can inspire the next generation of paediatricians?**

By providing insight into the best specialty (and sub-specialty) – we're a friendly, enthusiastic bunch!





**MIKE'S SLEEP TIPS**  
 Make your bedroom as quiet, dark and comfortable as possible  
 See page 28



**Dr Ashish Patel**  
 ● ST6 General Paediatrics & Sim Fellow  
 ● Birmingham Children's Hospital  
 @DrKidneyAsh



**BAKING**

# Ash's Baking School

**WELCOME BACK TO** another masterclass at Ash's baking school! Now you have mastered muffins and a tiered cake, the logical next bake was bound to be cookies. Cookies are an easy but rewarding bake, you can essentially combine all the ingredients in one bowl. I love having one (or five!) with a cup of tea or coffee, and you can play around with the flavours to make some delicious treats for your teams. These chai spiced sugar cookies are a firm favourite of my Indian mother. They combine my love of masala chai with baking and take me right back to my village in India. Enjoy and continue to spread the love of baking!

**Instructions**

1. Preheat your oven to 180°C and line two baking trays with baking paper.
2. In a large bowl sift together the plain flour, bicarbonate soda, baking powder and salt, and place to one side.
3. In another bowl combine the sugar, cinnamon, ginger, cardamom, masala chai and black pepper. Remove 30g of this sugar mix to roll the cookie dough balls in later.
4. Add the softened butter to the sugar spice mix and beat until

**CHAI SPICED SUGAR COOKIES**

**Ingredients**

- 345g plain flour
- 1 teaspoon bicarbonate soda
- ½ teaspoon baking powder
- ½ teaspoon salt
- 220g granulated sugar
- 2 teaspoons ground cinnamon
- 1 teaspoon ground ginger
- 1 teaspoon ground cardamom
- ½ teaspoon masala chai
- ¼ teaspoon ground black pepper
- 125g unsalted butter (soft)
- 1 egg
- ½ teaspoon vanilla extract

- combined and the mixture looks light and fluffy.
5. Next beat in the egg and vanilla extract until combined.
  6. Add the flour mixture and combine together to form a cookie dough.
  7. Create balls of dough and coat in sugar spice and place on your lined baking trays – you can make roughly 24 cookies, or fewer if you want them to be slightly bigger. Sprinkle some sugar spice on top.
  8. Bake for roughly 8-10 minutes. Leave to cool completely.

**VIRTUAL EVENTS**

## TIPS FOR ARRANGING A VIRTUAL EVENT

**AS THE NUMBER OF** digital learning events increases (clearly the need is still there) I have compiled my key tips for putting on your own virtual event. Last year when the London School of Paediatrics Annual Conference was cancelled, we set about transforming the event to a digital format and learnt countless lessons on the way.

**ATTEND A VIRTUAL CONFERENCE**

**BEFOREHAND:** You'll get a feel for what works and what doesn't, as well as which sessions translate to a virtual forum. It also highlights common technical pitfalls to avoid.

**CHOOSE SOFTWARE CAREFULLY:** A lot on the market, and most charge for premium features. All provide slightly different features. Do consider how much a package costs, or if any grants are available when deciding if you're charging attendees a fee.

**TECHNICAL DIFFICULTIES:** There will undoubtedly be issues on the day. Have someone on hand to troubleshoot and provide IT support, as well as easing the host's nerves.

**COMMUNICATION IS KEY:** You may never meet your speakers face to face, so clear, well-worded emails are crucial. Be specific! This goes for technical instructions too. Delegate communication should also be considered – a clear, eye-catching programme needs to be distributed ahead of time.

**CONTINGENCY:** Have a plan B, in case of difficulties, poor connection or tardiness. This includes a back-up facilitator, programme and device if necessary.

**INTERNET CONNECTION:** Organisers and speakers. Enough said.

**ZOOM FATIGUE:** Beware! Schedule short sessions with regular breaks. Encourage people to get up and stretch their legs. Keep sessions varied to spark interest, and interactive to stimulate engagement.

**FEEDBACK:** Be creative in how you ask for it and get it out promptly. Link to a URL or QR code whilst you have your delegates' attention.



**Dr Andrew Chapman**  
 ● Paediatric ST4  
 ● Northwick Park Hospital



**BOOK**

**BROKEN BRAIN: BRUTALLY HONEST, BRUTALLY ME** *By Aria Nikjooy*



**Dr Francesca Long**  
 ● STS Paediatrics  
 ● Tameside General Hospital

**ARIA NIKJOOY WAS** working as a paediatric trainee when he received the devastating diagnosis of Grade IV Cerebellar Medulloblastoma. This memoir is an exploration of his journey from initial diagnosis and treatment, to subsequent recurrences of the tumour and his death.

Aria does not shy away from the painful aspects of his diagnosis; the physical effects on a young man, the impact on his wife and young son, and his desperation to return to the job that he loved. It is raw, honest and not always an easy read.

There are times when his anger and frustration are palpable. However, there is also humour; Aria has a knack for picking up the comedy even in his darkest moments. Powerful imagery is present throughout the book, not just regarding his surgery and chemotherapy, but in the quiet way he describes his love for his wife and son.

I would thoroughly recommend this memoir to all my colleagues, not only as an opportunity to re-examine their views on their own mortality but, as Aria states, to “remember the person behind the patient”.



**BOOK**

**THE SLEEPING BEAUTIES: AND OTHER STORIES OF MYSTERY ILLNESS**

*by Suzanne O’Sullivan*

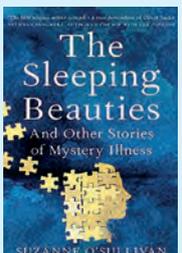


**Dr Shilpa Shah**  
 ● Consultant Paediatrician  
 ● Craigavon Area Hospital  
 ● @drshilpashah

**DESPAIR AWAITS HOPE** as a princess lies still. What poisoned fruit has she bitten into and is there a way out of the sleep that engulfs her?

Suzanne brings us fascinating stories of ‘mystery illnesses’ and in doing so, unravels a profound truth – we are as much an expression of our genes as we are a product of our environment. In a sense we are biology within a sociocultural phenomenon. As a clinician herself she

explains how mental illnesses requires more than a look within. Many answers in fact reside outside – be it the venom or the antidote. It is the very embodiment of culturally acquired illness templates that results in a behaviour pattern eventually resulting in functional symptoms. Through this book she implores us to broaden our horizons – else sleeping beauties will lie asleep. Forever and ever more.



**BOOK**

**THE GIRAFFE, AND THE PELLY AND ME**

*by Roald Dahl*



**Sophia**  
 ● Aged 8

**THE STORY IS** about four characters, a boy called Billy, a Pelly (a pelican), giraffe, and a monkey. They all have to clean lots of windows for the Duke as they have spent all their money on buying a house and they needed money to eat. When they get to the Duke’s house, the Pelly with the boy in his mouth end up picking berries for him. I thought the sad bit was when the Pelly got shot in the beak and the Pelly became really sad. The Duke said, “No worries Pelly, we can fix that.” I liked the ending the most because it was quite cheerful compared to what had happened to the Pelly. I would give the book ten out of ten, because I thought it was funny and I enjoyed the rhymes.

**APP**

**HEEADSSS** [app.heeadsss.uk](http://app.heeadsss.uk)



**Dr David James**  
 ● Consultant Paediatric Emergency Medicine  
 ● Southampton Children’s Hospital  
 ● @drdavejames

**THE HEEADSSS APP** provides adolescent psychosocial screening and resource signposting to young people from 10-24. HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs, Sex, Suicide prevention, Safety) is an internationally used tool to screen young people for potential risk and preventable harm. We developed the app locally in Wessex to provide

a bridge between asking screening questions and providing resources which can be sent directly to the young person by text or email. The database contains national resources as well as local resources for each region within the Wessex area, all mapped to individual HEEADSSS domains. The app was initially funded by Health Education England with further funding from Healthier Together, the National Academy for Social Prescribing and Arts Council England. It contains



sections for professional or parent led screening as well as a self-screening section for young people. We are keen to grow into other regions and are currently looking at the best way to achieve this.



# Providing care for children from around the world

For Dr Faizah Azim Hashimy working in the United Arab Emirates means working with a diverse group of children



**Dr Faizah Azim Hashimy**

- Chief Resident, Paediatric Residency
- Dubai Health Authority (DHA)



**BEING A PAEDIATRICIAN** in the United Arab Emirates means being a paediatrician that can cater for the wellbeing of children around the globe. I graduated from Dubai Medical College in 2017 after which I became an intern in Dubai Health Authority Hospitals, namely Latifa Hospital and Dubai Hospital. Later I joined the paediatric residency training programme as well.

Yet the first place I encountered paediatric patients was not during my intern years or even during my years as a medical student. Rather, my first time seeing a paediatrician at work was when people would visit our home to seek advice and care from my father, Dr Mohammad Azim Hashimy.

**My father was the model of an ideal healthcare provider:** he was generous with his patients, gentle, and made sure his patients got the care they needed. He would often see those patients at home after his work hours in the hospital and the clinic, seeing as not all the patients could afford hospital visits. With every patient visit I witnessed, it became more and more clear to me that I wanted to make a difference in the world in the same way my father did.

**Now for more than a decade,** I have called the UAE my home since I first moved here from Afghanistan in 2009. I came here with the goal of pursuing my higher education, becoming a medical doctor, and following in my father's footsteps, specialising in paediatrics.



**Working here,** I have been able to see first-hand what developed healthcare infrastructure really looks like; the UAE boasts a healthcare system with medical facilities which are modern and equipped with the latest treatment options, as well as tertiary centres, hospitals, and primary healthcare centres with different sub-specialties.

**The UAE has** a comprehensive, government-funded health service and a rapidly developing private health sector that delivers a high standard of healthcare to the population. Healthcare is regulated at both the Federal and Emirate level. Public healthcare services are administered by different regulatory authorities in the UAE including the Ministry of Health and Prevention, Health Authority-Abu Dhabi (HAAD), the Dubai Health Authority (DHA) and the Emirates Health Authority (EHA).

**Additionally, DHA hospitals** have a reputation for having one of the very well equipped NICU facilities in the region. The NICU facilities' large bed capacity allows not only for a larger number of patients to receive treatment, but the large number of

admissions gives us the chance to engage in management of critically ill neonates and perform different types of procedures during our training. Witnessing the growth of the premature neonates, their strength to withstand the stormy course of their stay in the unit and growing into healthy children is a major source of hope for the future.

**Moreover, with more than 50%** of the UAE's population being foreign-born, doctors here have the opportunity to see a variety of health conditions, be it inherited disorders which run in families such as syndromes and blood diseases or infectious diseases which are not common in the UAE but more so in travellers and visitors from all over the globe.

**Through the time** I have spent as a medical professional here in the UAE, I can say with certainty that working as a paediatrician in the UAE is like working in the centre of the world. Working here means being able to provide care for patients of every race, religion, and culture in addition to the citizens of the UAE, enabling us to fulfil the main aim of being a doctor: to serve humanity regardless of where they come from. 🌍





# Wellbeing

## The quest for meaningful sleep

Dr Mike Farquhar explores the need for sleep, both for patients and staff, and highlights the conditions that have led to excess pressures



**Dr Mike Farquhar**

● Consultant,  
Paediatric Sleep  
Medicine  
● Evelina London  
Children's Hospital

🐦 @DrMikeFarquhar

**IN OUR EVELINA London Sleep Clinic, we support many families whose children have significant sleep disruption in the context of complex physical and neurodevelopmental difficulties and differences.**

When children don't get the quality sleep they need, this can impact their health but can also cause far-reaching problems within the family. When parents and carers are chronically sleep deprived, it affects their physical and mental health, their ability to maintain jobs and, fundamentally, their ability to be the best parent to their children.

Quality sleep depends on a foundation of good routines and habits, often supported by behavioural interventions to effect change. This can often be misunderstood by those who think that if children have poor sleep, it's always because these principles are "not being done properly".

A harsh truth is that the 'rules' can be followed perfectly but for some, particularly those with complex needs, these simply aren't sufficient. Families

**"The resource gap has been filled by NHS staff drawing on their own reserves. Many are now running on fumes..."**

become despondent, convinced they've failed, not always recognising how chronic sleep deprivation is affecting them. For many families when I first meet them they are, like Wile E. Coyote in the *Roadrunner* cartoons, often already over the cliff edge, suspended in mid-air unaware they're already at the point of no return, about to plummet to the ground.

These children may need consideration of sedatives, to give parents time to recharge their own batteries. They may need social care support, providing respite or carer input. Above all, these families need to know they haven't failed, that they can give their all, for that not to be enough and for that not to be their (or anyone's!) fault - that some problems are too big to be solved by them alone.

Those same principles must apply when we think about our own teams. RCPCH has, for many years, long before COVID, emphasised the importance of looking after our members, providing support both individually and by changing the way departments and deaneries consider these issues. As a sleep physician, I've focused on helping members improve their own sleep, especially for those who work shifts, to try to give them the best individual foundation to face the challenges of our daily work.

The greatest problems we face in the NHS though are systemic, endemic, and weren't caused by the pandemic.

The Health and Social Care Committee, chaired by Jeremy Hunt,

recently published a report that told us what we all know - our NHS has been chronically under-staffed for years, and the resource gap that created has been filled by NHS staff drawing on their own reserves. Many are running on fumes but, like Wile E. Coyote in mid-air, haven't realised it yet.

### Self-care

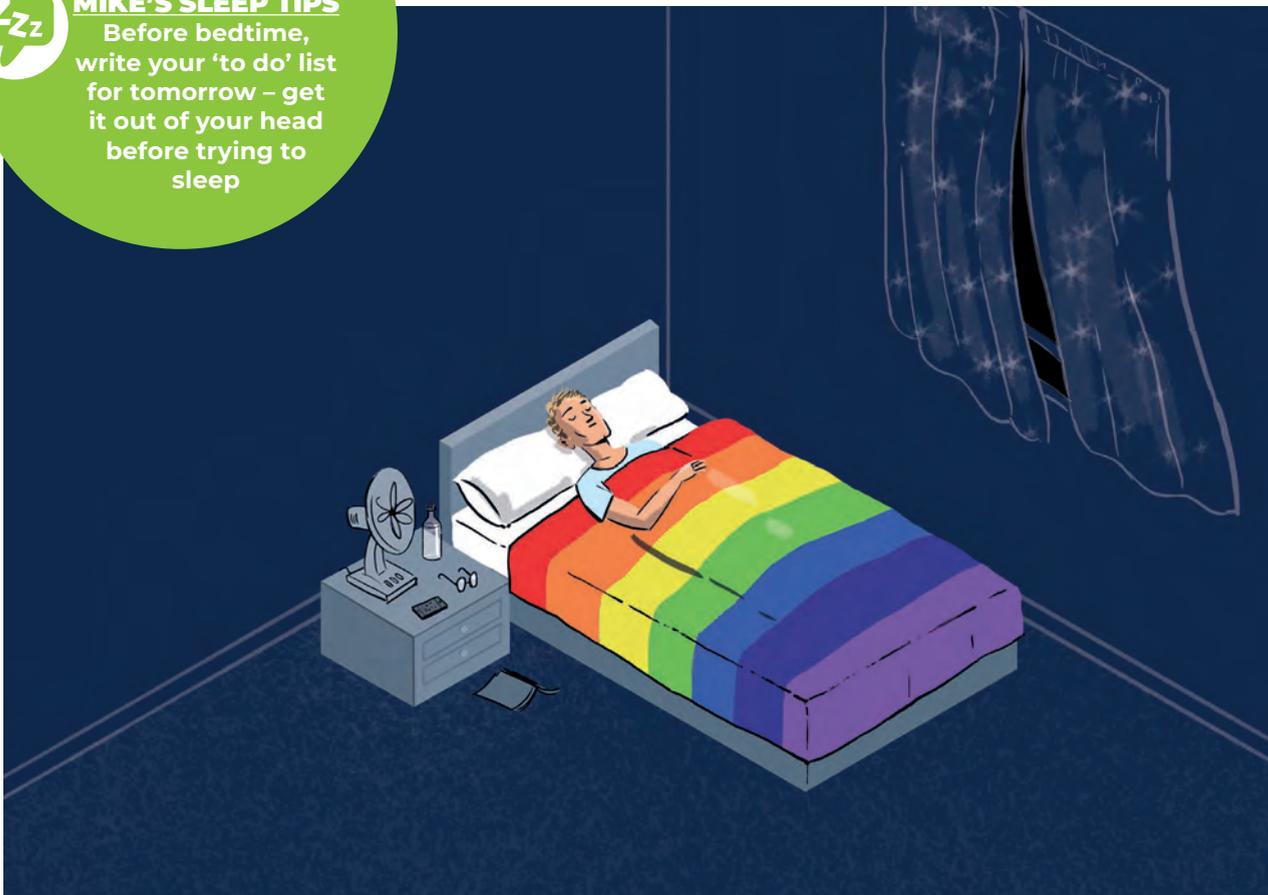
Hunt's report echoes earlier reports like the Health Education England Mental Wellbeing Commission, published February 2019, which asked "Who cares for those who care for the nation's health?", and the GMC-commissioned *Caring for doctors, caring for patients* report, published December 2019, whose co-author Professor Michael West said, "We can't simply go on the way we are, loading more responsibility onto doctors already struggling to cope. Where workloads are excessive, patient care suffers."

'Wellbeing' has been a cornerstone of the NHS response to the pandemic, with lots of fantastic work done to support staff. The brutal truth though is that, as brilliant and needed as that work is, by itself it isn't sufficient to deal with the problem. Solutions focused on individuals alone, no matter how fabulous, will never be enough to compensate for the massive systemic issues that have put us under immense pressure for many years now, a situation that has often been very much normalised across the whole NHS. We must be honest about



### MIKE'S SLEEP TIPS

Before bedtime, write your 'to do' list for tomorrow – get it out of your head before trying to sleep



this, otherwise individuals end up blaming themselves, thinking they've failed, for not being able to deliver for our patients and their families to the standards we know they deserve, for reasons which are not really within their control.

### Back to basics

As stated by Hunt, we need major reform of, and investment in, the NHS workforce – and that is going to take time. Until then we will have to work with what we have.

Where we now face long waiting lists and children and families who need our input and support, we must take the longer view, and emphasise that if we don't get looking after our staff right now, then many more will become ill, burn out and leave the profession... and children and families will end up waiting even longer for the care they need.

We must emphasise the importance of the basics, such as getting regular rest and breaks within shifts, and meaningful

regular time away from work to recharge. There is absolutely value in all the brilliant work to help individuals think about their own wellbeing. These need to be supported by departments and hospitals, but just like in my clinic, while these form part of an essential foundation, we must acknowledge they aren't a complete solution in themselves. We must allow ourselves to admit that in the modern NHS we can individually give our all, that that may not be enough, and that isn't necessarily the 'fault' of individuals and departments... and we must better communicate that message to our patients, their families and the public.

The World Medical Association Declaration of Geneva reminds us that healthcare practitioners must "attend to their own health, wellbeing and abilities in order to provide care of the highest standard".

In the context of a system that is currently incapable of meeting our population's health needs, we

must remember that looking after healthcare staff is a key professional responsibility, borne primarily by employers, NHS organisations and Government, and that individuals must not be made to feel guilty for needing time and space to look after themselves, in the best interests of them and our patients.

... but yes, working to get good sleep most nights is always going to be a small but important building block of our own individual responsibilities around this!

### Useful Links

Evelina London Sleep Clinic

[www.evelinalondon.nhs.uk/sleep](http://www.evelinalondon.nhs.uk/sleep)

Sleep, breaks and wellbeing for health professionals

[www.rcpch.ac.uk/sleep-breaks](http://www.rcpch.ac.uk/sleep-breaks)

Advice from Dr Mike Farquhar on managing the effects of shift work

[ep.bmj.com/content/102/3/127](http://ep.bmj.com/content/102/3/127)

Paediatrics 2040 – Working lives: Supporting report on wellbeing

[paediatrics2040.rcpch.ac.uk](http://paediatrics2040.rcpch.ac.uk)



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- Renapime® [cefepime] for bacterial infection

*MHRA advice:*

- Domperidone for nausea and vomiting: lack of efficacy in children; reminder of contra-indications in adults and adolescents

*Dose changes:*

- Epipen® preparations (adrenaline/epinephrine) [body-weight ranges for children's dosing updated]
- Idursulfase [updated age range]
- Qvar® (beclometasone dipropionate) [age-range extension]

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Slenyto, the first and only licensed melatonin indicated for the treatment of insomnia in a paediatric ASD population\* (2 to 18 years where sleep hygiene measures have proved insufficient)<sup>2</sup>



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#### SLENYTO® PROLONGED-RELEASE TABLETS 1mg and 5mg

**PRESCRIBING INFORMATION:** Please refer to Summary of Product Characteristics (SmPC) before prescribing. **ACTIVE INGREDIENT:** Melatonin 1mg or 5mg. **INDICATIONS:** Insomnia in children and adolescents aged 2-18 years with Autism Spectrum Disorder and/or Smith-Magenis syndrome, where sleep hygiene measures have been insufficient. **DOSAGE AND ADMINISTRATION: Dose titration:** Recommended starting dose is 2mg once daily. If an inadequate response is observed, increase the dose to 5 mg, with a maximal dose of 10 mg. Data are available for up to two years treatment. Monitor at regular intervals (at least every 6 months) to check that Slenyto is still the most appropriate treatment. After at least 3 months, evaluate treatment effect and consider stopping if no clinically relevant treatment effect is observed. If a lower treatment effect is seen after titration to a higher dose, consider a down-titration to a lower dose before deciding on a complete discontinuation of treatment. **Administration:** Once daily 0.5-1 hour before bedtime with or after food. Swallow whole, do not crush, break or chew. To facilitate swallowing, tablets may be put into food such as yoghurt, orange juice or ice-cream and then taken immediately. **CONTRAINDICATIONS:** Hypersensitivity to the active substance or to any of the excipients. **SPECIAL WARNINGS AND PRECAUTIONS:** Use caution in patients with renal insufficiency. Not recommended in patients with hepatic impairment. Children under 2 years: not recommended. Slenyto may cause drowsiness, therefore use with caution if the effects of drowsiness are likely to be associated with a risk to safety. Not recommended in patients with autoimmune disease. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine. **INTERACTIONS:** Concomitant use with fluvoxamine, alcohol, thionidazine, 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. **DATE OF REVISION OF PRESCRIBING INFORMATION:** March 2019.

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

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

**References** 1. Paediatric Formulary Committee. *BNF for Children* (online) London: BMJ Group, Pharmaceutical Press, and RCPCH Publications <http://www.medicinescomplete.com> [Accessed July 2020]. 2. Slenyto SmPC May 2020.

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