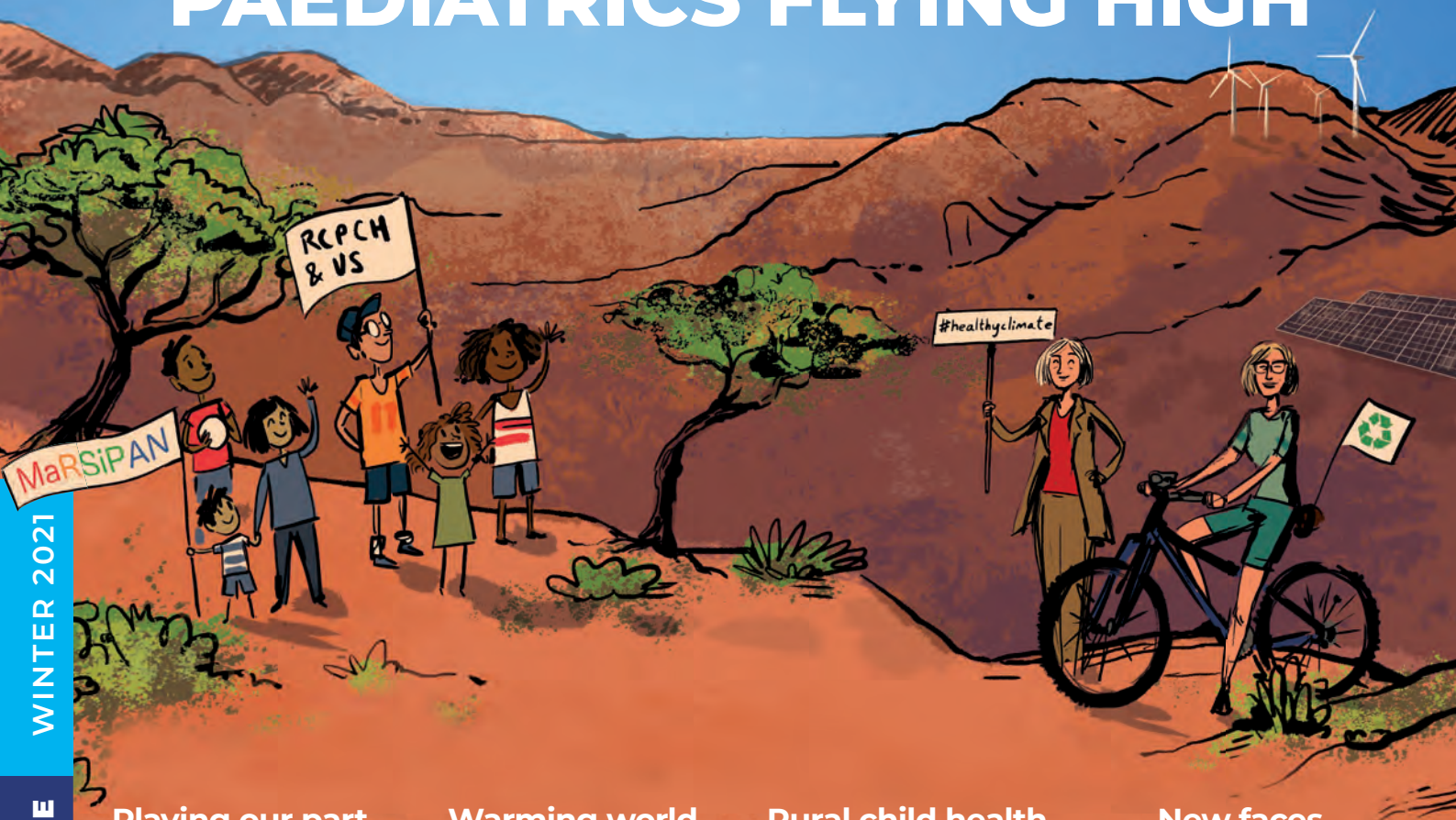
RCPCH

Milestones

The magazine of the Royal College of Paediatrics and Child Health

PAEDIATRICS FLYING HIGH



WINTER 2021

INSIDE

Digital Growth Charts API

From print to digital for better child health

To support the drive to digitise healthcare, the RCPCH has developed an award-winning API offering the following:

- Safe, accurate and familiar-looking digital growth charts for clinicians, whatever their digital platform
- Automatically calculated centiles and SDS (z-score) for height, weight, head circumference and BMI. Plus, bone age and event tracking functionality
- Easy integration into your existing clinical system. Plus support and links for developers and health professionals to get you started
- Opportunities for EPR suppliers to build clinical apps and interfaces

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

HTN AWARDS 2020 WINNER

OpenUK Awards 2021 Shortlist
OpenUK

To find out more: www.rcpch.ac.uk/digital-growth-charts

To sample the demo/documentation: https://growth.rcpch.ac.uk

To email us for further info: growth.digital@rcpch.ac.uk

Medicines for Children

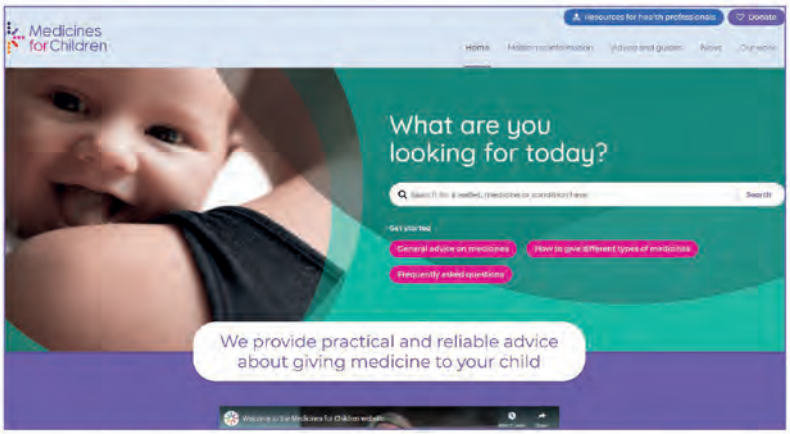
*"I am very proud of **Medicines for Children** and the support it provides to parents and carers in the UK, and around the world. I sincerely hope that you enjoy looking around the new website."*

Dr Camilla Kingdon, RCPCH President

Celebrating 15 years of delivering the best and most up-to-date information, **Medicines for Children** has relaunched the website with a brand new look.

The website continues to provide all of the key information on over 220 children's medicines, specially written to help parents and families, but now it offers even more resources on how to safely give medicines to children.

medicinesforchildren.org.uk



How to give medicines: liquid medicine using an oral syringe

How to give medicines: eye drops

Resources for health professionals

Editor's pick

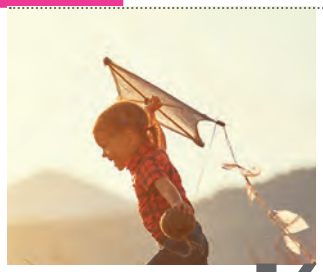
The editorial team is pleased to bring you our Winter edition of *Milestones*. I hope it brings some relief and down-time as our days get shorter and more hectic, and solidarity between us as College members. There is a theme running through many of the fabulous articles, of looking beyond the immediate 'fixable' problem and deliberate exploration of what is unfamiliar to us and therefore uncomfortable to hear, with the acknowledgement that this may not lead to solutions. Simply asking, listening and learning opens up the possibility of personalised care for our patients and colleagues alike, and avoidance of a sticking-plaster approach which neither builds resilience in health, nor in our healthcare system or workforce. My personal favourites for the reasons above, and in my new role in weight management, are pieces on the ever-emerging impact of the pandemic on disordered eating at both ends of the spectrum, screening for poverty, understanding masked neurodivergence in our workforce, and the power and comfort of *Team Time* storytelling.

Dr Dita Aswani
Consultant Paediatrician
Sheffield Children's Hospital

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

Contents

Winter 2021



14

12

16

THIS ISSUE

EVERY ISSUE

Milestones

25 Our history, your future RCPCH

jamespembroke media

Head of Design: Simon Goddard **Project manager:** Lizzie Hufton **Publisher:** James Houston. *Milestones* is published four times per year on behalf of the Royal College of Paediatrics and Child Health by James Pembroke Media, 90 Walcot Street, Bath, BA1 5BG. **T:** 01225 337777. **Advertising:** Alex Brown, Head of Corporate Partnerships **advertising@rcpch.ac.uk**

EDITORIAL Managing editor: Aisling Beecher @AislingBeecher **Editorial board:** Dr Seb Gray @SebJGray Dr Hannah Baynes @HLB27 Dr James Dearden @drjamesdearden Dr Dita Aswani @DrDita Dr Maddy Fogarty Hover @I_am_spottacus

FSC www.fsc.org MIX Paper from responsible sources FSC® C017177

Update

The latest news and views

KEEP IN TOUCH

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

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

STRATEGY

OUR VISION FOR LEADING THE WAY IN CHILDREN'S HEALTH

Dr Camilla Kingdon

● *RCPCH President*

@CamillaKingdon

WELCOME TO OUR winter edition of *Milestones*! I think this is probably the most important edition of each year. I have to confess to finding winter a tough time with the shortening of daylight hours and the chill in the air.

My daughters always remind me that this time of year gives us a legitimate excuse to do lots of baking and organising of parties and festivities, but nevertheless I think it's the one edition of *Milestones* which I look to as much as possible to lift my spirits. I'm delighted to tell you that the 2021 Winter edition is going to do exactly that!

I would like to take this opportunity to acknowledge the huge pressures our entire workforce is under currently. Winter is always our busiest time but 2021 seems to be taking activity to new and unprecedented levels. I don't think there is any part of our services that is not under immense pressure as we deal with recovery from the pandemic at the same time as coping with very large numbers of children needing care and attention across all parts of the system. I am in awe of how hard everyone is working, and the level of commitment displayed by all. I am, however, not complacent about how hard it is for every one of us. The College is committed to doing all that we can to find solutions with all our partners across the four nations, showcase ideas and innovations, and speak up when patient safety is threatened.

While this edition is the final one for 2021, it is with great pride and optimism that this edition also showcases our College Strategy for 2021 to 2024. This is our forward-looking plan for the next three years – the 'guide rails' for our work going forwards. I would love all our readers to look carefully at what we are committing to do. The rationale for consulting widely and then carefully describing our strategic direction for the future is that it gives us clarity of purpose for what we need to prioritise and also what we are not best placed to do. The world of child health is huge and the needs are massive. The risk of taking on too much and delivering very little is real and so our strategy will help us to stay on course. We describe a number of exciting ambitions, and we invite our members to not just hold us to account but also hopefully get involved in delivering our goals. We are committed to regular reviews so that we can, if needs be, nimbly change course should something significant and unanticipated impact either our paediatric workforce or child health more widely.

RCPCH climate change recommendations
Medical schools should look at including the climate crisis in undergraduate education

I recognise that there are times when it feels like the problems are insurmountable and the solutions are scant. It is at times like these that our interconnectedness becomes our most precious weapon – recognising how connected we are as paediatricians is hugely important in helping us cope with the most difficult situations. *Milestones* is one of the ways we connect, and I sincerely trust this edition helps each of us remember that we are part of a wider community of colleagues committed to the same goals.

With my best wishes to you all,

Camilla

COLLEGE PRIORITIES

- Support innovation and development of digital skills
- Make the College accessible to all levels and all specialties
- Deliver professional paediatric exams and training in the UK and abroad
- Act on the perspective of children and young people, putting them at the heart of everything we do

FOCUS ON

- Creating a College that feels like a place for all members
- Inspiring paediatricians of the future
- Safeguarding the future of the College

▶ *Visit*
www.rcpch.ac.uk/college-strategy

HQ

New members' area at RCPCH

Jo Revill
● *RCPCH CEO*
@8jorev

THE SWITCH TO remote working and the fact that many more members have been able to join our events, webinars and conferences online has led to a rethink about how we use the building. The office building that we have in Holborn, built in the 1980s, has provided us in the past with the ability to run many activities there – our training courses, committee meetings, evening events and our &Us activities on Saturday mornings.

But the design has not been conducive to new ways of working and didn't enable members to meet staff more easily or to make use of the facilities that we have, so we spent the summer carrying out a refurbishment of the building to create more collaborative spaces and move to a more open-plan layout.

We have also created a new members' area on the ground floor, so that members and Fellows can benefit from the facilities here, having a space with meeting rooms, wifi and where they can enjoy a more relaxing conversation with colleagues. We do hope that you will come to the College and enjoy this new facility when you're able to do so.

I wanted to mention the input of the Epilepsy QI collaborative work. We were pleased to receive additional funding to expand upon our activities this year. Clinical teams across the country are participating in monthly support calls as part of an eight-month programme giving practical training and support to build up teams and help engagement with young people and families. I think it's an example of where we can really support teams living the daily reality of the challenges when resources may be limited. Well done to our volunteers, young people and staff who have worked so hard to achieve this.

RCPCH climate change recommendations

Governments should include a child rights risk assessment in all climate policy decisions

OUR SUSTAINABILITY JOURNEY

100% OF OUR WASTE IS ALREADY RECYCLED

95% OF OUR NEW FURNITURE IS RECYCLABLE

80% OF OUR ENERGY HAS BEEN REDUCED BY SWITCHING TO LED

80 MEMBERS ARE VOLUNTEERING IN OUR CLIMATE CHANGE WORKING GROUP

15 MEMBERS ARE WORKING WITH US ON A PLAN TO REDUCE OUR CARBON FOOTPRINT

2040 OUR COMMITMENT TO BEING A NET-ZERO ORGANISATION

INVOLVEMENT

Representing paediatricians on the Joint Committee for Vaccination and Immunisation

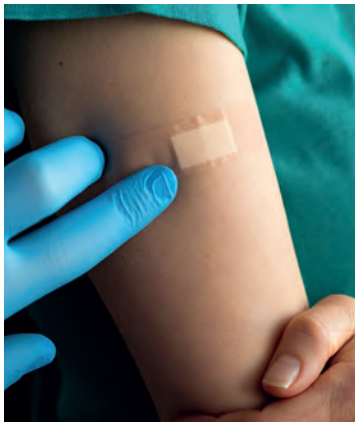
Dr Maggie Wearmouth

- *Retired Consultant Paediatrician / GP*
- *East Sussex*

@WearmouthM

I AM A retired paediatric consultant, currently a working GP with an interest in paediatrics and as a vaccinator. I have been a member of the Joint Committee for Vaccination and Immunisation (JCVI) since 2012. The JCVI gives independent and expert vaccination advice to the Secretary of State. There are normally 20 members. There are two other paediatricians, Prof Adam Finn and Prof Simon Kroll, and another GP with an interest in paediatrics, Prof Anthony Harnden.

In pre-pandemic times, the committee met three times a year with occasional sub-committees.



Life suddenly got busier when JCVI was given responsibility for advising the UK government about the COVID-19 vaccination programme and a sub-committee was established, chaired by Prof Wei Shen. The JCVI has transformed from a low profile/high status committee to being a central player in determining and explaining vaccine policy on the global stage. Confidentiality, accountability and political neutrality are extremely important.

We have meetings twice a week which need hours of advance reading. They may be called at short notice if rapid advice or international discussions are needed, the most recent being the risks of myocarditis in children related to mRNA vaccines involving UK and US colleagues.

Out of eight females on the committee, four have voting rights but I am the only one with time to undertake a role in communicating the advice through the media. I have taken part in live interviews and public phone-ins on national media, often at short notice. This can be time consuming but also fascinating and very rewarding, as it is vital that we are transparent about our advice to help maintain public confidence in the vaccines.

I co-authored the ethics framework for COVID-19 vaccination of children. We focused on the goals of vaccination in terms of risks, benefits and alternatives as well as the scope of information needed for valid consent involving children and parents and guardians. We really wanted to emphasise the care and altruism shown by young people living with vulnerable family members.

I spent years advising parents about vaccination, especially MMR. I remain passionate about the positive vaccination message that can be conveyed by paediatric staff who are trusted by parents and patients alike.

Top tips when talking to patients/parents about vaccinations:

- Listen to concerns with empathy and respect
- Reassure that it is OK to be unsure
- Agree common objectives such as wanting to protect the child from harm
- Explore previous experiences and information sources
- Explain how vaccines work in simple terms

Not everyone will be able to allow themselves or their child to be vaccinated but a supportive consultation can lay positive foundations for future advice.

Read about COVID-19 vaccinations for children and young people www.rcpch.ac.uk/covid19-vaccination

NEW ROLE

New Chair of the BPSU Scientific Committee

Dr Peter Davis
- *Consultant Paediatric Intensivist*
- *Bristol Royal Hospital for Children*

@BPSUtweet

I AM HONOURED to have been appointed the new Chair of the BPSU Scientific Committee. I am a consultant in Paediatric Critical Care at Bristol Royal Hospital for Children, which means that from time to time, I encounter some of the rare conditions that the BPSU monitors. I have a particular interest in epidemiology, and until recently I was the chair of the Paediatric Intensive Care Audit Network (PICANet) Clinical Advisory Group. I was also the Chief Investigator for a BPSU study of chylothorax, and more recently I have been involved with the study of PIMS-TS. The first findings of which were published earlier this year, and data collection continues as we continue to monitor the effect of the COVID-19 pandemic on children.

The BPSU is rightly held in high regard worldwide for the work that it has undertaken over the past 35 years. Its strength has always been the engagement that we have had from our consultant body, completing their 'Orange Cards', and this will remain necessary as we go forward with the BPSU. My aim is to engage more paediatricians to link actively with the BPSU and its work, including through the recent development of webinars, which have been very successful, as well as reaching out to the various sub-specialty groups to ensure that we have a wide range of conditions being studied.

Rare diseases are currently in the spotlight, with various initiatives from government, and through the BPSU, paediatricians have a unique system through which to investigate and broaden the understanding of uncommon and unusual conditions affecting children. It is an opportunity that should be too good for us to miss!

Surveillance of BPSU Rare Childhood Disease

▶ ***Find out how you can get involved with the BPSU www.rcpch.ac.uk/bpsu***

Staff Spotlight

Patrick Cullen

- *Head of Membership*

@patrickwfcullen

I HAVE WORKED at the College since 2018 – I was interviewed on the morning of my wedding day and was offered the job just before the wedding dinner, so things got off to a great start!

I can honestly say that running the membership team is a real privilege, because paediatric staff are some of the most dedicated and warm-hearted people you could hope to represent. That doesn't mean it's easy of course. Our small team deals with over 100 member queries a day, as well as providing this magazine and loads more content, all intended to help you feel connected to the wider paediatric community.

My favourite part of the job is getting to spend time with clinicians, especially the few times I've been able to visit a paediatric department and get a better feel for the daily reality. It helps us to keep things in perspective; no matter how busy we may feel, it's almost always a thousand times busier for you guys working on the frontline.

I am fortunate to be able to work flexibly, which means I spend Wednesdays with my three year old son, although at times it feels tougher than a work day! Beyond that, you'll find me playing or watching football, particularly indulging my masochistic side as a Crystal Palace season ticket holder.

NEW APPOINTMENT

NEW CHAIR OF THE BOARD OF TRUSTEES

Joanne Shaw
● *Chair of the Board of Trustees*

IT IS A HUGE privilege to be joining the College as successor to Mary Marsh as Chair. My excitement comes from respect for the contribution that the College makes to the health and wellbeing of children and young people, not just in the UK but around the world. A long career in healthcare has taught me the importance of genuine partnership between people and health professionals, to create the best outcomes and to enable a sustainable NHS for everyone. I can see that technology, in particular, is changing the relationship between individuals, their own health and wellbeing, and the people and systems that provide their care. Having been until recently on the board of NHS England, and as current Chair of Audit & Risk at Cancer Research UK, I can see that COVID-19 has dramatically accelerated these developments and given us a new set of challenges and opportunities, as well as leaving us with some old ones.

In my role as Chair, I will lead the Board of Trustees in having overall scrutiny and oversight of the College's activities. This involves particular focus on assurance around risk, financial issues, and ensuring fulfilment of its charitable objectives. Council and Executive Committee both report directly to the Board of Trustees.

It is clear that the College is emerging from the pandemic stronger and more confident in its role as a trusted voice on child health. I would like to see it add even greater value for its members, and for more members to be actively engaged in its work. I am looking forward tremendously to working closely with the President and Chief Executive, fellow trustees, members and staff to implement the new strategy. So far almost everything has been remote, so I can't wait to get off screen and into the real world!

JOURNAL

BMJ PAEDIATRICS OPEN

Imti Choonara
● *BMJ Paediatrics Open Editor-in-Chief*
@BMJ_PO

MÉDECINS SANS FRONTIÈRES (Doctors Without Borders/MSF) is an international medical humanitarian organisation specialising in responding to humanitarian emergencies. It provides healthcare to millions of children, who would otherwise receive no healthcare. Unfortunately, research into health problems of children living in areas of conflict or remote rural areas in poor countries is limited.

MSF Paediatric Days was started in 2016 with the aim of addressing urgent paediatric issues of direct humanitarian concern. The most recent MSF Paediatric Day was held online and involved more than 1,000 people from over 90 countries worldwide. *BMJ Paediatrics Open* is proud to have published a review of the two-day event. Five major themes were discussed: essential newborn care, community-based models of care, paediatric tuberculosis, antimicrobial resistance in neonatal and paediatric care, and the collateral damage of the SARS-CoV-2 pandemic on child health.

We hope to continue to work with MSF to address the imbalance in research and publishing, with more articles on neglected diseases and neglected communities.

JOURNAL

ADC JOURNAL UPDATE

Nick Brown
● *Archives of Disease in Childhood Editor-in-Chief*
@ADC_BMJ

JOURNALS ARE IN the (near) uniquely privileged position of being able to disseminate information that changes practice and to provide a forum for debate, all one hopes for the better. Used sensitively, these assets might foster an affection and loyalty follows, but these can't, of course, be taken for granted. One prerequisite is knowing when to change, when to tweak, essential to which is working out what energises and (in the broadest sense) entertains readers

The paediatric emergency department is (now more than ever as some COVID-19 dust settles) unarguably the hub of hospital activity as well as the main acute portal of entry from primary care. Emergency medicine is unique in terms of scope, practice and prerequisite speed of thinking. This thinking is the catalyst for our new paediatric emergency medicine (PEM) section convened by Cynthia Mollen at the Children's Hospital of Philadelphia. Your ideas here are so important – we want to combine science with infrastructure and interface with international differences – and your thoughts so welcome.

TRAINING

GMC approves new training programme

Dr Christine Pierce

- *Consultant Paediatric Intensivist*
- *GOSH*
- *RCPCH Officer for Training and Quality*

@0603

I AM LOOKING FORWARD to the challenges of my new role as Officer for Training and Quality at the College. As a way of introduction, I am a Paediatric Intensive Care Consultant at Great Ormond Street Hospital and was the Clinical Lead for the development of the Progress Curriculum at the College. This is an exciting time in Paediatric Training with the onset of Shape of Training and the movement towards a two-level, run through specialty training programme. The paediatric training programme will be underpinned by 11 training principles which are introduced in the Paediatrician of the Future document. This document articulates the standards we should be aiming towards in training and maximising learning opportunities through good supervision. The aim is to encourage flexibility whilst promoting integrated care and efficient multi-disciplinary working. The GMC has recently approved Progress+, our updated curriculum which supports the two-level, run through specialty training programme. Progress+ builds on the success of Progress and will be implemented in 2023. As the Progress curriculum is now well established the focus has now rightly shifted to ensuring the quality of training, where every patient encounter is seen as a learning opportunity. Progress+ will drive improvements in the trainee experience across the four nations and supports flexibility for trainees with increased opportunities for out-of-programme training.

Working in the College has been a fantastic experience. I am looking forward to continuing to work with old friends and getting to know new colleagues, who have a common aim of advocating for child health.

▶ ***For more information on Progress+*** ***www.rcpch.ac.uk/progressplus***

Dr Arpana Soni and her paediatric nurse colleagues Shelina Yasmin and Arlinda Bala

TRAINING

Introducing 'Training principle of the month'

Dr Fiona Hignett

- *Consultant Paediatrician*
- *Poole Hospital*
- *Outgoing RCPCH Vice Chair of the Trainees' Committee*

@FionaHignett

AS MY TENURE WITH the Trainees' Committee (TC) draws to an end, I've been reflecting on how fortunate I've been in collaborating with the most inspiring and diverse group of College staff and paediatricians. The fantastic work of the TC will of course continue, with the next exciting initiative: bringing to light the 11 training principles from 'Paediatrician of the Future'. Over the next year, each month the TC will highlight a 'Training Principle of the Month' by sharing personal stories, case studies and teaching resources to support trainees in getting the best possible training experiences and achieving the Progress+ curriculum key capabilities.

For me, the heart of the training principles is to provide trainees with a high-quality, bespoke and personalised training journey as highlighted by principle 7, 'training time and learning opportunities are prioritised', and 11, 'progression and length of training are personalised'.

Now more than ever, we recognise how intrinsically linked all aspects of physical, mental and public health are – so it's fantastic that principle 5 advocates 'a biopsychosocial approach is applied at all times'. With this comes the welcome ambition to increase collaborative training and learning opportunities with allied colleagues in general practice, child and adolescent mental health and public health settings.

We know from young people that amongst other things, the best doctors are those who are respectful, kind, open minded and actively listen – so it's our job to make sure that we fulfil these attributes to the best of our ability by ensuring 'patients and families are heard' (principle 4).

Hopefully this has given you a flavour of what to expect. As with all TC initiatives, it's a team effort – so if you have any ideas or would like to get involved, Laura and the team would love your help.

Thanks TC – it's been a blast (especially the karaoke!).

▶ ***Explore our new training principles***
www.rcpch.ac.uk/training-principle-1

RCPCH climate change recommendations

Paediatricians should consider how they can promote sustainability in their hospital

World in action

Members of our Climate Change Working Group on how warming affects global child health

p14

Read more

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

Diary Dates

We're working on our programme of courses for 2022, but here are some of the upcoming online courses and events. More will be published on our website in the next few weeks

- **Expert witness in child protection (Level 3+, 4, 5)**
  1 December
- **How to Manage: Common cardiac problems**
  19 January
- **How to Manage: FASD in community paediatric services**
  7 February
- **How to Manage: Leadership and Practice in health improvement**
  8 February
- **Statement and report writing – England/Wales (Level 3)**
  18 February
- **How to Manage: Paediatric Allergy Training 1 (PAT 1)**
  2 March
- **How to Manage: Gastroenterology**
  7 March
- **How to Manage: Benign haematology**
  17 March
- **Statement and report writing – England/Wales (Level 3)**
  1 April
- **Statement and report writing – Northern Ireland (Level 3)**
  17 May
- **How to Manage: Paediatric Allergy Training 2 (PAT 2)**
  21 June

WEBINARS

- **Childhood obesity – medical management**
  Our experts present practical and current guidance on how to identify obesity in the clinic, providing an approach to broaching the subject with children, young people and their families.

- **Lead toxicity in children – a continuing problem**
  Hear current evidence, guidance and information to increase awareness of lead exposure in children.

- **BPSU-RCPCH webinar series - Type 2 diabetes in children and young people**
  Prof Julian Hamilton-Shield & Prof Tim Barrett present practical information and guidance for managing type 2 diabetes in children.

See more

See all College webinars
www.rcpch.ac.uk/webinar-archive

The impact of climate change on child health at home and abroad: COP26 and beyond

Date: 26 November

Join us online for our first climate change event to find out:

- Why this is a priority for the College
- What COP26 means for children and young people
- The impact of climate change on global child health: roles and responsibilities of paediatricians
- Understanding the mental health needs of children and young people in relation to the climate emergency

Find out more: rcpch.ac.uk/climate-change

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

RCPCH climate change recommendations

All children should have access to their fundamental economic and social human rights

Getting to Gold

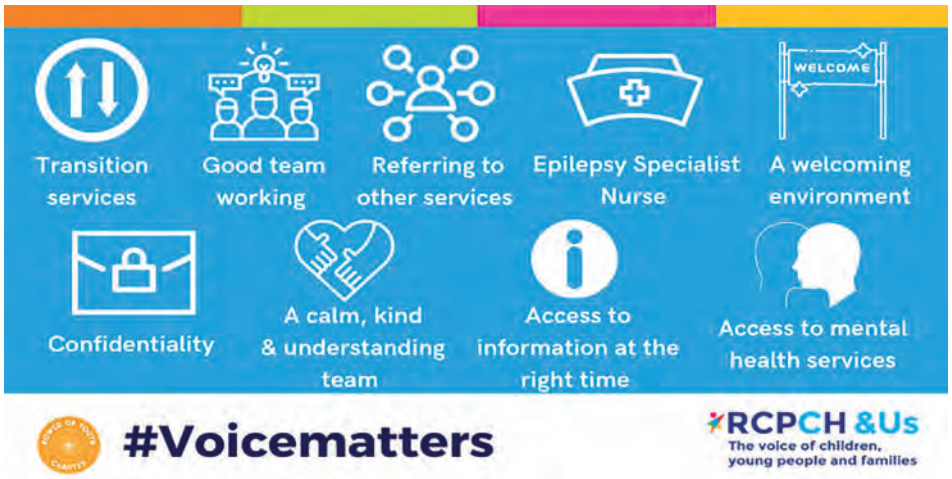
Young people from the Epilepsy12 Youth Advocates have been working together through lockdown with clinics to help them to be gold standard services. In September they presented their findings to the Epilepsy12 OPEN UK annual conference

TWO VOLUNTEERS SHARE THEIR EXPERIENCES OF BEING INVOLVED:

OWEN: I've been involved since the beginning of the project, and despite COVID-19, we've achieved a huge amount over the last year where we have been helping clinics to think about being a gold standard service for supporting worries associated with epilepsy. We've won two national volunteer awards, supported the audit report with our own chapter, virtually visited clinics, been interviewed for RCPCH Insight, recruited, and supported new volunteers and developed a guide to creating high quality services. It's all been about engagement and working together, all done online which was new for all of us.

HOLLIE: I'm a new volunteer that joined during COVID-19. The reason why I joined the youth advocates is because I really wanted to meet others with epilepsy, to learn more about epilepsy and our meetings with RCPCH &Us involve sharing our experiences, plus I wanted to be part of something that could help others in the future by improving epilepsy paediatric services. I really enjoy being able to laugh and have fun despite our individual struggles with epilepsy. RCPCH &Us is a safe environment that encourages us to support each other and I enjoy being part of RCPCH whose work will help others in the future.

Creating gold standard epilepsy services by the Epilepsy12 Youth Advocates



More info

You can read more from the Epilepsy12 Youth Advocates in their chapter in the Epilepsy12 report and download their guide to creating gold standard services

www.rcpch.ac.uk/epilepsy12-youth-advocates

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

The role of the paediatrician in child and adolescent eating disorders

Paediatricians play a key role in supporting and caring for children and young people with eating disorders. **Dr Simon Chapman** looks at the recent rise and examines the complexity behind this

Dr Simon Chapman
- *Consultant Paediatrician*
- *King's College Hospital*

@eatyourpeas

Over the last 18 months, eating disorder incidence has doubled, with many key voices in the field reporting an increase in case complexity and severity of presentation. Large numbers of distressed young people have found themselves under eating disorders services, with smaller but unprecedented numbers needing admission to acute paediatrics. The driving factors for this are thought to be a combination of the isolation brought about by lockdown, uncertainty around exams, fear of COVID-19 for themselves and their loved ones, and the media focus on health, obesity and fitness. Food insecurity at the start of lockdown may also have played a role.

Paediatricians play a valuable part in recovery

What are eating disorders?

Not all who are unable or unwilling to eat have an eating disorder. All mental illness can affect motivation to eat, and food refusal can also be a way someone might communicate their distress to others. Confusingly, this is termed 'disordered eating', rather than 'eating disorder'. The International Classification of Diseases (ICD-11), produced by the World Health Organisation, has broadened the term 'eating disorder' to 'feeding and eating disorders'. Together it defines them as 'abnormal eating or feeding behaviours that are not explained by another health condition and are not developmentally appropriate or culturally sanctioned'. It differentiates between feeding disorders and eating disorders: feeding disorders 'involve behavioural disturbances that are not related to body weight and shape concerns, such as eating of non-edible substances or voluntary regurgitation of foods', whereas eating disorders 'involve abnormal eating behaviour and preoccupation with food as well as prominent body weight and shape concerns'.

How do I know if it is an eating disorder?

Young people with eating disorders can be identified by their cognitions and their behaviours, especially a fear of 'fatness', or an overvalued emphasis of weight and shape on wellbeing. Being presented with food or placed in situations where there is an expectation to eat precipitates anxiety. Behaviours might include attempts to avoid eating, or to offset its impact by exercising off, or 'purging', the calories. Onset of an eating disorder is often gradual, beginning with well-meant intentions to focus on health and fitness. At the beginning, understandably, parents often applaud this newly expressed motivation they witness in their young people, but often find themselves back-pedalling later when the behaviours become entrenched and inflexible. Concern raised by families is dismissed by young people as misplaced as, by this point, they rarely have insight into how

frail they have become; they are victims of an eating disorder that has taken them by stealth.

Younger children may present with only weight loss and no cognitions. They often do not know what calories are, and fears relating to body weight and shape are not expressed. They are often physically unwell when they present. The most recent young person admitted to my ward was a primary school-aged girl who had taken part in a fundraising run with her parents to raise money for the NHS. Buoyed up by her success, she had been unable to stop escalating her training.

What works?

The evidence base for treatment of restrictive eating disorders is family therapy anorexia nervosa (FT-AN). Although the name may imply the cause is rooted in the family, in fact the reverse is the case. It reasons that the young person has been taken over by the eating disorder and cannot be expected to have any motivation to recover. The parents or carers who have the young person's trust must therefore act, supported by professionals, and feed them themselves. Psychoeducation is a key part of this; therapists provide education on the nature of starvation, how it affects a person's physical health, their growth and development, how it can affect their thinking and behaviour. The most important intervention, however, is food. Recovery cannot begin without it. Many families and clinicians mistakenly think that what young people need is 'therapy' to deal with the anxiety that arises from food and eating. In fact, most are too ill to participate in therapy and the primary goal is to re-establish eating, usually with prescribed meal plans: 'Food is medicine', as the adage goes.

The paediatrician

Eating disorders carry the highest risk of mortality of all mental health conditions, and although paediatricians are now involved in the care of affected young people more than ever, they still only see a fraction of all cases. It is quite common for high levels of medical risk to be managed without any paediatric input. Paediatricians, however, are best placed to conduct physical risk assessments to exclude other causes, stratify risk and guide on safe refeeding. Early on when anxiety is high, they are the most obvious choice to do the psychoeducation too: the paediatrician's voice of concern about a young person's frailty alone can be a powerful intervention.

Junior MaRSiPAN (Management of Risk in Sick Patients of Anorexia Nervosa)

Junior MaRSiPAN was devised by paediatricians, child psychiatrists, dieticians and therapists to provide guidance on physical risk assessment. It comprises a 'risk assessment tool': a composite early warning score to quantify risk from malnutrition. In a national survey of all acute UK hospitals in 2019, 98% of respondents reported using the tool. Since publication in 2012, the document is in revision and is expected to merge with adult guidance of the same name. Although originally a group publishing guidance, Junior MaRSiPAN has grown into a network of more than 70 paediatricians across the UK who specialise in eating disorders (up from only five in 2012), supporting their local eating disorders teams to manage the physical health aspects of young people's care. They see their role as providing expertise in acute paediatrics, as well as the late effects of malnutrition on growth and development, to a cohort of vulnerable children and young people. The child and adolescent eating disorders teams, for their part, greatly value the support and input – to the extent they now pay for paediatric sessions in many centres.

Conclusion

Paediatricians bring much needed expertise to eating disorders services and should see their input as valuable and impactful. They are good with children and families, and their voice is powerful in changing the eating disorder narrative for families, meaning they are more likely to have a better experience of care and better outcomes. For more training, the College launched a course on how to manage eating disorders and intend to hold more next year. Any paediatricians taking on an eating disorders role are encouraged to join Junior MaRSiPAN and the British Eating Disorders Society (BrEDS).

Explain your medical concerns to patients

Advice for paediatricians

1. Remember to calculate the percentage median BMI – there are apps that do this for you.
2. Use the Junior MaRSiPAN tool to attribute risk – people can be more ill than they first look.
3. Institute a refeeding plan early on.
4. Work closely with your eating disorders team.
5. Avoid numbers in your conversations: focus on health and recovery.
6. Avoid negotiating.
7. Young people will be ambivalent about eating and may have no insight into their frailty: being explicit about your medical concern is therapeutic.
8. If you don't have a pathway, reach out to your local eating disorders team to create one: it is a great quality improvement programme.
9. If you are a paediatrician who has been approached to support your local eating disorders service – get in touch.

Useful Links

- British Eating Disorders Society **www.breds.org.uk**
- MaRSiPAN **www.marsipan.org.uk**

The impact of climate change on global child health

Members of our Climate Change Working Group (CCWG) update us on their latest activity and, in light of COP26, focus on how paediatricians can play a role in speaking for children who will be most impacted by the global climate crisis

Dr Bernadette O'Hare

- *Senior Lecturer in Global Health*
- *The University of St Andrews*
- *Chair, RCPCH CCWG International workstream*

@bernieaohare

NEARLY ALL CHILDREN are exposed to environmental hazards, including breathing air which exceeds the World Health Organisation's recommended guidelines for particulate matter.

Children breathe more air relative to their weight, so they are exposed to more airborne toxins and therefore, have higher levels in their blood while their organs are still forming, which will have lifelong impacts. On top of that, millions of children living in the countries which contributed least to climate change are exposed to other environmental hazards, including not having clean water to drink, adequate sanitation and protection from household air pollution. In our new position statement, we urge global leaders to remember that the climate emergency is a child's rights crisis. Their needs should be front and centre of all future decisions.

Acting as advocates

It is fitting that paediatricians stand with children in demanding urgent action to mitigate and adapt to climate change. As children's advocates, we need to advocate for a rapid and just transition away from fossil fuels by discontinuing exploration, subsidies, and the use of fossil fuelled vehicles to reduce air pollution.

Higher-income countries are most responsible for climate change, and children in lower-income countries will bear the brunt of the impacts; therefore, we call for investment in climate-resilient, low-carbon, and sustainable health and education systems to ensure every child can access these essential services.

As a paediatrician who has practised in Africa for many years, I am interested in the impact of global structural injustices on children's rights, which has allowed millions of children to be exposed to environmental hazards. These injustices include an imbalance in the flow of goods, services, intellectual property, capital, and people. Global players (higher-income countries, multinational corporations, banks, and

Our priorities for global action on climate change:

1. Child health to be a central theme in all climate change policy decisions.
2. Delivery of a rapid and just transition away from fossil fuels.
3. Investment in climate-resilient and sustainable health and education services.

international financial organisations) write the rules governing these flows. Cross-border human rights obligations mean that governments are required to prevent human rights abuses abroad, including those that occur due to climate change. This obligation includes regulating the actions of entities over which they can exercise control, such as multinational corporations, banks, and international organisations. I believe that paediatricians as child rights advocates could analyse the pathways between the policies and practices of global actors and child health outcomes, that act across borders, including climate change. We could identify barriers and suggest remedies, with the vision that all children, both in higher- and lower-income countries, have access to their health determinants, which is their fundamental right.

Dr Haytham Ali

- *Neonatologist and Assistant Professor of Paediatrics*
- *Sidra Medical and Research Center, Qatar*
- *Deputy chair, RCPCH CCWG International workstream*

Guided by the College's vision for a healthier future for children and young people across the world, the CCWG aims to use the collective voice of paediatricians and child health practitioners to influence the international climate change agenda and to put the impacts of climate change on the health of children and young people (CYP) at the centre.

Climate change, a child rights crisis

As a practising neonatologist, I have a responsibility to protect vulnerable premature infants from exposure to environmental risks such as noise and temperature extremes. The world is responsible for tackling the current climate change emergency that is disproportionately impacting vulnerable groups of CYP. Children in high-risk climate change areas lack access to essential services such as medical care, education, nutrition, and social wellbeing. This in turn limits CYP's resilience and adaptability, further increasing their vulnerability to subsequent climatic exposure, shocks, and stresses in a vicious cycle.

Climate change emergency

The climate emergency is real, the world has already warmed by more than 1.2°C compared with pre-industrial levels. Ninety-nine per cent of the disease burden from climate change is disproportionally born by lower-income countries, and 88% by children aged less than five years.

The year 2021 witnessed an increase in climatic disasters in Europe, North America, China, India, and South Africa. One billion children are at extremely high risk of the impacts of climate change according to the 2021 UNICEF climate change risk calculator. In addition:

920 million
children are exposed to water scarcity

820 million
children are highly exposed to heatwaves

600 million
children are exposed to vector-borne diseases

400 million
children are exposed to cyclones

340 million
children are exposed to river flooding and 240 million to coastal flooding

Need for urgent, collective action

In the worst-case scenario, 'business as usual', by 2050 1.45 billion children will be living in areas where the average temperature has increased by 2°C. In the best-case scenario, with actions taken that were committed to in Paris in 2015, that number can be reduced to 150 million.

In 2016, the legally binding Paris agreement to limit the rise in average global temperatures well below 2°C came into effect. Each year the Conference of the Parties (COP) takes place to review the compliance and progress of the treaty and make contingencies. Delayed by the COVID-19 pandemic, COP26 was rescheduled to take place in November 2021 in Glasgow. There is an opportunity for the College and paediatricians to advocate for putting CYP at the centre of the climate change agenda.

What is COP26?

COP26 is the 26th Conference of Parties. It's a summit of all the countries which are part of the UN's climate change treaty, the UN Framework Convention on Climate Change or UNFCCC – 197 in total. It usually takes place annually, and this year has particular emphasis in the UK as COP26 is being hosted in Glasgow.

The CCWG International Workstream

The five CCWG workstreams share the ultimate goal to effectively use our collective voice and expertise as paediatricians to influence the international climate change agenda, focusing in particular on the health impacts faced by children and young people now and in the future. The international workstream aims to engage with College members overseas, CYP themselves, and other organisations working with CYP on climate change. The workstream has chosen to focus over the next three years on five main domains: Research; Advocacy; Collaboration; Education; Children and Young People's voice. The CCWG is a real opportunity for members to contribute to the College's work in tackling climate change.

We look forward to your active contributions and invite you to visit www.rcpch.ac.uk/climate-change

RFDS flying over Kata Tjuta

Rural Australian Aboriginal child health

Some paediatricians have a more difficult commute than others, but none so much as **Dr Andy Tandy,** who is a real-life flying doctor. Here he talks about his experience working as a paediatrician in some of the most remote locations

Dr Andy Tandy

- *Consultant Paediatrician / Flying Paediatrician*
- *Western Australia Country Health Service*

"I respectfully acknowledge the traditional custodians of this land on which we are working and pay my respects to their elders past, present, and evolving."

So starts Acknowledgement of Country as a welcome to all readers of *Milestones*. A welcome that is customary by today's standards in Australia. No lesser respect is warranted for Australian first nation people and the world's oldest continual living culture. Perhaps best known to you as Aboriginal people, I shall refer to this in preference, but readers should be aware that this title is contentious to some.

I've been working with Aboriginal communities in rural and remote Australia since 2013. I came following 20 years of work as a Consultant in General and Community Paediatrics in Taunton, Somerset where I became endeared to rural communities. Then marriage brought me to Australia and work introduced me to rural life Australian style. Living perhaps several hours drive via dirt road from a hospital, and that hospital being 1,000 miles from the nearest city, is rural on a whole different scale. Many Aboriginal families live here and have medical needs far in excess of their non-Aboriginal counterparts. A vocation in me to help improve Aboriginal child health was thus born.

My colleagues and I help 'close the gap' (as the campaign is known) by narrowing the health and social determinants between Aboriginal and non-Aboriginal peoples. Fortunately, Australian resources are available including of course, the world-famous Royal Flying Doctor Service (RFDS), which makes so much of this possible to those communities in rural and remote areas. As the motto for the RFDS goes, "The furthest corner. The finest care". It makes one proud to be a part of it all.

In my time here, I've cared for children in Aboriginal communities in iconic Alice Springs and the central Australian desert lands of the Northern Territory, and in Broken Hill and Wilcannia, New South Wales. Working with those whose culture and language remains strong has been my privilege and something that so many Australians are not exposed to. Where English may be only a third language within Aboriginal communities but is undoubtedly

much better than my single words in their languages. Where the red earth of the outback gets under your skin, and you welcome that. Where the stars of the night sky can't fail to impress on you a deeper meaning to life.

I work where diseases that continue to plague Aboriginal children include acute rheumatic fever, post-strep glomerular nephritis, non-CF chronic suppurative lung disease, and malnutrition in some yet type two diabetes in others. Where scabies and chronic ear disease are endemic and where we still need to treat babies for congenital syphilis. Infectious disease is always top of the list of differential diagnoses but there are other problems too. In Western Australia, I specialised in assessments of fetal alcohol spectrum disorder (FASD) for those Aboriginal children whose fate is sadly sealed in the womb. Despite many Aboriginal communities being dry, alcohol is heavily consumed by individuals in others and in utero damage is caused before mums even know they're pregnant. Since 2018 I've worked with Aboriginal people for the Western Australia Country Health Service (WACHS) at Port Hedland Hospital in the Pilbara region, on the tropical north coast of Western Australia (WA), and work closely with the RFDS retrieving and transferring babies. Working in Australia, I've had cause to utilise most of the clinical skills needed as a general paediatrician in Somerset, whilst learning new skills in the process. Snake bite management for one. It's been professionally invigorating.

In all this time, I've seen a lot of Australia from the air from which one gains an actual perspective of how vast is much of all that is Australian. WACHS, for example, is the largest country health service in Australia and one of the biggest in the world. It provides care to over half a million people, including an estimated 55,000 Aboriginal people, over an area the size of Western Europe. When we transfer a child to Perth from Port Hedland, it's a 3,200 km round trip. That's a lot of land from above that appears untouched by humans but is known so intimately by generations of Aboriginal


Andy at Port Hedland

people as home. Their connection and respect of their land, referred to simply as "Country", is everything for them and humbling for those of us who know what damage other humans have caused to land that is not respected. For a summary of where Aboriginal people have come in the years since colonisation, watch the short WA Department of Health YouTube video, appropriately named Journey of Health & Wellbeing.

Going the extra air miles

Returning to sing the praises of the RFDS, readers need to understand not a day goes by when lives are not saved in regional and remote areas of Australia by this national treasure. Yet, this fast and free emergency service is but one of the many roles of the RFDS. In addition, they run GP health clinics; dentistry; telehealth; and transport specialist doctors to provide local care in the most remote of community clinic locations. Including taking me to the Aboriginal community of Jigalong, made famous by the 2002 film Rabbit-Proof Fence and which explains the generational trauma caused to the 'stolen generation' of Aboriginal children. I encourage you to watch it. Or to Balgo in the Great Sandy Desert at the remote eastern extremes of the Pilbara, for which we are responsible from Port Hedland 700km away via aeroplane; a journey by car of almost 2,000 km via dirt tracks that would otherwise take more than a day. And for all you aircraft enthusiasts, here are the 2019/20 statistics for the RFDS covering just our state of Western Australia: 9,053 patient retrievals, landing 16,047 times, covering 7.96 million kilometres. That's almost 200 around-the-world trips. The fleet consists of 16 Pilatus PC-12 turboprop aircraft and two Pilatus PC-24 jets. The latter can fly at 45,000ft at a speed of 815kmph and as high and fast as I'm ever likely to travel!

What of my typical working day? Our paediatric department comprises two consultants, one senior registrar and one daytime intern. Each morning is spent attending patients on the children's ward and babies born on the maternity unit. Up to 70% of our inpatients are Aboriginal. A day a week I spend all day in the clinic at the hospital, to which families may have travelled anything from 10 minutes to six hours. A morning each week is spent running a clinic at the nearby Aboriginal Health Clinic. Off and on during the day, there are children to assess in the ED, and regularly births on our maternity unit require resuscitation to varying degrees. There are always phone calls from more remote clinics asking for advice. Suppose there is a retrieval request to collect a baby from somewhere in the Pilbara that involves a flight with the RFDS, then anything from four to 12 hours of a working day will be further consumed. Then, of course, there are always emails to type and electronic patient records to complete. Teaching medical students at the Rural Clinic School brings welcome conversational dialogue. Then there's the on-call work. My consultant colleague and I are either first or second on-call most weeknights and every weekend for the two weeks that I work in Port Hedland. I then return to Perth for two weeks at home in Fremantle. Like so many in the mining industry in WA, I'm sort of a 'FI–FO' worker. One that 'flies in and flies out'. To my surprise, I've become a 'flying paediatrician' in the twilight of my career and I'm happy for that.

References

- Western Australia Country Health Service **www.wacountry.health.wa.gov.au**
- Royal Flying Doctor Services **www.flyingdoctor.org.au/wa**
- Journey of Health & Wellbeing video **www.youtube.com/watch?v=cDYGjkcjUdg**

Screen for poverty?
Not my job – I treat patients!

Working in paediatrics, what can you do to change the conditions that make patients suffer ill health?

Dr Helen Leveret
- *Paediatric ST4*
- *Royal United Hospital Bath*

@whamproject

RECENTLY I HAVE been wondering 'what is the role of a paediatrician?' We all know we are supposed to be holistic practitioners providing family-centred care. But I for one recognise that I am guilty of just seeing 'the wheezer' in front of me, prescribing the salbutamol so I can stretch them to four hours and get them out the door. I don't always remember to see the young person as a member of a family, living in a social context. What are the conditions that led 'the wheezer', or rather 'the young person who has a wheeze', to present to the hospital today? Do they live in a home with a mould problem that has triggered their attendance? If so, is it my job to think about that? Is it my job to do something about that?

Professor Sir Michael Marmot writes "Why treat children only to send them back to the conditions that made them sick?" As paediatricians, what can we practically do to try and change the conditions that make our patients sick?

I listened to some of the fantastic talks from this year's RCPCH Conference on the impact of health inequalities and how to address these. I was inspired by watching 'Child Health on Trial', where the children of the nation spoke out against child poverty themselves. I was struck by the findings of the recently published National Child Mortality Database report, which identified a clear association between risk of death and level of deprivation. The evidence presented at the Conference was clear: integrated care leads to better outcomes for children and families. It's through integrated care that we can try and change the conditions that 'make them sick'. The desire for action within our paediatric community at the Conference was palpable.

Taking action

An article in Archives titled 'Public health for paediatricians: Fifteen-minute consultation on addressing child poverty in clinical practice' was presented at a departmental journal club. The response from senior colleagues was so positive that this has now been turned into action, with a local team of us working together to implement change.

- We are introducing screening for poverty to the admission proforma
- We have adapted the 1-2-3 family wellbeing leaflet for signposting families to resources to our local context
- We are forming partnerships with local organisations such as food banks
- We are linking up with our colleagues at the council and those involved in commissioning services for young people

A call to arms. We need to move from local projects to national action. As a College of healthcare professionals, we have a duty to use our voice to advocate for the children and families who are suffering ill health and poor wellbeing as a result of living in poverty.

Let's share resources and share ideas. We are building a national network; a Wellbeing and Health Action Movement (WHAM). We have set up a website. The website provides a forum to unite our voices to advocate for change at a national level, and is packed with information, evidence and resources to help you implement change where you work. We want to see our network of healthcare professionals addressing poverty as a cause of poor health and wellbeing in children, young people and families grow; so that across the UK every contact with a child, young person or family within a healthcare setting is seen as an opportunity to address the wider social determinants of health in a meaningful way.

The College's health improvement committee is also putting together a toolkit of resources to help healthcare workers communicate with families about the wider determinants of health which will be available for members to access early next year. The pandemic has provided us with an opportunity and a motivation to act. Let's not send children back to the conditions that made them sick.

▶ ***Join the campaign***
www.WHAMProject.co.uk

Autism in paediatrics

Having received a diagnosis of autism while training in paediatrics, **Dr Sarah Vepers** shares her experiences and provides tips on how to support colleagues on the spectrum

Image: Taken from www.the-art-of-autism.com

Dr Sarah Vepers
- *Clinical Fellow in Paediatrics*
- *Royal Hampshire County Hospital*

@sbouxx

AS A TEENAGER I often felt lonely and different to my peers. I felt left out, even from my own friendship groups. I struggled to express my emotions – or even understand which emotions they were sometimes. I was often late to school and handed in homework late. My teachers didn't seem to mind too much as long as I got the grades... This is actually a glimpse of the beginning of my journey to medical school, and a part of my neurodivergent self. Over a decade later, towards the start of my training in paediatrics, I received my diagnosis of autism.

Many individuals, a large proportion of them women, are diagnosed later in life, often after a child has received the diagnosis first. There are a number of theories surrounding this phenomenon, including the way many girls are socialised from an early age, special interests stemming from trying to fit in with others and learnt behaviours to seem more typical when with others – alongside hiding autistic traits, which is coined 'masking'. Problems come from hiding your true self and the energy it takes to keep the mask on. There is a strong association with depression and anxiety and autistic people are at higher risk of suicide; these, alongside the phenomenon that is known as 'autistic burnout' can lead to significant morbidity and reduced quality of life. Coupled with the stress of a medical career and training, it is no wonder many autistic doctors find themselves in difficulty.

When at school I pushed myself to 'be more social' as I thought this would help me feel less lonely. I joined Army Cadets for example. I became more aware of my difficulty with eye contact and would try and look at people more (often towards their nose or close to their eyes to make it less uncomfortable). At medical school I found objective structured clinical examinations (OSCEs) particularly difficult. Starting to learn to clerk patients also made me feel quite anxious, especially at the beginning (or if it involved being recorded – which I had to do for a special study module (SSM), as well as my GP placement as an FY2).

Offering support

I found that during community paediatrics it helped being able to understand where some of my patients were coming from when they came for their assessments and reviews, as well as finding a way to help them and their families by pulling together resources for them to access whilst they were awaiting various stages of their patient journeys (I make a lot of lists)! I also think that adding a different way of looking at things, looking at a problem from different angles, can really help the team when caring for patients.

In terms of supporting us, sometimes it is as simple as not writing someone off because of their differences. Our communication differences are just that, a difference – much like having a different accent or speaking English as a second language. Ask what might be helpful for them. Encourage consultation with occupational health and the local professional support unit. Consider signposting them to the peer support groups Autistic Doctors International or the Association of Neurodivergent Doctors. Think about autism training in the department (though avoid disclosure of the individual's diagnosis unless they have given their permission). Explore your own knowledge and prejudices surrounding autism and please, please don't come back with "we're all a little autistic, aren't we?" when someone has struck up the courage to disclose this very personal information about themselves!

Here are some ideas to support colleagues on the spectrum:

- Kindness and compassion (for everyone we work with)
- Be accepting of differences
- Ensure clarity of communication and requests
- Highlight any quiet areas which can be used for breaks
- Include us in social things...
- ...but don't worry too much if we decline
- Aim to provide predictability e.g. rotas in advance and no sudden changes (appreciated by all trainees, I'm sure!)
- Be aware of possible sensory issues such as lights, noise, smells
- Be understanding that when anxious, communication may be reduced
- Give unambiguous feedback, avoiding hints and metaphors

Useful Links

Autistic Doctors International
@DoctorsAutistic
Association of Neurodivergent Doctors
@Divergent_Docs

Welcome to Paediatrics!

Welcoming ST1s to the West Midlands Paediatric Family

Elke (right) at a Welcome to Paediatrics! day

Dr Elke Reunis

- *ST4 Paediatrics*
- *Royal Wolverhampton NHS Trust*

@EReunis

THE BEGINNING OF paediatric training – an exciting, but also potentially daunting time: a steep learning curve of new knowledge and skills, a new ePortfolio to navigate and exams to conquer. For some, it also means moving to a completely new deanery or even a new country!

I was super lucky that Welcome to Paediatrics! (WTP!) was founded in 2018, the year I started my paediatric journey. It was hosted by a group of enthusiastic trainees, with the School of Paediatrics support, with the aim to improve the regional induction and fast-track the integration of ST1 trainees into the West Midlands Paediatric Family.

The trainee-consultant collaboration meant that we had the opportunity to meet our Head of School and Training Programme Director, as well as chat to senior trainees one-on-one. Through a mixture of lectures, small group discussions, informal breaks and an evening social, I not only learnt about the essential information relating to training, but also heard about all the educational opportunities, got to reflect on how to manage potential challenges of training, and was signposted to support available within our region. I felt it set me up to hit the ground running and I wanted to pay this forward to new ST1s. Over the years, I therefore got involved with the WTP! Team and this year co-hosted it with my ST4 buddy Shosh [below]. We wanted to share our experience to encourage other regions to set up a ST1 day too, if you don't already have one. Any questions, please get in touch!

Dr Shoshana Layman

- *ST4 Paediatrics*
- *Royal Wolverhampton NHS Trust*

@ShoshLayman

SINCE ITS CONCEPTION in 2018, a total of 100 new ST1 trainees have attended WTP! Consistently receiving glowing feedback, WTP! has evolved from a jam-packed morning as part of the first ST1 regional teaching day, to a dedicated stand-alone day, giving trainees more time to absorb the information, speak to peers and senior trainees. The day now also includes support specifically set up for International Medical Graduates by our IMG Support Network.

In the COVID-19 era, this year's WTP! was once again held virtually, but that didn't stop us mingling, using breakout rooms and ice breakers! All attendees said this year's WTP! was well structured and informative; the top-rated talks were those focusing on Kaizen, the highs and lows of training, and trainee wellbeing. This year, nearly all trainees said WTP! helped them to feel more settled in the deanery and they better understood what paediatric training in the West Midlands involved. Despite the COVID restrictions, comments about this year's WTP! very much echo those made in previous years, and include "absolutely brilliant, helpful and welcoming". Trainees enjoyed "meeting and chatting to other colleagues" through the use of breakout rooms, with "approachable hosts and helpful seniors" who provided useful tips and answered questions throughout the day.

Trainees involved in WTP! have reported that it is an excellent way to welcome new trainees to the West Midlands and sets them up to thrive during their paediatric training journey. The trainee-consultant collaboration has been paramount to our success; we highly recommend creating a similar induction programme if your region doesn't already have something like this.

As attendees in 2018 we got inspired to get involved in organising WTP! We hope those who attend WTP! 2021 feel the same.

Scan the code to see all the previous WTP! programmes

Paediatrics in Europe – post Brexit!

UK involvement in the European Academy of Paediatrics is as busy as ever post-Brexit

Dr Rob Ross Russell

- *Consultant in Paediatric Intensive Care & Respiratory Paediatrics*
- *Addenbrooke's Hospital*
- *Chair, European Board of Paediatrics*

@robrr2

CONCERNS THAT BREXIT would isolate RCPCH from colleagues and issues in Europe do not (as yet) seem to have materialised. Sub-specialist societies as well as the European Union of Medical Specialists (UEMS, the European body responsible for medical training across Europe) remain completely inclusive, with UK involvement as active as ever.

The European Academy of Paediatrics (EAP) has been especially busy. The EAP has two major roles, advocating in Brussels on important areas of policy, and representing all paediatric training issues as the paediatric section of UEMS.

Areas of advocacy over the last year have focused on vaccination issues – not just COVID related, but emphasising the importance of all routine vaccinations in a population increasingly sceptical. We have also been meeting with the new EC Health Commissioner, Stella Kyriakides, to press for greater paediatric data to be included in 'Health at a Glance' – a key driver for health policy in many European countries. Other work on supporting healthcare access for migrant children has also been valuable.

EAP has also been successful in their research activities – EAPRASnet is a Europe-wide network of practice-based primary care paediatricians working with EAP and AAP-PROS to gather better data on children's health. We have also successfully bid for European Commission funded projects.

Trying to harmonise paediatric training across Europe has been a huge challenge. Inconsistencies in training patterns (both duration and content) currently restrict the ability of trainees to move between different countries. We work with specialist societies and countries to develop Europe-wide training requirements for core paediatrics, and for the 14 recognised paediatric subspecialties. This work allows all countries to have a framework for consistent training programmes and sets out requirements for trainers and training centres. A key element of that harmonisation has been the creation of a Europe-wide knowledge-based examination.

European involvement is of great importance. Greater mobility of trainees, harmonised training programmes and a greater understanding and involvement in our mutual problems can only help to improve the care of children.

Dr Sian Copley

- *Paediatric ST7*
- *Alder Hey Children's Hospital*

@sianncop

THE YOUNG EUROPEAN ACADEMY OF PAEDIATRICS (YEAP) was created to represent paediatric trainees in EAP activities, as an infrastructure for research and dissemination of information and to promote collaboration across paediatrics within Europe. We have representatives from 24 European countries and input into EAP working groups on issues such as advocacy, adolescent health, migrant health and infection prevention and control, as well as leading on areas of work of particular interest to trainees. A key aim is to work collaboratively to harmonise and improve paediatric training and opportunities for young paediatricians across Europe.

Recent projects undertaken by YEAP include studies looking at training programme experiences, working conditions and burnout in paediatric trainees across Europe. We also input into EAP campaigns and produce monthly blogs on topical issues affecting child health and paediatricians.

Being part of YEAP has been a great joy, and added an extra dimension to my paediatric training; paediatricians across Europe face similar challenges, and working together with our neighbours will help us provide better care to the children we look after as well as improve paediatric training and opportunities for both trainees and paediatricians.

European Academy of Paediatrics
Paediatric Section of U.E.M.S

Learn more about the work of the EAP www.eapaediatrics.eu

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

After her OOPE, Eimear has returned to training with fresh enthusiasm

TRAINEES

Tips for an out of programme experience

Dr Eimear McCorry

- *ST6 Paediatrics*
- *Craigavon Area Hospital*

@dr_emccorry

MORE AND MORE trainees are embarking on an out of programme experience (OOPE) for a variety of reasons. For me it was about time – time to gain new experiences, time to start (and finish!) projects and time to develop personally and professionally. My OOPE as a Clinical Leadership Fellow brought me outside the world of paediatrics, working in new ways, in unfamiliar environments and with people from different backgrounds. Along the way I picked up hints and tips that helped me maximise what I achieved. Hopefully sharing a few of these will help others.

Firstly, I found it useful to surround myself with the right people. I had a formal supervisor to help me identify what I wanted to achieve educationally and professionally, ensuring I maintained momentum and focus. I had a mentor in whom I could confide as well as drawing on their personal experiences. I also found it vital to have an out of programme friend, someone in a similar position who understood the new challenges.

Although the idea of a break from all things portfolio related might appeal, I found it essential to continue with this. I documented all my activities, ensuring I wouldn't forget any of the many things I was involved in. Similarly, staying engaged with reflective practice helped me to learn so much about myself and focus on those non-clinical skills.

I was presented with many unexpected opportunities during my OOPE and some of my most valuable experiences were things that I hadn't anticipated. I thoroughly recommend keeping an open mind. On the other hand, I also discovered the importance of learning to say no! We all like to please people so this may be easier said than done but I found it important to consider what was presented and decide if it was something that would benefit me and fit in with my plans for the year.

My final, and perhaps most important, piece of advice is to enjoy! This might seem obvious but I had been so caught up in busy rotas, service provision and ticking all those training boxes, that I was taken aback by what I could achieve with some time out of programme. I found this time refreshing and energising and I have returned to training with renewed enthusiasm.

WELLBEING

IT'S A MATTER OF PRIDE? WHEN HELPING HURTS.

"YOU'RE A DOCTOR... you must be so proud to work in the NHS?" "You've worked so hard to be where you are... you should be proud of yourself?" "Your family must be so proud of you?"

There's no denying a certain amount of pride in the role we have in the NHS helps me get out of bed in the morning. But when does that carrot turn into a stick? When can diligence and hard work tip into perfectionism and people pleasing; key ingredients in the burnt-out soup? How can we rein things back in?

Firstly, don't look to others for recognition. Recognise the fact that your best is always enough, it's all that can be asked of you.

Secondly take the chance to feel good at the end of a day; not in the completion of that long to do list but in how you were as a human being. Those snippets of conversation you had with a colleague, that smile you were able to give a patient's family, or even that you found time to go to the toilet for once.

Last but not least, listen when people pay you a compliment. Also be quick to recognise and encourage others too and then we can take a healthy pride as a team in the amazing things we do for our patients every day!

Dr Rachel King

- *ST5 Paediatric Trainee*
- *Queen Alexandra Hospital*

@DoctorsKing

RCPCH climate change recommendations
All countries should prioritise a rapid and just transition away from fossil fuels


Learning some basic Makaton is helpful

TRAINEES

A hub for trainees in the North West

Dr Helen Manning
- *ST6 Paediatrics*
- *Royal Manchester Children's Hospital*

@nwpaediatrics

WHEN TEACHING WAS forced to stop due to social distancing, the North-West Deanery launched a new platform to record and archive our virtual regional teaching. For the first time, this also allowed us to share teaching across the Greater Manchester and Lancashire area and the Cheshire and Merseyside area of the North-West Deanery.

To do this, we rebranded our teaching to launch STEP (Specialist Trainee Education Programme), with a logo representing our area. We increased our use of social media to promote wider educational opportunities and launched our website centred around the amazing art of our then-trainee, Lina See.

Initially, the website was written by our regional teaching committee to promote our teaching sessions and provide a timetable and schedules for each training day. However, since its inception, it has continued to develop. We now have a study leave calendar to encourage trainees to use their study leave allowance to continue developing interests within paediatrics. We have wellbeing sections promoting support networks, including sessions with a psychologist, 'Stepping up to Consultant' and 'Stepping up to Middle Grade' sections and special interest group pages.

We're excited to see how the website continues to develop going forward, with planned pages for return to work support and for each hospital in our area to promote their many educational opportunities and much more!

▶ *Visit www.nwpaediatrics.com*

PATIENTS

COMMUNICATING WITH A NONVERBAL CHILD

WORKING AS A carer for a child with Dravet syndrome, a rare condition characterised by epilepsy and severe autism, I learnt to adapt to different modes of communication. Every child is unique so capabilities will differ. I find that after getting to know the child and being attentive to their needs, over time they will let you know how best to communicate with them – so follow their lead! Learning some basic Makaton can also be a useful skill to have as many non-verbal children communicate using these signs.

My advice

1. Exaggerate your actions. Don't be afraid to be silly and use both your body and your loud cartoon character voice to act out what you are trying to say. Using a particular saying or the similar sounding voice from one of their favourite TV characters can aid in engaging the child. The child may be encouraged to then copy your gestures when responding to you.
2. Let the child guide you and follow their lead. They may take time to answer you and it is natural to want to fill the silence with another word but allowing them time to respond gives them the opportunity to communicate.
3. Smile with your eyes and maintain eye contact as much as possible. This will act as a cue to the child that you would like to communicate with them and your attention is focused on them.
4. Don't forget to listen to each child's parents, they know best! Parents and/or care givers know their child better than anyone, so it's especially important to spend time listening to their particular concerns as well as their tips on what they find works when communicating with their child. Finally, watch parents and carers communicate in their own ways with their child and mimic them when it's your turn to interact.

Georgia Raniolo
- *Final year medical student*
- *Queen Mary University of London, Malta Campus*

@georgiaraniolo

RCPCH climate change recommendations
All health professionals should consider how they can reduce their carbon footprint

Sahana with her award at this year's HSJ Patient Safety Awards

QUALITY IMPROVEMENT

Why should trainees be involved in QI?

Dr Sahana Rao
- *Consultant Paediatrician*
- *John Radcliffe Hospital*

@dr_sahanarao

QUALITY IMPROVEMENT (QI) is integral in providing safe, high-quality care to improve patient outcomes. During rotations between trusts, trainees are best placed to identify not only areas for improvement but also to share learning from best practices elsewhere. Trainees work tirelessly and are keen to improve services, but often lack time, skills or resources to make impactful change.

The Institute of Medicine identifies six dimensions of healthcare quality: safe, effective, patient-centred, timely, efficient, and equitable, which should be considered while setting priorities for improvement. QI projects could be inspired by clinical work, audits, incidents, complaints, patient feedback, and may be influenced by your departmental or organisational agenda. Trainees must have access to structured teaching on QI methodologies and QI resources and it is also desirable to have a nominated mentor. QI is now a core component of undergraduate and postgraduate curricula as the advantage of training in QI is well-recognised by healthcare organisations and policymakers.

There is joy and satisfaction in improving patient care. Through QI, I also have met friends and built collaborations outside my clinical practice in paediatrics. Engaging in QI enables trainees to develop leadership, negotiation, and project management skills. Experience in improving services enables clinicians to gain professional capabilities in human factors and patient safety. QI harbours resilience, team-working, recognising people's strengths and limitations, and supporting them. These are vital skills and valuable qualities for career development as consultants and future healthcare leaders.

▶ ***Visit QI Central, the College's QI sharing hub***
qicentral.rcpch.ac.uk

HISTORY

HISTORY TAKING: SUMMER LOVING

Dr Richard Daniels
- *ST5 Paediatrics/ Neonatology*
- *Barnet Hospital*

@ccdaniels65

WRITING IN WINTER, I got to thinking about how life as a paediatrician would have been so different back in the day. I don't just mean BC (Before COVID) - my mind drifted even further back.

I mentally teleported to Maryland, USA on a crisp winter's day in 1957. I was sitting at the staff desk of a local hospital listening to a cacophony of coughs and crackles idly scrolling through the latest Twitter storm – it's my fantasy here!

"Another seasonal cough..." remarked one doctor. "Tell me about it," replied another, "I wish there was some way to tell them apart!" The door opened in a gust of wind and there was Dr Robert Chanock.

A Chicago native, he'd moved to Cincinnati before being drafted to Korea where a ruptured appendix ended his war and set him on course to become one of the world's most eminent virologists.

Chanock spoke. "Your wish is my command. I've just discovered RSV!" He'd matched human samples to one isolated from chimpanzees and rebranded it for the new host reservoir. Bedlam reigned in the ED and Chanock slipped back to his lab where he cracked on with his work in developing vaccines for adenovirus, influenza, hepatitis A and rotavirus, because the man really loved his work.

Back in the present day, Tony Fauci has described Chanock as "an outstanding scientist whose innumerable contributions to the understanding of viral diseases helped make the world a healthier place for millions".

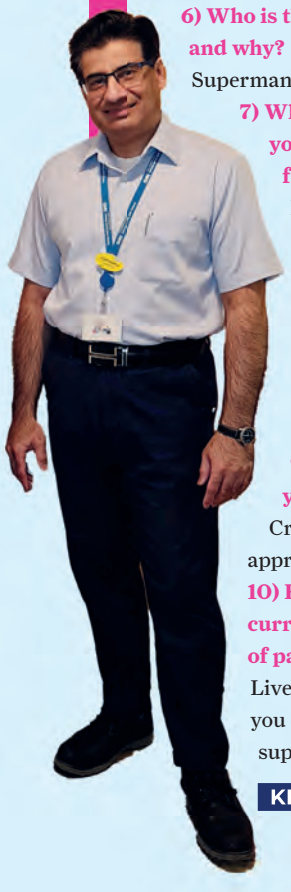
Chanock was more circumspect about his life's work. Asked what the biggest contribution could be to prevent viral morbidity, he simply replied "Have your children in the spring."

Anyone know how to make this a public health project?

STARTER FOR TEN

We put 10 questions to a paediatric registrar and a consultant – this time it's a father and son!

Supervisor
Dr Yahya Mubashar
Consultant Paediatrician, Torbay Hospital, Devon



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

2) After a hard day, what is your guilty pleasure?
Having a nice cup of coffee while reading an entertaining book.

3) What two things do you find particularly challenging?
Trying to do innovative working through financial constraints. Finishing clinics on time.

4) What is the best part of your working day?
At the end of a busy shift, when my team and I have no outstanding jobs to handover to the oncoming team.

5) What is the one piece of advice you wish you could impart to yourself as a junior trainee?
Always remain grateful and humbled for being in a privileged position to help people.

6) Who is the best fictional character of all time and why?
Superman, inspiring selfless service to mankind.

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

8) If you were bitten by a radioactive gerbil, what would you like your superpower to be, and why?
To be able to listen to people talking to themselves in their minds, just to know what their anxieties and fears are so that I can communicate with them better.

9) What is the most encouraging thing one of your colleagues can do to make your day?
Crack a joke unexpectedly (relevant and appropriate of course) that makes everyone laugh.

10) How do you think you, your colleagues and current trainees can inspire the next generation of paediatricians?
Live a balanced work and home life, love the work you do, be a passionate learner and aim to leave a supportive, stimulating and joyful legacy.

Trainee
Dr Tayyib Mubashar
ST1 Paediatrics, New Cross Hospital, Wolverhampton
@taymub

1) Describe your job in three words
Rewarding, joyful, hopeful.

2) After a hard day, what is your guilty pleasure?
A nice cup of hot chocolate with my wife!

3) What are two things you find particularly challenging?
Sometimes the sheer volume of patients. The challenge of limited resources allocated for paediatrics.

4) What is the best part of your working day?
Cracking jokes with the long-term patients on the ward: they really do become like part of the ward family!

5) What is the best advice you have received as a trainee?
My father said, "Don't let the struggle in the middle put you off the reward at the end. When choosing a specialty, look at the consultants and ask yourself, can I see myself living like them. If your answer is yes, go for it".

6) Who is the best fictional character of all time and why?
Doctor Strange: the guy has more superpowers than all the Avengers combined and it helps doctors become more accessible to the kids!

7) What three medications would you like with you if you were marooned on a desert island filled with paediatric patients?
Paracetamol, Difflam spray, Augmentin Duo (banana!)

8) If you were to be bitten by a radioactive gerbil, what would you like your superpower to be and why?
Reading minds: who wouldn't want the ability to empathise with patients more clearly whilst also being able to get some insider stock-trading tips!

9) What is the most encouraging thing one of your colleagues can do to make your day?
Making a hot drink: it really makes you feel like someone cares! Plus we all need caffeine sometimes!

10) How do you think you and your colleagues can inspire the next generation of paediatricians?
By showing our enthusiasm for paediatrics and being skilled teachers.

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

RESOURCE

Best Beginnings

Alison Baum
- *CEO of Best Beginnings*

@AlisonBaum

I FOUNDED BEST BEGINNINGS in memory of my uncle, Professor David Baum, an inspirational paediatrician who was a former RCPCH President. Throughout my childhood he inspired me to make a difference whenever I could and following his tragic death on an RCPCH charity bike ride, I named my first son after him.

Both my sons were born early with significant health issues. Despite being married to a paediatrician, coming from a family of doctors and having an incredible support network, the experience was overwhelming. If I, a scientist by background with the knowledge and confidence to gather evidence-based information found the experience so challenging, then, I wondered, what must things be like for women who don't happen to have these privileges?

I set up Best Beginnings in 2006 with the expressed aim of improving outcomes and reducing inequalities. Our NHS approved Baby Buddy app has been the primary way by which we've supported more than 350,000 parents across the country to give their children the best start – disproportionally those from communities that experience inequalities.

We're now launching a new version of Baby Buddy which supports parents and caregivers with personalised daily information through pregnancy until their child's 1st birthday. Baby Buddy 2.0 actively supports the Healthy Child Programme and includes a Digital Personal Child Health Record. I invite paediatricians across the UK to download and use the new app in 'professional mode' and to recommend it to the families you support. Together we can make a difference for future generations.

▶ ***Visit www.bestbeginnings.org.uk***

best beginnings
for every parent, for every child

BOOK

NOTES ON A NERVOUS PLANET

by Matt Haig

Dr Robert Boon
- *Consultant in General Paediatrics*
- *Royal Manchester Children's Hospital*

@robboon69

TO MISQUOTE JOHN LENNON "Life is what happens to you while you're busy staring at Twitter on your phone" – and that is essentially the take-home message from Matt Haig's *Notes on a Nervous Planet*. This is his follow-up book to the best-selling *Reasons to Stay Alive*, which charted his successful battle with the depression that nearly killed him. In his latest work, he convincingly details how constant exposure throughout our waking hours, to idealised and unrealistic lifestyles presented to us through the prism of social media is a recipe for unhappiness. He provides a roadmap to help us reduce our anxiety levels and to connect to what really matters in our lives. We need to switch off and start being a lot kinder and more accepting of what and who we are, and celebrate our differences, rather than chasing unobtainable and ultimately unsatisfying goals. A life-affirming read.

BOOK

INVENTING OURSELVES, THE SECRET LIFE OF THE ADOLESCENT BRAIN

by Sarah-Jayne Blackmore

Dr Shilpa Shah
- *Consultant Paediatrician*
- *Craigavon Area Hospital*

@drshilpashah

I FIRST HEARD of Sarah-Jayne at the College's Adolescent Health Conference in 2019. At once I was intrigued by all the research exploring various aspects of adolescent behaviour, unearthing the enigma that is the adolescent brain. I knew I had to read her book to find out more!

Sarah-Jayne maintains optimism throughout this book where she explains how the sense of self and social self become important determinants of adolescent risk taking. This may seem a deterrent but can be a unique opportunity to offer pro-social influences to an ever-plastic brain. Risk taking is not necessarily a bad thing, she explains. It helps adolescents to learn and consolidate experiences. Empowering them to make decisions may come with challenges but in the longer term will help them discover their own strengths. Sarah-Jayne's book gives me hope and helps me look at this age in a brighter light. I would highly recommend this book to everyone who seeks to understand this ever-misunderstood age.

Working in a difficult environment

Paediatricians face many challenges, varying around the world. **Dr Soroor Al-hamad** shares her experience of working as a paediatrician in Iraq

Dr Soroor Al-hamad

- *Paediatrician*
- *Hawalati Down's Syndrome Clinic*

@ss_hamad

2011 WAS THE year that my career in paediatrics began. I did my residency in Al-Ramadi Teaching Hospital of Paediatrics, completed my masters degree in Tikrit University and joined RCPCH as a member in 2019.

As a paediatrician, I consider it an honour to have the opportunity to impact the life of a child. This is why I chose paediatrics. Now I am working in my own practice, my preferred area in paediatrics is children with Down's syndrome. Unfortunately, most of them and their families have no support in Iraq, so I decided to help them and arranged the first Down's syndrome clinic in Iraq, which is Hawalati Down's Syndrome Clinic. I would spend hours studying different conditions that affect this population from birth to 16.

Dr Soroor Al-hamad with her colleagues

Each day my team and I are grateful to have the opportunity to help another sick child, the only thing that matters is trying to help them and make them feel as comfortable as possible. All Iraqi children are without health insurance – they rely on the Iraqi central government-run public healthcare system, with little advocacy or diversity of treatment options.

The healthcare system in Iraq consists of primary healthcare centres (PHCs) and tertiary hospitals. There are a lot of PHCs serving a large number of the population but unfortunately, the buildings need refurbishment. In addition, there is a lack of the basic equipment, and there are severe shortages of medicines and supplies. Most people think hospitals provide better care than PHCs, although the picture in the tertiary hospitals is similar. Iraqi people with higher incomes prefer to visit the private sector. Another issue is the poor IT or effective health information systems. The services are overburdened and this forces the doctors to see a large number of patients per hour. As a result, the consultation time is short and the risk of misdiagnosis and mistreatment is high.

The main strength of the service is the staff. Despite the absence of good training programmes for undergraduates and postgraduate doctors, they make every effort to help children and their families. They also continually educate themselves and stay up to date on anything relevant to children's health. As a doctor working in a bad health system, we are often blamed by parents for everything from shortages in medicine, the lack of vaccinations, the complication of the child's condition to the lack of good health equipment. For that reason, being a doctor in Iraq is considered a unique experience.

One of the challenges the women and newborns face is the lack of a good maternal and child care before, during and after pregnancy and childbirth. This is due to the bad management systems of PHCs. The immunisation programme has been especially affected since they are linked with the quality of PHC service. There are a variety of medical conditions in Iraq from infectious diseases, malnutrition, cardiovascular diseases, metabolic diseases to cancer and hereditary conditions.

I would not say that there is no good part to working as a paediatrician in Iraq, but we are working in hospitals where the level of perceived quality of care is low. The state of physical infrastructure is not satisfactory and requires major repairs, equipment is grossly deficient, drug supply is very short and essential services are not available. However, we can save children's health and decrease their suffering depending largely on our excellent understanding of medicine and paediatric illnesses, together with the simple facilities to diagnose a child accurately. This is our great challenge, in my view.

Wellbeing

Team Time storytellers

Storytelling can be a valuable tool in promoting staff wellbeing, but when face-to-face opportunities are limited, new strategies to engage staff are needed. **Dr Lalith Wijedoru** discusses how *Team Time* was used to support healthcare teams during remote working

Dr Lalith Wijedoru

- *Consultant Paediatric Emergency Medicine*
- *Alder Hey Children's Hospital*

@LalithWijedoru

THE WORLD HEALTH Organisation warned of the inevitable psychological trauma that would come with the pandemic, and the need to support frontline healthcare teams. I was put in charge of staff wellbeing for the emergency department. I knew my task was huge and that wellbeing strategies had to be bold to match the enormity of the challenge.

In response to the pandemic, the Point of Care Foundation developed *Team Time* as an online, socially distanced storytelling initiative, modelled on face-to-face *Schwartz Rounds*. Compared to *Schwartz Rounds*, *Team Time* was pitched as streamlined, downsized, and designed for individual teams rather than whole organisations. From the traumas of my paediatric training, I knew first-hand the power of stories as a vehicle to heal emotional wounds, both old and new. I wanted to pilot this new initiative in our emergency department. With the support of the trust's Associate Director for Organisational Development, we ran fortnightly *Team Time* sessions for three months. Music played a big part, with popular music matching fortnightly themes to promote the sessions on the departmental Facebook page and emails.

The feedback from our first cycle was fascinating. Storytellers, most of whom were initially sceptical, became converts to the cathartic process of sharing their story. Silent observers marvelled at how much they got from just listening to staff stories without even typing or saying a word. The overall theme from the qualitative data was that of healing. The main sub-themes: revealing of self; being heard; and connecting with others interestingly ran parallel to the principles of psychological first aid the WHO had been advocating for from the start: Look; Listen; Link.

I shared our findings with the Trust Board of Executive and Non-Executive Directors at Alder Hey and they subsequently offered support for re-starting *Schwartz Rounds* in an online format, pledging funding for 30 *Schwartz Round* and *Team Time* facilitators across all four trust divisions.

Team Time in the emergency department won third place in the Elizabeth Molyneux Prize for Paediatric Research at the Royal College of Emergency Medicine Virtual Scientific Conference in October 2020. We then submitted a showcase to the national Health Services Journal (HSJ) Awards entitled 'Flourishing in Adversity' and were delighted to win the popular Staff Engagement Award. And to take us back to where it all started, the Point of Care Foundation awarded Alder Hey 'Most Powerful *Schwartz Rounds*/*Team Time*' at the annual Schwartz Awards.

It is often through adversity that people gain the courage to throw caution to the wind and innovate with a what-have-we-got-to-lose attitude. Creating an open culture of storytelling in a department, division, or trust takes time, perseverance, creativity, and compassion.

Storytelling is about deep and active listening with the intent to understand, rather than with the intent to reply. Doctors are often known for wanting to 'fix' things with a solution. *Team Time* and *Schwartz Rounds* require a 'listen' rather than 'reply' attitude. Having seen what I can do as a facilitator and listener rather than as a paediatric emergency medicine 'fixer', I have decided to set up my own wellbeing company for public and private sector workers to find connection with each other, and to improve working lives. It will be bold. It will not be cautious. It will deliver a different type of healing: through the power of staff stories.

For more information visit www.behindyourmask.co

Team Time Storytelling painted by Aliza Nisenbaum, Tate Liverpool Exhibition (2020-21)

ASH'S BAKING SCHOOL

Ash's Baking School

Whether it's a quick refuelling snack, or a sweet breakfast treat, winter is the perfect time for **Dr Ashish Patel**'s cinnamon buns

Dr Ashish Patel

- *ST7 Paediatric Nephrology & Sim Fellow*
- *Birmingham Children's Hospital*

@DrKidneyAsh

WINTER IS COMING! In reality it has been here for the past six months given the RSV surge and viral wheeze storm we have all been facing. Like most, I struggle to find motivation in the cold weather and dark nights. One of my fondest winter holidays was spent at Disneyworld Florida. Here I ate the most incredible cinnamon buns for breakfast – they were just magical! I have wanted to recreate them for a number of years. Whilst these buns can't compare to the magic of Disney, they can provide a vital refuel snack for the team after morning ward rounds. Enjoy and continue to spread the love of baking!

Bring a taste of Disney to your kitchen or staff room

CINNAMON BUNS

Ingredients

For the dough:

345g plain flour
60g caster sugar
1 tsp salt
7g instant acting yeast
120ml water
60ml milk
45g butter
1 egg

For the filling:

70g soft butter
1.5 tbsp cinnamon
60g dark soft brown sugar

For the glaze:

120g icing sugar
2 tbsp milk
pinch of salt
1/2 tsp vanilla extract

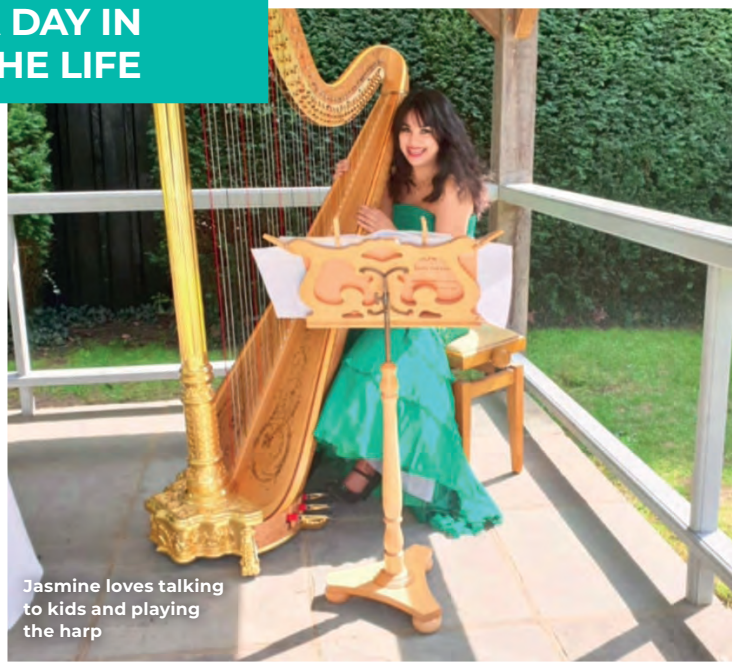
Instructions

1. Add the flour, caster sugar, salt and yeast to a mixing bowl and whisk together to combine.
2. Microwave the water, milk and butter together until warm, but not boiling (you should be able to dip your finger in without burning yourself). Add to the dry ingredients.
3. Using a dough hook, turn on your stand mixer to low speed and begin mixing. Add your egg and increase the speed to medium. Continue until all combined and the mixture is coming away from the bowl easily. You can do this in a bowl with a wooden spoon or your hands but it will get messy!
4. Generously flour your surface, scrape the dough out and knead with dusted hands for four to five minutes until a smooth round dough forms. The dough will be very sticky and wet at first but keep kneading with flour until smooth. Place in a lightly greased bowl and cover with a tea towel for 15 minutes.
5. Make your filling by mixing your soft butter, cinnamon and dark brown sugar in a bowl with a wooden spoon – it needs to be of spreadable consistency.
6. Sprinkle flour on your surface and rolling pin. Place your dough on the surface and roll out into a rectangle roughly 17 inches long and 12 inches wide.
7. Spread your filling evenly with a palette knife all the way to the edges. Then fold and roll your dough gently to a long sausage. Cut the ends off and then cut evenly into 10-12 pieces. Distribute your buns in a 10 inch cake tin with the cinnamon swirls facing up. Cover with kitchen foil. Allow the buns to prove in a warm area for 90 minutes (I use a switched off oven that has been cooled down for 15 minutes). They should roughly double in size and join together.
8. Remove the kitchen foil and bake in an oven preheated to 170 degrees for 25 minutes until golden brown. If they begin looking too brown, you can cover with kitchen foil from 20 minutes.
9. Combine your ingredients for the glaze whilst the cinnamon buns are baking. It needs to be of a runny consistency. Once baked, spread your glaze immediately over your buns and allow to cool completely.

▶ ***For resources to support your wellbeing this winter visit www.rcpch.ac.uk/wellbeing-covid-19***

"I can relate to children more easily"

Jasmine Yap
4th year medical student, King's College London
@jasmineharpist



Jasmine loves talking to kids and playing the harp

I am an aspiring paediatrician because I've always got along with kids really well. I love how they have absolutely zero filter when they talk to you (I just smile through the insults!) because I like hearing about their weird and wonderful thought processes. I also find that I relate to children more easily than adults. Plus, they're adorable.

A typical day of medical school at the moment involves getting up at 5:30am because I have a long commute into central London for early morning ward rounds... I'm currently placed on obs and gynae, so I like being able to practice doing lots of history taking, clinical skills, and examinations – especially hearing foetal heart rates on pregnant women and doing neonatal assessments on newborns!

The most difficult part of medical school, for me, is that I'm a very sensitive person and the type to cry when other people do. So when I see patients cry, I sometimes find it quite difficult to hold back tears and keep it together to continue the conversation. This used to worry me a lot for when I do become a doctor, but I think it will help me to empathise more with my future patients. It's also made me so much more grateful to my lovely friends, who are always there to talk if I do come across a difficult situation.

The best part is being able to talk to such a large variety of people – patients, their families, healthcare professionals, staff, and other students.

I learn a lot from talking to patients and it's great being able to consolidate this knowledge with HCPs. But at the same time, other students at the hospital will always relate to you so it's nice to have a little support bubble that you can go to when you're stuck or need advice.

My most memorable moment was seeing a baby being born for the first time – it was very emotional, and I could not have thought of a more wonderful family and midwife to allow me to share that experience with them. I definitely found extra excuses to check the baby's observations afterwards, because he was just too cute! Another moment I have to mention was when I was volunteering with our university's Teddy Bear Hospital scheme, I asked a little girl if she knew what the heart was for, and she said, "It makes you love".

When I'm finished medical school I like to...

...play the harp. I've been playing for almost 12 years, and it's always been my favourite self-care activity. Music can be so calming, and music therapy is something I'm very interested in; pre-COVID I used to play for the patients and staff at the Royal Marsden Hospital, and they said it really helped in alleviating some of their anxiety. Playing the harp does wonders in elevating my mood, and I think music in general helps bring people closer together. I also find that taking a break from studying to play is great for helping me focus during exam periods!

BNF for Children

The first choice for concise medicines information for children

British National Formulary *for Children* 2021-22 provides up-to-date guidance on prescribing, dispensing, and administering medicines, plus legal and professional guidelines for children. It is your day-to-day handbook for using medicines safely and effectively supporting your decision-making at the point of care.

Extensive updates in the new edition include:

New monographs on:

- Cablivi® [caplacizumab] for acquired thrombotic thrombocytopenic purpura
- Cosentyx® [secukinumab] for plaque psoriasis
- COVID-19 vaccine for active immunisation against COVID-19 disease

MHRA advice:

- Aminoglycosides: increased risk of deafness in patients with mitochondrial mutations
- Epilepsy: updated advice on antiepileptic drugs in pregnancy following comprehensive safety review

To view the full list of content updates please visit **www.pharmpress.com/BNFC**

Published: September 2021

Price: £59.95

RPS Members: £29.95 (Save 50%)*

Paperback

*50% discount applies to first copy

Order your copy today at **www.pharmpress.com/BNFC**

Pharmaceutical Press

ROYAL PHARMACEUTICAL SOCIETY

With good sleep, anything is possible

Slenyto, the first and only licensed melatonin indicated for the treatment of insomnia in a paediatric ASD population[1] (2 to 18 years where sleep hygiene measures have proved insufficient)[2]

slenyto Good nights. Better days.

Prolonged-release melatonin

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, thioridazine, imipramine, benzodiazepines and non-benzodiazepine hypnotics should be avoided. Use caution with 5- or 8-methoxypsoralen, cimetidine, oestrogens, CYP1A2 inhibitors, CYP1A2 inducers, NSAIDs, beta-blockers and with smoking. **FERTILITY, PREGNANCY, LACTATION:** Avoid use of melatonin during pregnancy. Consider discontinuation of breastfeeding or discontinuation of melatonin therapy taking account of the benefit of breastfeeding for the child and the benefit of therapy for the woman. No known effects on fertility. **DRIVING:** Melatonin has a moderate influence on the ability to drive and use machines. **UNDESIRABLE EFFECTS: Very common:** None. **Common:** Mood swings, aggression, irritability, somnolence, headache, sudden onset of sleep, sinusitis, fatigue, hangover. Consult SmPC in relation to less common side effects. **PHARMACEUTICAL PRECAUTIONS:** Do not store above 30ºC. **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

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.

Date of preparation July 2020 UK/SLY/2020/1133