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

Community building

AUTUMN 2025

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Editor's pick

Welcome to the autumn 2025 edition of *Milestones*! As well as our usual features, this issue covers a diverse range of subjects which (hopefully) will bring something of interest to all reading with some excellent advice throughout covering topics from supporting surrogacy to running a workshop. Harry and Alice reflect on their time as Clean Air Fund clinical fellows – an important topic, no matter where your community is. The pages that follow will certainly provide us all with some newfound knowledge on how we can help each other in our own communities.

Speaking of communities, three trainees offer some insight into the world of community paediatrics and share their ideas for improvement in their training. This is relevant to all with many crosscutting themes across all sub-specialties. Think about what could be done in your area to make training better, and get in touch with the BACCH team if you have any further suggestions.

Andrew, RCPCH Representative for Senior Members, Senior Fellows and Honorary Fellows, discusses his role and we hear from three paediatricians who share their stories of retirement and some very wise words! Look out for more of these inspiring retirement/peri-retirement stories in future editions.

Five fellows tell us about their experiences of the RCPCH Visiting Fellowship Scheme, applications are open now for next year if people are interested in applying. Sticking with an international theme, Neelakshi talks about her volunteering roles and getting involved with the Soft Landing community.

Last, but by no means least, we hear from the most important part of any paediatric community, the children and young people. Catherine from RCPCH &Us challenges us all to think about how we engage with them. Happy reading!

Dr Hannah Baynes
General Paediatric Consultant
𝕏 **@HLB27**

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

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Milestones

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

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EDITORIAL **Publishing coordinator:** Helen Alexander **Editorial board:** Dr Seb Gray 𝕏 **@SebJGray** Dr Hannah Baynes 𝕏 **@HLB27** Dr James Dearden 𝕏 **@drjamesdearden** Dr Sharna Shanmugavadivel 𝕏 **@HeadSmartFellow**

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Update

The latest news and views

President's update

Professor Steve Turner

- *RCPCH President*

I am delighted to see the community theme woven throughout this edition of *Milestones*. When I say 'community', I mean social groupings and not the delivery of healthcare in the community (a subject I'm happy to talk about, perhaps in a later edition).

As paediatricians, you and I are part of a self-selected group of particularly sociable individuals. We were likely part of many communities before we qualified. In addition to our families, there were communities for school, sport, music, religion, neighbourhood. Today we are part of social groups in and out of work, in person and via social media.

Why do we seek communities? It's more than spending time together to avoid being alone. I have the privilege of attending paediatric meetings in the UK and internationally, and there's something warming about the 'buzz' of being together that facilitates education and learning. I gain metaphorical (and sometimes actual) hugs and pats on the back from my communities. The saying 'we are greater than the sum of our parts' is highly relevant.

As we move from job to job, doctors often find themselves as newcomers and communities are important here, too. There was no respiratory paediatrics where I was training, but it was an area that interested me. At that time, all paediatricians were assumed to be able to look after all respiratory presentations, apart from children with cystic fibrosis, whose respiratory care was provided by gastroenterologists. I gingerly travelled to respiratory meetings, not knowing a soul apart from the very senior clinicians whom everyone knew. But very quickly, I was welcomed into this community and looked after by colleagues both senior and junior.

Our college is a community, perhaps a complex community of communities. In this edition, there are contributions from several communities, including Community Child Health, our senior members and our international members' community through the RCPCH Visiting Fellowship Scheme. I hope you enjoy reading about and reflecting on these different perspectives. Perhaps it will inspire you to write an article for *Milestones* describing your community?

Child poverty

Advocating for action on child poverty

Dr Helen Stewart

- RCPCH Officer for Health Improvement

The findings of the College's recent survey on child poverty were stark. Of the 371 paediatricians who took part, 99% said poverty is contributing to ill health among the children they treat. From malnutrition to missed appointments, from damp housing to delayed discharges, the evidence is overwhelming.

The survey also revealed how poverty is changing our clinical practice. Nearly 80% of respondents reported that the health impacts of poverty are becoming more severe. Many of us are spending more time managing preventable conditions, writing housing support letters or adjusting care plans to fit what families can afford. One respondent captured the frustration: "You try your best, but it's like swimming against the tide."

But tides can turn. The UK Government has pledged to raise the healthiest generation of children and will publish a new Child Poverty Strategy in the autumn. These ambitions are inseparable. We cannot improve child health without addressing one of its most powerful determinants: poverty.

That's why the RCPCH and the Child Poverty Action Group (CPAG) are amplifying the voices of paediatricians. Our joint briefing brings clinicians' experiences to the forefront, and we're sharing these findings directly with ministers and policymakers to call for bold, evidence-based action.

A key recommendation is to abolish the two-child limit to benefit payments, which could lift 350,000 children out of poverty and ease the pressure on families struggling to meet basic needs. We're also urging the government to address the hidden costs of healthcare – taking Scotland's lead in setting up a Young Patients Family Fund to help families meet the costs of attending hospital and accessing healthcare.

Time will tell whether the Child Poverty Strategy delivers the action children need, but we'll continue to amplify the voices of paediatricians and push for the policies needed to reduce child poverty and improve health outcomes.

▶ ***Read more about the briefing at cpag.org.uk/news/child-poverty-front-line-nhs***

Leadership programme

If you want to go far, go together

Dr Ronny Cheung
- *RCPCH Officer for Health Services*

I remember the day I stepped into the role of joint head of service in my trust. I'd been a consultant for a few years, but nothing prepares you for the transition into leadership. Suddenly, it wasn't just about managing your patients, your clinic or ward round, it was about setting a direction for a whole service, navigating competing priorities and trying to be a calm, persuasive voice in an NHS that wasn't always listening.

And it didn't stop there. Moving first into more senior trust-level and then national roles meant I had to adapt again – to think strategically, influence stakeholders beyond paediatrics and champion child health in boardrooms where it often wasn't even on the agenda.

If any of that resonates, you're not alone. It's exactly why we've relaunched the RCPCH Clinical Leaders Programme – a nine-month, hybrid, peer-based leadership programme specifically for senior paediatric clinicians. The ambitious vision we all have for better care won't be realised without clinical leaders who can drive change on the ground. That means you – our members who are tasked with delivering on these ambitions on behalf of the children and young people we serve.

This development programme isn't about leadership jargon. It's about the real stuff – how to lead teams when morale is low. How to design services when the money's tight. How to hold your nerve when others don't see why child health matters as much as you do. And how to find a professional community of people who 'get it' because they're facing the same pressures you are.

"The ambitious vision we all have for better care won't be realised without clinical leaders who can drive change"

I'm delighted to have worked with experienced child health leaders across the UK to create and deliver the programme – with particular thanks to Dr Tom Holliday, a consultant paediatrician and the intellectual leadership powerhouse behind the Darzi Fellowship in Clinical Leadership in London for the past few years, who will co-facilitate the RCPCH programme.

Whether you're a clinical director, nursing or AHP lead in child health – current or imminent (in the next 12 months) – this programme will help you grow the skills, confidence and strategic thinking you need. Starting in October 2025, we'll meet in person for three immersive days at the College in London (with keynotes, workshops and a celebratory dinner), and continue learning through monthly webinars and small group Action Learning Sets over the next nine months.

More than this, you'll build a network of child health leaders, who'll support you and learn with you, not just during the programme, but for the rest of your career. Because leadership isn't a solo sport, and in a system where child health is at risk of being sidelined, our ability to lead together with clarity, confidence and community has never been more important. Let's shape the future of child health – together.

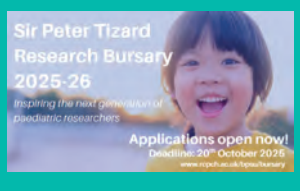
▶ ***Applications for the 2025-26 programme close 31 August, visit rcpch.ac.uk/clinical-leaders to find out more and apply.***

Impact Review

Highlighting the impact the College had in 2024, our review recognises the collective efforts of colleagues, clinicians and the children and young people we engage with, and our diverse range of partners both in the UK and internationally. Read it here: **rcpch.ac.uk/impact-2024**

Research bursary: applications open

The BPSU is once again inviting applications for the Sir Peter Tizard Research Bursary 2025-26 from early career paediatricians wishing to undertake epidemiological surveillance. Winners are given a fully funded slot on the BPSU reporting scheme and a stipend towards their training needs. Find out more: **rcpch.ac.uk/bpsu/bursary**



Journal: ADC update

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

𝕏 **@ADC_BMJ**

Heaven forbid I launch unbridled, brazenly disinhibited into this quarter's column, but with no time to dawdle in the blocks, that's exactly what I'm doing. "Apply the brake," my inner adjacent (and so often eschewed) instructor whispers, firmly, hissingly. The foot extends in acknowledgement, but half-heartedly, as I feel no need to apologise or rein in my excitement at (in deference to anyone brought up on a staple of Thursday night's *Top of the Pops*) this week's top five:

1. A WHO-commissioned systematic review series based on trials of the acute management of asthma – the sort of thing that gives evidence-based medicine the gravitas it deserves.

2. The Pavlovian pleasure and pride I get simply from looking at the nearest running order – metabolic emergency medicine, adolescent health, public health and oncology – all with clinical paediatrics seeping from their every pore.

3. The editorialists' collective wisdom in flagging the public health issues (food fortification and vaccination hesitancy, to name but two) that can't be afforded even a transient distraction from focus.

4. The modest, intensely personal Voices section, which affords a glimpse into other lives and eras, is so movingly portrayed that the house is left without dry eyes.

5. My wonder and awe for trainees. We're interacting more and more often – RCPCH talks, their engagement in reviewing, enthusiasm for research and passion for child health. It's a privilege to meet and know them.

Thanks for tuning in, as always.

Journal: BMJ Paediatrics Open update

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

𝕏 **@BMJ_PO**

I am happy to report that *BMJ Paediatrics Open* has continued to grow and develop through 2025. Gratifyingly, we have had a recent review upwards of our impact factor, which is now 2.3, but perhaps even more significant is the fact that *BMJ PO* now ranks in the top 50 journals in the paediatrics category (49/191).

As highlighted before, we attribute much of the positive growth to the targeted topic collections. We are coming to the close of submissions for **Disability and Development in Early Childhood** collection, with five published papers and several others awaiting publication. Several challenging new topic collections are now live: the India-specific **Paediatric and child healthcare in India: Opportunities and solutions**; **Children in conflict settings**; and the China-specific **The burden of neurodevelopmental disorders in China**.

Top recent picks from me highlight the wide range and importance of the topics we showcase:

- Exploring inequality through the lens of adolescents: a photovoice study in Bissau, Guinea-Bissau
- Child death review: Understanding variations in practice using normalisation process theory
- Cost of diarrhoea: A household perspective from seven countries in the Global Enteric Multicentre Study (GEMS)

"Perhaps even more significant is the fact that *BMJ PO* now ranks in the top 50 journals in the paediatrics category"

Our social media editors continue to work hard to push out the content that we publish via LinkedIn, Facebook and X. In particular, our LinkedIn account regularly features *BMJ Paediatrics Open* content – check it out and follow: **linkedin.com/showcase/paediatrics-and-child-health-at-bmj**

Please sign up for e-alerts if you have not done so already (**bmjpaedsopen.bmj.com**), and remember, as RCPCH members, you benefit from a 25% article processing charge (APC) discount when you submit to *BMJ PO*. If you submit anything for a topic collection, you also receive a 25% APC discount, and reviewers receive a 25% discount if they submit a paper within 12 months.

▶ ***Sign up for e-alerts at bmjpaedsopen.bmj.com Members interested in reviewing should visit authors.bmj.com/for-reviewers/become-a-reviewer***

RCPCH Podcasts

Tune into RCPCH Podcasts

Members and guests discuss a wide range of child health topics, such as improving patient safety, tackling health inequalities and supporting your working life and wellbeing as a health professional: **rcpch.libsyn.com**

Coming soon: Dr Guddi Singh on BBC Radio 4 and new WHAM wellbeing resource

From 29 September, tune into BBC Radio 4 as Dr Guddi Singh takes a hard look at child health in *The Three Ages of Child*. Plus, WHAM is launching a new wellbeing resource for clinicians. Want the scoop? Guddi shares more in the *Milestones* winter edition.

New paediatric mental health training course

CYP Acute Psychiatric/Psychosocial Emergencies (CYP APEx)

Dr Samantha Jones

- *Consultant in Paediatric Emergency Medicine & Paediatric Mental Health Lead*
- *University Hospitals of Leicester NHS Trust*
- *RCPCH Officer for Mental Health*

The data says it, and you will have seen it, in clinics, wards and emergency departments. Incidents of children and young people (CYP) with mental health concerns have risen dramatically over the past decade. Recent data suggests admissions to acute paediatric wards for mental health concerns have increased by 65% with approximately 50% due to self-harm, while admissions for CYP with eating disorders/disordered eating have increased by over 500%. Suicide/self-harm is second only to malignancy as the leading cause of death in 10- to 17-year-olds.

I'm the current RCPCH Officer for Mental Health. I'm part of an intercollegiate (RCPCH, RCEM, RCPsych) MDT initiative brought together by the charity Advanced Life Support Group (ALSG) to develop the CYP APEx course.

It's been developed to support staff as they come into contact with CYP who are acutely dysregulated and/or in distress/pain. Trauma and physical illness training in paediatrics are well-established (eg APLS, EPALS), but training for the mental health elements of care remains in the starting blocks.

Supported by ALSG, and led by Karen Street (former RCPCH Officer for Mental Health), Mark Buchanan (MH lead, RCEM) and Virginia Davies (previous RCPsych Paediatric Liaison Network Chair), an MDT group has been writing the manual, producing materials and developing associated e-learning to create the course.

Pilot-course participants told us:

"I felt safe throughout to try my best and learnt so, so much! It's been the best course I've ever been on by a mile."

"What this course did well was tackle some of the challenging issues and did it with the utmost professionalism and reverence that it deserves."

▶ For more information or to attend a course, please contact enquiries@alsg.org or scan the QR code to book a place.

This course advocates a structured approach to equip health professionals encountering acutely distressed CYP with the knowledge, skills and attitudes to be competent, confident and compassionate in providing safe and effective care until an appropriate onward care plan is in place.

Central to the success of the programme is the use of simulated patients who take on the roles of the acutely unwell CYP and challenge course participants to practise their communication skills in a safe but authentic setting. Alongside the simulations are workshops – written by experts, but drawing on the participants' experiences – to contextualise and embed the learning. The content has been reviewed by CYP with lived experience, and their voices incorporated.

Having demonstrated aspects of the course at the RCPCH, RCEM and RCPsych conferences, we've trialled all of the materials and are ready to launch in October 2025.

Redefining retirement
Four paediatricians reflect on flexible careers and the value of staying involved and active

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Diary dates

Events are online unless otherwise stated. We will add to this list over the coming months, so keep an eye on our website

- **Starting out as an expert witness in paediatrics: Part 1**
  10 September 2025
- **Effective Educational Supervision**
  10 September 2025, 22 October 2025
- **How to Manage: Non-malignant haematology**
  23 October 2025
- **How to Manage: Eating disorders**
  12 November 2025
- **Statement and report writing – Northern Ireland (Level 3)**
  5 March 2026
- **Statement and report writing – England/Wales (Level 3)**
  11 May 2026

▶ **Find more at *rcpch.ac.uk/courses* and *rcpch.ac.uk/events***

RCPCH Learning

- **Learning resource**
  Talking to patients about air pollution: Simulated conversations
  In collaboration with GOSH and Camden Council, we've developed four short video simulations where child health professionals incorporate air pollution into their conversations.

- **RCPCH-BPSU Webinar:**
  Don't forget rheumatic fever!
  Dr Tom Parks and the panel discuss the BPSU study and provide a refresher on Strep A disease and post-infectious disease at a time when UK children are at increased risk.

- **RCPCH Webinar:**
  Understanding childhood poverty
  Ailbhe Cashman, Poverty Proofing Coordinator at Children North East, discusses the barriers to health families experiencing poverty may face and provides information on what you, as an individual or as a service, can do to help.

▶ **Bitesize Learning**
learning.rcpch.ac.uk/bitesize-learning
▶ **Thrive Paediatrics Resource Hub**
learning.rcpch.ac.uk/thrive

RCPCH &Us 10th birthday celebrations

We were delighted to welcome Her Royal Highness The Princess Royal to the College on 24 July. The Princess Royal met more than 30 children, young people, parents and carers who shared their volunteering experiences in projects such as Asthma &Me Ambassadors, Epilepsy12 Youth Advocates, and the National Paediatric Diabetes Audit (NPDA) Communications Project.

The event concluded with a series of impassioned speeches on the importance of child health, including one from young volunteer Grace, who shared her personal experiences of being part of RCPCH &Us.

Discover how we ensure CYP voices are heard at **rcpch.ac.uk/work-we-do/rcpch-and-us** and look out for a special RCPCH &Us takeover of *Milestones* this winter.

Spin the wheel, share your expertise

- **Catherine, aged 19**
- **Lisa, parent 'expert by experience'**

At this year's RCPCH Conference in Glasgow, we gave the RCPCH &Us stand a party theme to recognise our 10th birthday this year. One of the games was spin-the-wheel, where visitors were invited to – literally – spin a wheel before answering a question corresponding to the colour they landed on. All the questions were developed by young people and based on the draft Engagement Standards framework, an ongoing project to draw up a recognised set of standards to support paediatricians when engaging children and young people's voices to improve health services. The visitors to our stand loved taking part in this game, and we wondered how many had watched *Wheel of Fortune* on TV and were fulfilling some hidden lifelong ambition!

Pick a colour

If paediatricians landed on blue, the questions were around trust, and they were asked to share things they might do so that children and young people feel safe and supported. Answers included: taking time to discover their interests; asking what's important to them; and trying to find common ground. More than one person mentioned the importance of asking the child or young person what name they preferred to be called rather than assuming, and others said they always started a consultation by asking who the child had brought with them, rather than talking to the parent directly.

If paediatricians landed on yellow, the questions were around making interactions age- and stage-appropriate. We loved hearing from one paediatrician who took patient engagement to a whole new level by pretending to be a Dalek during a consultation to make his message more accessible to a young child.

The game was important as it inverted the traditional dynamic by allowing children and young people to lead the conversation with health professionals. It exemplified the College's commitment to genuine co-production rather than one-way consultation, providing clinicians with a valuable opportunity to reflect critically on how their services are experienced from a young person's perspective, an aspect that can be easily overlooked in the demands of everyday clinical practice.

Our advice to doctors reading this article and thinking about how they engage with children and young people? Continue the great work you're doing, but never be afraid to think outside the box. Imagine you are the child, young person or parent, and put yourself in their shoes. Think about how you would like your doctor to be with you. Ask how they would like you to engage with them and don't be afraid to let your guard down a little – even if that does mean channelling your inner Dalek – to ensure they have the best patient experience.

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 are a network of young voices who work with the College, providing information and advice on children's rights and engagement.

Celebrating 10 years
RCPCH&Us
The voice of children, young people and families

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Indoor and outdoor air quality have a huge impact on children's health

Looking back on the Clean Air Fund partnership

As the Clean Air Fund clinical fellowships draw to a close, two fellows reflect on their experiences in the RCPCH Health Policy team

Dr Harry Apperley
- *Paediatric Registrar*
- *Royal Brompton Hospital*
- *RCPCH Clinical Fellow*

Dr Alice Willson
- *Paediatric Registrar*
- *North Western Deanery*
- *RCPCH Clinical Fellow*

Alice: We're coming to the end of our fellowships so it's a good time to reflect. Remind readers how you became an RCPCH clinical fellow.

Harry: I'm an ST5 Paediatric Registrar in London, with a respiratory interest and prior academic experience in global health, as well as roles in leadership and change culture. I also love cycling and my commute increased my interest in air pollution.

Alice: And what have you observed on your cycles to the Royal Brompton?

Harry: Well, the air quality in London is rubbish. I track it using a couple of apps: AirTrack by Air Aware Labs and Clean Air in Cities. I'm interested in how we record air quality. From national data to individualised exposure tracking, there's great scope for policy and behaviour change to improve health and wellbeing. I've written about it for RCPCH's Air Pollution Companion.

Alice: I'm glad you mentioned the Air Pollution Companion; it was one of our big outputs this year. Research shows clinicians lack knowledge and confidence when it comes to air pollution, so we've collated lots of useful training materials in one place.

Harry: It's an area we can all integrate into our clinical practice and make a huge difference to the communities we serve. We've just released our final upload – the *Clean air, healthy childhoods* report – which covers the impacts of indoor and outdoor air pollution on child health.

Alice: That's relevant, given current plans for Awaab's Law, which will require social

"It's an area we can all integrate into our clinical practice and make a huge difference to the communities we serve"

landlords to address damp and mould hazards that present a significant risk of harm to tenants. Tell us more.

Harry: Speaking to paediatricians, we know there's an increasing burden on patients living in highly polluted areas and substandard housing. Some innovative centres (particularly the Royal London Hospital and Alder Hey Children's Hospital) have developed novel clinics trying to solve these problems.

Alice: And what are the main learnings?

Harry: The clinics are amazing, and it's great to speak to clinicians who have dedicated time to piecing together the jigsaw of health and housing, showing the enormous impacts we can have on patients' lives. The socioeconomic challenges facing families often feel insurmountable, but it's gratifying to hear success stories of tangible change. The challenge is how you set that up or fund it in a non-tertiary/research-oriented setting. Our recommendations (*see panel, opposite*) don't just involve replicating a specialist clinic, but changes that can be made as individual clinicians, all the way up to advocating for much-needed national policy changes.

Alice: Wow, sounds like a big piece of work. I've certainly seen an increasing number of children with respiratory disease where housing is inadequate. But of course, it's not just about indoor pollution – outdoor pollution levels also have a massive impact on respiratory health.

Harry: What we're both hearing from clinical practice and teaching is that it's increasingly futile to try and care for patients without understanding the context and environment in which they live.

Alice: Absolutely, there needs to be a shift in curricula, exams and general ethos. Having national bodies unified around this is helpful. We saw with our air pollution in the UK position statement that the RCPCH can initiate change with effective advocacy for child health. I hope *Clean air, healthy childhoods* will continue to shift the dial on how the environment impacts health.

Clean air, healthy childhoods

Covering the impacts of indoor and outdoor air pollution on child health, here are our recommendations from the recently published report:

For the UK Government and administrations:
- **Introduce an update to the Clean Air Act, ensuring legal rights to clean air**
- **Meet the WHO's 2025 air quality guidelines**
- **Expand Awaab's Law across the UK to cover private renters**
- **Fund air quality monitoring in schools and empower councils to act on breaches**

For local authorities and housing teams:
- **Improve housing conditions with faster responses to mould and damp complaints**
- **Forge stronger partnerships with healthcare services**

For boards, trusts and integrated care systems:
- **Pilot 'hub and spoke' models to link specialist clinics with local services**
- **Allocate time for detailed consultations and housing advocacy**

For Royal Colleges and medical schools:
- **Embed environmental health in core curricula**
- **Encourage research, CPD and education on environmental health across specialties**
- **Use the RCPCH Air Pollution Companion to upskill healthcare professionals to have conversations with children and families on the impact of air pollution**

For clinicians:
- **Incorporate environmental history into routine care**
- **Complete an accredited CPD activity on environmental impacts on health and health inequalities**
- **Use evidence-based tools to advocate for healthier environments**

▶ *Discover the Air Pollution Companion:* ***rcpch.ac.uk/key-topics/air-pollution*** *and read our air pollution in the UK position statement:* ***rcpch.ac.uk/resources/air-pollution-uk-position-statement***

Vaping cessation clinic

It's been six months since the clinic opened its doors in Alder Hey Children's Hospital. Here are the lessons learnt so far

Professor Rachel Isba

- *Consultant in Paediatric Public Health Medicine*
- *Alder Hey Children's NHS Foundation Trust*
- *Professor of Children and Young People's Health, Lancaster Medical School*

Melissa Ashe

- *Policy Lead/ Advisor to the CEO*
- *Alder Hey Children's NHS Foundation Trust*

If you'd told us 10 years ago that we'd be running fortnightly clinics focused entirely on supporting young people with vaping-associated nicotine dependence, we might have raised an eyebrow. But here's what we've learned so far, and a few things for fellow paediatricians to consider as you plan and provide holistic services for children and young people (CYP) in your area.

The explosion of youth vaping over the past couple of years has been impossible to ignore. Promoted as a smoking cessation tool for adults, it's quickly become a habit for a generation of teens – most of whom have never smoked a cigarette in their lives.

Young people in North West England have been clear that they want us to support them to become nicotine-free, so in collaboration with public health colleagues across NHS Cheshire and Merseyside, the AdVANCeS (Adolescent Vaping-Associated Nicotine Cessation Service) clinic was set up at Alder Hey Children's Hospital. Despite a lack of evidence to draw from, the clinic was funded initially for a year and saw its first patient in January 2025.

Getting started

We initially accepted referrals from within the hospital for 11- to 15-year-olds (or up to 17-year-olds, if still under specialist paediatric services) ready to talk about cutting down or quitting vaping. However, now we are accepting referrals from other settings and working towards a model where 14- and 15-year-olds can self-refer.

The clinic is delivered by a clinically active consultant in paediatric public health medicine, usually face-to-face at the hospital (although other options are made available). These young people often have other health and wellbeing needs, such as substance use or adverse childhood experiences, so a holistic and therapeutic approach has been key as we've learned how to constantly adapt and improve the service. We see young people across the whole 11-15 age range, but we hear stories of even younger children using vapes.

The approach

Given the lack of guidance to support those looking to set up stop-vaping services for CYP, we based our clinic on the model used by the Adolescent Substance Use and Addiction Program at the Boston Children's Hospital. We offer an hour-long first appointment to establish trust and a therapeutic relationship. Each appointment is tailored to the individual and includes an assessment of nicotine dependence, an exploration of motivation to quit, a discussion about the impact of vaping and nicotine on health and wellbeing, and specific harm reduction advice, using a motivational interviewing approach. We also take a household smoking/vaping history and use this opportunity to signpost other family members to services.

We work closely with the young person to co-produce their management plan. Areas we'll cover include the frequency, format and timing of follow-up appointments. Where clinically appropriate, we offer nicotine replacement therapy in the form of patches and/or gum. Young people attending Alder Hey's Youth Forum have told us they want something "fruity" to replace the flavoured aspect of vaping, so sugar-free gum is also offered.

Next steps

The service is constantly evolving, largely in response to ongoing engagement with CYP. The clinic will undergo an independent, light-touch evaluation after a year, but research (and funding) focusing on this age group is needed urgently to understand what interventions could be used to support the large numbers of under-16s who want to become nicotine-free. Our advice to paediatricians is that you don't have to be an expert in vaping or addictions, but these young people do require a distinct approach that respects and recognises their unique vulnerabilities.

While it is promising to see the UK Government ring-fence £80m to support the ambitions of the Tobacco and Vapes Bill, we hope funding for services to specifically support CYP who want to stop vaping will be featured and prioritised in those programmes.

The AdVANCeS clinic runs out of Alder Hey Children's Hospital

Pregnancy loss and fertility issues in the workplace

The College has introduced a new policy to enable teams to support staff experiencing pregnancy loss and fertility issues

Dr Jemma Shanley

- *Paediatric Registrar ST4*
- *NIHR Clinical Research Fellow*
- *University Hospital Southampton*
- *Wessex RCPCH Trainee Committee Representative*

I'm delighted to tell you about our new RCPCH policy, which recognises and supports colleagues experiencing pregnancy loss and/or fertility challenges. For those working in paediatrics, these experiences can be particularly triggering, given the nature of the specialty and its focus on children and families. The inability to grow a family can have a profound emotional and psychological impact. Unfortunately, these issues are often overlooked or misunderstood in the workplace, affecting mental wellbeing and career progression.

Pregnancy loss affects one in four individuals, and fertility difficulties impact one in six couples[1]. These are not rare experiences – they deserve empathy, understanding and structured workplace support. With paediatrics being predominantly a female workforce, committed to advocating for families, we are well positioned to lead this change.

This policy aims to provide:

- Guidance on time off following pregnancy loss or during fertility treatment
- Consideration for a supported return to work or temporary changes in duties
- Signposting to local and national sources of support

This initiative was inspired by personal experience – navigating multiple miscarriages and unsuccessful IVF rounds as a paediatric trainee highlighted the lack of support structures in place. Many workplaces still do not have formal policies to support time off for pregnancy loss or fertility treatment.

In 2024, NHS England published a *National pregnancy and baby loss people policy framework*, recommending 10 days' additional paid leave for NHS staff in England who experience pregnancy loss. However, there remains no legal protection for individuals or partners undergoing fertility treatment, and infertility is not recognised as a disability under the Equality Act. Despite this, the Equality and Human Rights Commission recommends handling such requests with care and compassion.

Creating change

Key considerations when putting together a piece of work like this: ask yourself, can I drive real change and have I got the right people in my corner? Serving as a regional representative on the Trainee Committee offered a platform to start this work. With strong advocacy from Emma Dyer, Chair of the RCPCH Trainee Committee, a fantastic group of trainees who helped to write the guidance, and sustained support from the RCPCH, momentum built rapidly. Other specialties soon followed, and the opportunity to present at conferences further amplified the message.

This guidance has now also been published on the Academy of Medical Royal Colleges' website to be accessed by those who need it, no matter what their specialty. I am incredibly proud of how this policy has been recognised and received. I hope that it empowers others to advocate for themselves.

To find out more, download RCPCH guidance on pregnancy loss and fertility issues in the workplace: rcpch.ac.uk/pregnancy-guidance

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The fellows receive their awards from President Steve Turner at this year's conference

RCPCH Visiting Fellowship Scheme

Five fellows reflect on the moments that inspired them and the lessons they'll carry forward into their careers

Each spring, the RCPCH Global Operations team welcomes paediatric clinicians from low- and middle-income countries (LMICs) as part of the Visiting Fellowship Scheme. This year, they were delighted to host 10 clinicians from Rwanda, Kenya, Nepal and Pakistan.

"The scheme offers clinicians a chance to take part in a clinical attachment in an NHS hospital, where they focus on quality improvement strategies in their specialties," says Misbah Bhamani, Global Programme Coordinator. The fellows also attend the RCPCH Conference, and induction and debrief workshops to deepen their understanding of governance, system efficiencies and quality improvement.

Dr Anne Mburu

- *PCEA Chogoria Hospital, Kenya*

A well-known African proverb states: "The one who never travels thinks his mother's soup is the best." With this notion in mind, I applied for the Visiting Fellowship Scheme to learn how to optimise care for preterm births.

I completed my observership at Homerton University Hospital, a tertiary level 3 neonatal unit in East London, under the mentorship of Professor Narendra. During my time there, I discovered that successful outcomes stemmed not just from sophisticated equipment and technology, but from the quality of care delivered. The hospital fostered a vibrant team atmosphere, marked by strong camaraderie among staff members. Daily teaching rounds were conducted to review cases of interest, monthly audits ensured compliance with various national guidelines, and clear communication channels were established between junior and senior staff to address any arising challenges.

I was particularly struck by the effectiveness of the neonatal referral network. The hospital received complex cases and could refer stable patients back once they were well enough. Moreover, upon discharge, preterm infants were actively followed up to ensure they met their developmental milestones.

In addition, I participated in the RCPCH Conference, where I gained insights into Ryan's Rule and Martha's Rule, which enhanced my understanding of patient rights. We also attended a leadership session emphasising the importance of 'following the why', which resonated deeply with me and will guide my future endeavours.

Uwera Noella

- *Kacyiru Hospital, Rwanda*

As a nurse specialist in paediatrics, this experience profoundly enriched my clinical practice and professional perspective. Coming from a low-resource setting, exposure to the UK's advanced paediatric and neonatal systems was eye-opening. The visit provided a unique opportunity to observe best practices in family-centred care, infection prevention, multidisciplinary teamwork and structured referral pathways at University Hospitals Bristol and Weston NHS Foundation Trust.

One valuable lesson was the importance of involving family in the care process. In the UK, both parents are allowed to stay with their baby – they are involved in decision-making and provided with essential support. This holistic approach not only promotes bonding but also improves health outcomes, a model I aim to advocate for in my setting. A particularly rewarding aspect was the opportunity to see how small, thoughtful changes in practice can lead to significant improvements in patient outcomes. It renewed my confidence and gave me the tools to push for better care.

Witnessing effective handover systems, communication between departments and a well-organised referral structure offered insights for improving our own neonatal and paediatric services. The availability of specialised staff and equipment, supported by robust procurement and IT systems, highlighted the importance of system-wide coordination, even in settings with limited resources.

The fellowship also reinforced the importance of infection prevention and control measures – something our team is actively working to strengthen at

home. Simple yet powerful practices like individualised equipment per patient, handwashing culture and regular decontamination routines are already being adapted to fit our context.

Dr Zeekash Malik

- *Children's Hospital Lahore, Pakistan*

As a consultant paediatrician and neonatologist from Pakistan, I felt honoured to attend the RCPCH Conference in Glasgow and complete an honorary observership at Evelina London Children's Hospital.

I observed clinical care in the NICU, high-dependency unit and several specialist clinics, including foetal medicine, outpatient neonatology and paediatric emergency care. I also had the chance to attend team meetings, teaching sessions and discussions on complex cases, which gave me a broader view of how neonatal care is delivered in a high-resource setting. This is relevant to my current practice as my hospital is a tertiary referral facility. What stood out most was the strong focus on teamwork, clear communication and involving families in care decisions. Seeing how evidence-based practices, quality improvement and safeguarding are deeply embedded in the system made me reflect on how we can adopt similar approaches back home.

As a clinician from an LMIC, this experience helped me understand the importance of a well-organised system. I'm thankful to the RCPCH for this incredible opportunity and to the team at Evelina for their warm welcome and support. This experience has enriched my knowledge, strengthened my confidence and reinforced my commitment to improving child health in my country.

The fellows enjoying conference

Dr Tahniya Jhuthi

- *County Government Department of Health, Mombasa, Kenya*

If I were to choose one word to describe how being in the UK felt, it would probably be wistfulness. Despite never having visited, that is what I felt as I passed buildings, parks and even the iconic telephone booths. I suppose that, looking with the eye of a visitor, everything was interesting and beautiful. Except, of course, the cold. Though everyone said the weather was getting better, I came from the beach with 32-degree heat, so I think it would be understandable that I was struggling with all the wind in Glasgow during the RCPCH Conference!

I spent my visit with Professor Melissa Gladstone at Alder Hey Hospital in Liverpool to observe how children with neurodisability and neurodivergence are managed. I was assigned to various subspecialties, and I saw how different aspects of care were coordinated. Each practitioner was very involved and attuned to their patients. This ranged from having multidisciplinary meetings to make things easier for parents, home and school visits to avoid disruptions to the child, as well as accommodations to make things a bit more bearable for caregivers.

Any organisation can and should be criticised to improve, but I hope people understand how well the NHS is doing despite the challenges it faces. I also saw the value in organising care into pathways, where each practitioner has a lot of experience in their area. It not only means patients get expert support, but it also eases the mental load on individual doctors, who no longer have to manage everything on their own – they're part of a team.

What I took away from the experience is how to actualise child-centric care. Such as organising physiotherapy at school so parents don't have to miss work to take their child to an appointment or having more tangible support for parents, like an afternoon off in respite. Having a better system of assigning patients to a specific practitioner would foster consistency and be better for long-term follow-up. Finally, I hope we can organise our multidisciplinary meetings for the more complex patients to include the patient's carers and the community health team.

Dr Theodonata Tuyisenge

- *Masaka District Hospital, Rwanda*

I had the best experience at Bristol Royal Hospital for Children, where I observed a well-established universal health coverage system and highly specialised healthcare services. It was inspiring to see evidence-based care in action – for example, in the management of eating disorders within general paediatrics and the use of digital tools in managing conditions like type 1 diabetes mellitus.

At the emergency department, I was amazed by the collaboration between different teams and the well-organised patient-receiving channel. I had a great time observing the advanced neonatal care at Saint Michael's Hospital. The NHS staff in Bristol were super accommodating, and I had a great time networking with them.

As a general paediatrician trained and working in Rwanda, the overall experience was rewarding. In addition to attending various professional development activities, I was able to reflect and be grateful for what our system has been doing, as well as discover plenty of opportunities for quality improvement back home. I again express my sincere gratitude to RCPCH and NHS staff for this top-notch opportunity.

▶ ***Applications for next year's cohort open in October 2025. Visit rcpch.ac.uk/visiting-fellowships or contact Misbah at misbah.bhamani@rcpch.ac.uk***

Supporting surrogacy: What paediatricians need to know

One surrogacy-born resident doctor shares why understanding is essential to providing respectful, inclusive and effective care

Dr Georgina Roberts

- *Resident Doctor, Paediatric ST1*
- *Torbay and South Devon NHS Foundation Trust*

Surrogacy-born people are growing in number rapidly across the globe, and their very origins are why you, as paediatricians, need to be familiar with this route to family building. As someone born through surrogacy, I am passionate about advocating for the rights of other people born in this way.

Born by traditional surrogacy in the UK, I was my surrogate's third pregnancy and my parents' only child. I've been fortunate to always know about my origins and to stay closely connected with my surrogate and extended surrogacy family – including my half-brother, who was also born through surrogacy to a different set of parents (pretty cool, right?).

Throughout my time at medical school, I encountered two surrogacy-created families. While I may be more sensitive to whispering in the staffrooms – 'Who's the legal mother?' or 'Which address do we send the discharge summary to?' – I would also suggest that surrogacy is not that unusual, and we're all likely to encounter it in our careers.

Currently, the surrogate woman is the legal parent at the time of delivery, but I've been campaigning to change this alongside the England and Wales surrogacy laws reform. As part of my awareness-raising and advocacy, I recently delivered an address to the UN Joint Select Committee. Most people turn to surrogacy as the best choice among the limited options available to them. Many have experienced trauma – such as infertility, recurrent pregnancy loss or serious medical conditions – that led them to this path. As a result, the emotions surrounding the surrogacy journey can be deeply complex.

Support for all families

That's why society needs to do everything possible to ensure that parents through surrogacy are treated no differently than other parents. This is where we come in: creating policies allowing them to make decisions around neonatal care, calling them 'Mum' and 'Dad' regardless of genetics, and using sensitive language throughout paediatric care to ask the right questions in a non-damaging way. As people working with babies and children, we see firsthand the effect of parental wellbeing on our patients, and we need to support parents to ensure that we get the best outcomes for our patients.

Many surrogates I know and have spoken to are clear that they don't want to be seen as the mothers of the children they carry. If they had wanted another child of their own, they would have taken this route. Their motivations are firmly rooted in the desire to give others the incredible gift of parenthood. Yes, their role is vital and they should be protected from any harm, but treating them as parents makes them feel uncomfortable and forces a responsibility and role on them that they do not want. Being open with these families and exploring how they would like to be treated

Parents through surrogacy shouldn't be treated differently

"We need to support parents to ensure that we get the best outcomes for our patients"

during their journey is vital to making the experience joyous for all involved.

As a young child, I was asked to draw a picture of my parents. Without a second thought, I drew my mum, my dad and my 'tum mum' (that's how my parents referred to my surrogate as a child). I could easily explain the roles these three distinct people played in my life to my preschool teacher. I'm grateful that my parents shared my origins with me, which has been a key factor in shaping my confidence and passion for surrogacy. Many families choose to be open about their surrogacy journey, and studies show that this openness leads to stronger connections between children and their origins. I encourage clinicians to follow these families' examples by openly discussing surrogacy, even if it initially feels unusual.

Top tips for paediatricians

Empower parents: Push boundaries for the full inclusion of parents in the care of neonates, children and young people.

Avoid assumptions: Don't assume the relationship of an adult to a child. If appropriate, ask the child who they are with and let them use the language they're comfortable with. This avoids embarrassing moments. I've been the child in one of these situations where the doctor said 'Oh, grandma's brought you in' – it was toe-curling.

Understand family history: Ask about everyone's genetic family history, because families are complicated and we should focus on what is relevant.

Celebrate the journey: Help make the birth and neonatal period as joyous as possible. Even if a mother hasn't carried or birthed her baby, they are still every bit a mother.

Georgina gave an address to the UN Joint Select Committee

Community paediatrics: Ideas for the way forward

Community Child Health (CCH) services are in demand but under-resourced. Here, three CCH trainees share ideas for improvement

Dr Claire Stewart
- *CCH Trainee ST5, London*
- *National Trainee Representative for BACCH*

Dr Vicki Smith
- *CCH Trainee ST8, Devon*
- *National Trainee Representative for BACCH*

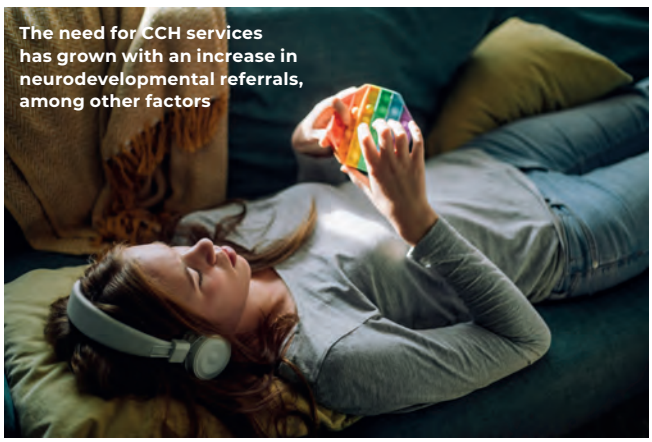
Dr Emily Thuell
- *CCH Trainee ST8, Devon*

Community Child Health (CCH) is the largest paediatric sub-specialty, focusing on the care of vulnerable children and families, including children with developmental disorders, complex health needs, neurodevelopmental conditions like autism and ADHD, and those requiring safeguarding support or in care systems. Community paediatricians work within multidisciplinary teams across agencies such as education, social care and local authorities. They hold essential public health roles, including developing safeguarding policies, implementing health promotion programmes and addressing social determinants of health. They also hold statutory responsibilities for child protection, child deaths, looked-after children and those with special educational needs and disabilities (SEND).

Formal sub-specialty training in CCH began in 2015, comprising a three-year programme, now starting at ST5, with a minimum of 24 months in CCH clinical training. The remaining 12 months provide flexibility for trainees to pursue areas enhancing their community paediatric expertise. With the introduction of Progress+, CCH rotations are no longer compulsory within core training.

Increased demand

Driven by rising neurodevelopmental referrals, increased safeguarding awareness, genomic testing advances and a greater focus on children in care, demand for community paediatric services has grown significantly in recent decades. As of April 2025, over 322,000 children and young people (CYP) are waiting for community health services, with over 180,000 waiting for community paediatrics[1].



The need for CCH services has grown with an increase in neurodevelopmental referrals, among other factors

Between April 2024 and March 2025, CCH services waiting lists rose by 11%, while adult community waiting lists fell by 2%. Concerningly, between February and March 2025, the CYP waiting list grew by 5%, equating to an additional 16,000 children[2]. This increasing demand is not matched by the current workforce capacity. The RCPCH 2022 census revealed a one-third reduction in the number of community paediatricians between 2017-22, projecting the figure would halve by 2040 without intervention[3]. To meet current demand, it's estimated that the workforce must increase by 50%, double the 25% shortage identified in 2017[2].

CCH Trainee National Survey 2025

We surveyed 88 resident doctors from across the UK, 77% of whom were less than full time. We asked what activities residents undertook on a day-to-day basis and how many clinics a week they undertook (*Figure 1, right*). Full-time residents worked approximately three to four clinics per week, and two clinics per week if they worked 60% of full-time hours.

The three main areas where residents would like to gather further exposure were public health (58%), palliative care (45%) and mental health (42%) (*Figure 2, far right*). Themes were then explored further by breaking down the curriculum and asking trainees to identify the specific aspects they needed more support with:

1. Public health data and outcome measures
2. Population health management and integrated care systems
3. Commissioning processes
4. Epidemics and public health crises
5. Public health QI

Responses highlighted the challenges associated with huge variability in the commissioning of services and the subsequent impact on exposure to certain

Figure 1

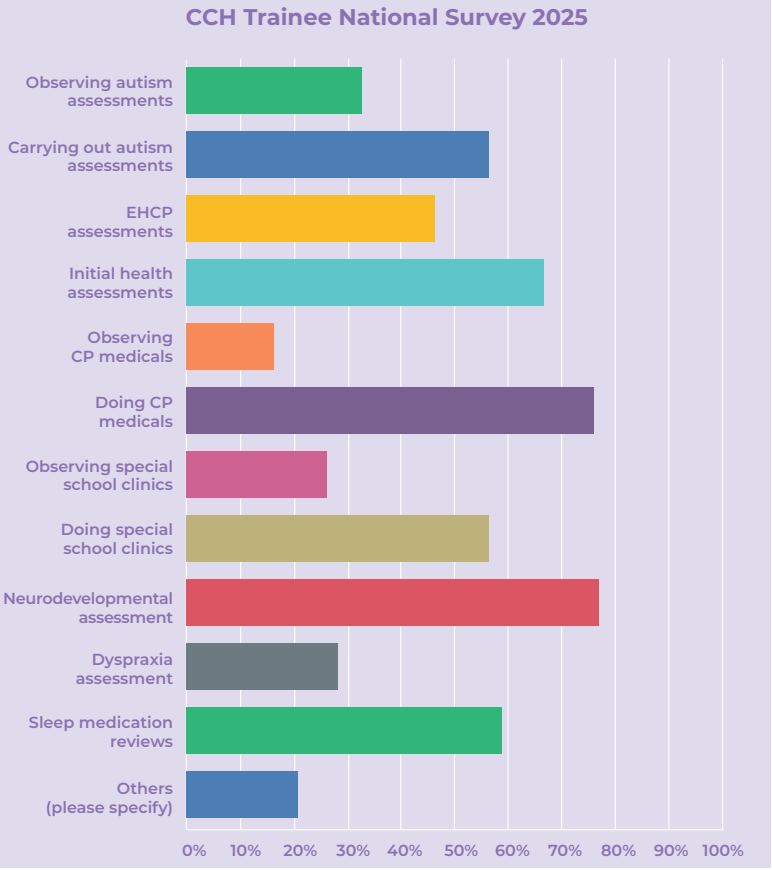
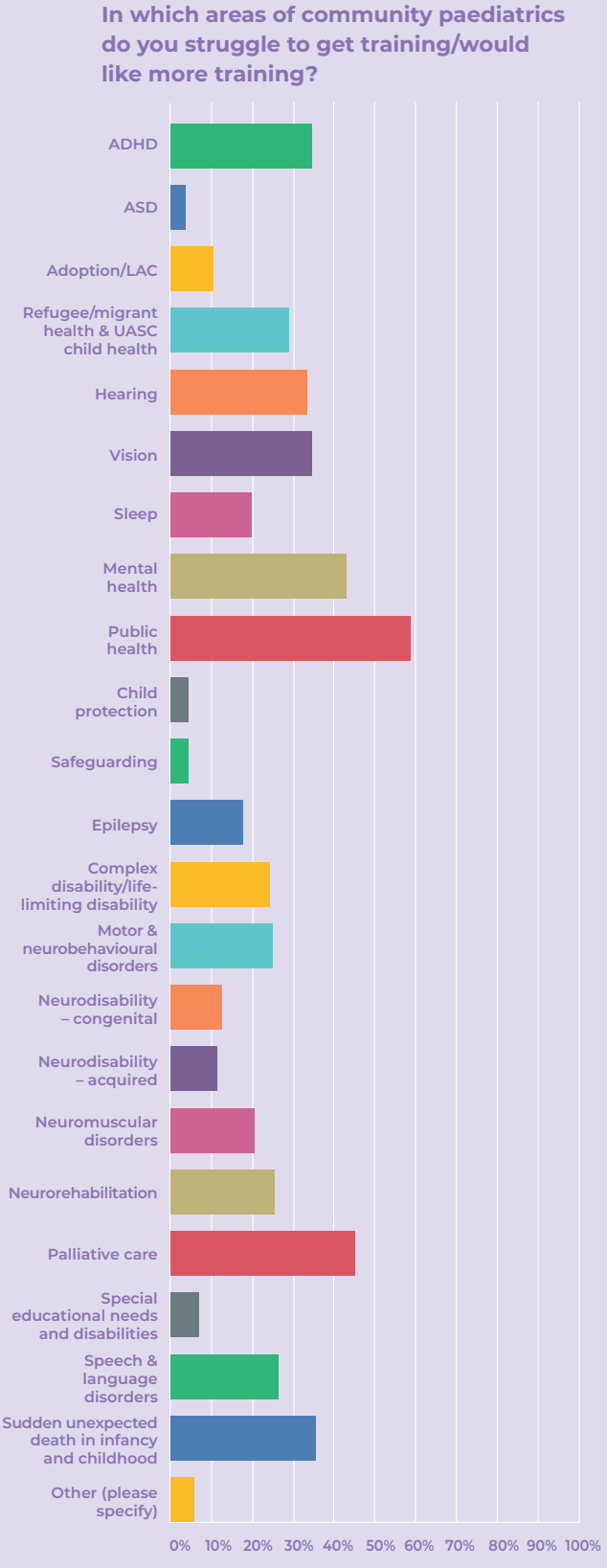


Figure 2



conditions, eg child and adolescent mental health services undertaking ADHD assessments in some regions and community paediatrics undertaking them in others. Overall, 72% of residents felt that their training was preparing them to be a consultant community paediatrician, although some felt this would depend on where they wanted to work and the role of the community paediatrician in that area.

"This increasing demand is not matched by the current workforce capacity"

Challenges facing CCH

Despite repeated recommendations by RCPCH and the British Association for Community Child Health (BACCH), community services remain underfunded. Our survey asked residents for their opinions regarding the challenges faced in CCH. Responses highlighted the increasing workload, reduced workforce and difficulties in commissioning (*Figure 3, overleaf*).

Figure 3

The 2024 RCPCH report *From left behind to leading the way* highlights the fact that community services continue to be under exceptional pressure and emphasises the importance of prioritising CCH services, investing in the CCH workforce and ensuring support for children in all settings is needs-led and does not require a diagnosis to access. The 2025 RCPCH report *Collaborative healthcare in England* suggests that the state of current services is unsustainable, and failure to address this will worsen the health and wider societal outcomes of the most vulnerable children and their families.

Help shape our services

Recognising that training could be better, and proactively seeking ways to make this happen, has led BACCH trainee representatives to create and implement the ideas currently being trialled in CCH, but we would love to involve as many doctors in training as possible and share ideas with paediatric colleagues.

By rotating through different teams and departments, trainees have a crucial role to play in identifying areas for improvement and testing solutions through local QI work. Sharing trainees' innovative ideas is a highlight of any national conference. One such project led by Dr Claire Stewart, My Voice Matters, was presented at the 2024 BACCH National Conference. This QIP responded to the national call to action to improve how pre-verbal, non-verbal and silenced children are safeguarded, and focused on improving how we capture the voice of the child in child protection medical assessments by introducing a co-designed communication toolkit. The initiative has been published in *Archives* (tinyurl.com/mbjesp22) and is being trialled in 20 NHS trusts and health boards across the UK – it's hoped this will help change safeguarding practices nationally.

Trainees can, and indeed are, shaping our services to ensure they are fit for the future and we'd encourage everyone to get involved – it is our future, after all!

▶ ***If you're interested in any of the initiatives outlined, email bacch@rcpch.ac.uk and check out the trainees' guide to the CCH curriculum: rcpch.ac.uk/BACCH-trainee-guide-download***

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BACCH supports CCH trainees

We may not be able to change how children's services are commissioned overnight, but we can work to improve training and ensure trainees feel empowered to help shape the services they deliver.

Trainees' guide to the CCH curriculum
A working group of trainees explored each of the learning outcomes and collated tips and examples for how these competencies can be achieved, including recommended resources. This resource is now available on the RCPCH website.

Monthly CCH lightning learning by national experts
These 30-minute virtual sessions focus on our CCH sub-specialty learning outcomes in rotation, with topics voted on by trainees. This has enabled us to be more responsive to trainees' learning needs, ensure everyone benefits from teaching by leading experts and address the isolation felt by CCH residents when working in smaller, remote teams.

Quarterly national CCH study mornings
With the centralisation of services comes new challenges for trainees in terms of getting sufficient experience to feel confident and competent. These tailored mornings address this and cover the harder-to-reach areas of the curriculum, such as palliative care, public health, mental health and sexual abuse.

CCH Population Health working group
Public health is the greatest unmet training need of CCH trainees, so we have established a working group of 41 CCH trainees to create new initiatives to address this, working in partnership with BACAPH.

Redefining retirement

Retirement isn't the end of the story. Four paediatricians reflect on flexible careers, unexpected turns and the value of staying involved, inspired and active

Dr Andrew Long

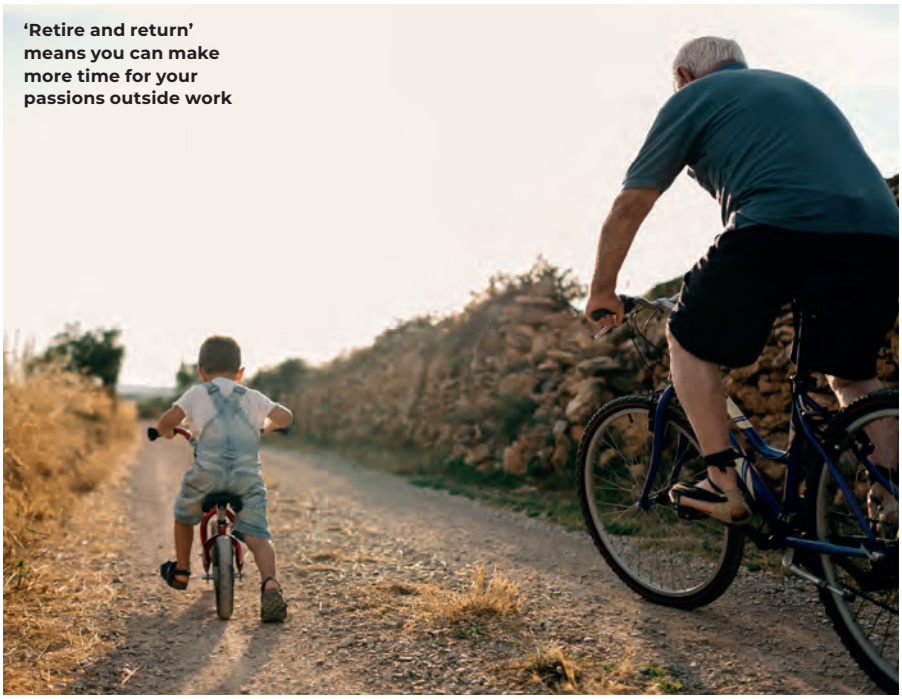
- *RCPCH Representative for Senior Members, Senior Fellows and Honorary Fellows*

I have the privilege of representing the views of over 1,000 'seniors', who come from all over the world. Although we're currently reviewing the criteria to be a senior member, most are retired paediatricians – although many are still very active in a wide range of activities. We meet via Teams monthly (and in person twice a year) to share experiences and keep ourselves updated with RCPCH activities.

I'm often asked about routes to retirement. Although I recognise that the age for full NHS pensions has been changing, many paediatricians choose to look at reducing their hours towards the end of their careers. Some also consider a change in direction, towards less intensive and more managerial or clinic-based working. My trust allowed me to 'retire and return', which meant that I was able to continue working, but on a reduced number of days, offering more time to pursue other interests.

Like many paediatricians, my early career was spent contributing to front-line care and developing new services. However, I went on to pursue medical education, spending time as director of medical education and contributing to the work of the Deanery as associate dean and head of school.

I made a bold decision to move trusts in my mid-50s, which was scary and challenging, but gave me a new zest for my paediatric work and enabled me to grow different networks, while assisting with the development of a new service. It also offered the opportunity to take on senior leadership roles (associate medical director; responsible officer) which might not have suited me earlier in my career.



'Retire and return' means you can make more time for your passions outside work

"My leisure time now is centred around grandchildren, cycling, swimming and baking – not necessarily in that order!"

Family and friends ask whether I've really retired. My answer is that retirement provides the opportunity to give up the things you found less rewarding (paperwork), continue to do the things you enjoy (teaching) but – most importantly – choose when you do them. My leisure time now is centred around grandchildren, cycling, swimming and baking – but not necessarily in that order! I also find the time to continue with volunteer work for a local hospice, a sailing charity (Sailability) and for the College.

Of course, every path to retirement looks different. In this issue, we hear from three paediatricians who've each taken unique and personal approaches to this next chapter – whether that means returning to work part time or shifting their focus toward new passions. Their reflections offer practical insight and thoughtful perspectives on what it means to transition out of full-time clinical work.

▶ ***Find out more about retire and return:*** ***england.nhs.uk/looking-after-our-people/the-programme-and-resources/pensions-and-flexible-working-in-your-later-career/retire-and-return***

Dr Charlotte Daman Willems

On countless grey Thursdays, crawling out of bed for the early ward round, retirement was an enticing dream. But as the moment approached, I realised I was also slightly anxious. I'd been part of a dynamic and busy team, built up over many years. How was I going to reinvent myself? My initial plan was to do it gradually, reducing my clinical commitments over a few years and handing over management to colleagues until I was left with just daytime clinics two days a week. In between, I thought, I could do those things I'd never managed to do – learn Latin, perhaps?

Then the pandemic struck and the world moved online. Time to embrace new challenges: the paediatric NHS111 pilot; working with the RCPCH team as we moved the clinical exam online (remember that?); and a world of art history courses that could be completed remotely. Suddenly, I was doing paediatrics in the morning and Caravaggio after lunch without leaving home. There were Latin courses too, but somehow, I was filling the hours already. As 'normal' life returned, I joined the vaccine team and met some amazing older people (as I jabbed them).

I wondered about working abroad – I found the time I spent with the ETAT+ project in Rwanda very rewarding – but didn't want a long-term clinical post. When the request for applications for the overseas Principal Regional Examiner (PRE) roles appeared it seemed ideal, I enjoyed examining both in the UK and abroad, and saw the MRCPCH exam as a way to support ongoing good care for children. I told myself that if I wasn't appointed it would reflect my age, rather than my abilities. I chose the Middle East and North Africa region as it offered challenges, and at the time included Sudan. To my delight, I was appointed and thus began a busy and exciting three years working with colleagues in the region and at the College as we brought the clinical MRCPCH back to life. It was an amazing experience working with a dynamic and varied group of clinicians who welcomed me, not only as a College representative but increasingly as a friend. My time in the role ended with us

Charlotte's PRE role in Egypt ended with a celebratory cake

cutting up my picture on cakes in Jeddah and Cairo – not something I would ever have anticipated.

Now, when a questionnaire asks about my working status, I'm finally comfortable with ticking the box that says 'retired'. In fact, I tick it proudly as I look forward to my next trip abroad, knowing I also have the opportunity to see that exciting-looking exhibition (over-65s get lots of concessions), go to a daytime concert, tend to my allotment (another new venture), read too many books and, who knows, perhaps finally sign up for that Latin course.

Dr Anne Kelly

Long ago, I'd planned to retire by the time I was 55. However, for those of us who are lucky enough to have stayed healthy, 60 is more like the new 50, even if we don't look like Liz Hurley! That said, I didn't like the idea of becoming the department's old curmudgeon, muttering about how different things used to be. The world has changed and so should we. Keeping that in mind, along with a long-held pipe dream, my partner and I decided to buy a petite maison in France with a view of some mountains. We'd finance it by continuing to work part time for as long as we were needed and were motivated to do so.

It seems everything can be done now on a part-time basis. I only wish this same enlightened thinking had operated when I first started training in paediatrics. Our employing trusts allow us to work flexibly three days per week, for several months at a time, interspersed with blocks of months away from work, following a pre-agreed yearly plan. This pattern is possible as neither of us now works acute rotas. In addition, we work during school holiday periods, allowing younger colleagues more flexibility when planning their leave. We're able to enjoy a slower pace of life in France and return to work refreshed through this mutually beneficial arrangement.

Anne's 'petite maison' in France

I feel lucky to have this flexibility, especially after experiencing stress earlier in my career while working full time, when my children were younger. Now, being able to choose when I work, I can reflect on its value and not have some of the more tedious tasks deter me from continuing.

Initially, I worked as a general/community consultant with an on-call commitment. This was followed by posts in two other trusts working in neurodisability and child safeguarding. Now, I undertake some expert witness work in family courts, which is demanding but also familiar through my NHS experience.

I've had some difficult experiences in my career, which have left me feeling phlegmatic about professional and personal issues that may arise. I look back with a mixture of relief and pride, especially as I didn't leave when times were tough. I persevered and can now enjoy my role. Planning is required for a staged retirement, and if possible, begin the process early.

Dr Tina Sajjanhar

When I qualified at the age of 23, retirement seemed a lifetime away, but the years have sped past. Reaching 60 was a time for reflection after 37 years and a very satisfying career in an NHS that I was passionate about. I qualified in 1987 from Guy's Hospital Medical School, intending to follow in my father's footsteps. He was a single-handed GP in Essex, having moved his family from India via Nigeria to England, and starting again at the age of 40. However, after my GP training scheme, much to the disappointment of my father, I took up a post at the Royal London Hospital as a paediatric SHO. I quickly knew I had made the right decision.

My journey to becoming a consultant was pretty straightforward – a registrar post followed by time in a paediatric intensive care unit and then a senior registrar post. I found myself thriving in the acute environment and resolved to follow a career in paediatric A&E. I accepted a consultant post at Lewisham Hospital in 1998, where I've worked ever since.

Working at the same place for nearly 27 years, I've had a varied career as a consultant paediatrician, experiencing so many aspects of the healthcare system and having the opportunity to influence and champion services for children. The stability of my permanent post allowed me to build a department and develop its reputation locally and nationally, and I feel immensely proud of the doctors, nurses, managers and healthcare professionals I worked with over the years.

My pre-retirement years were not without drama. I recall thinking about retirement from my early 50s, recognising that a certain amount of planning was required, but then in 2019 I was diagnosed with metastatic breast cancer, which made me realise I was not infallible and that some things were out of my control. That, alongside the pandemic, put paid to many of the plans I'd made.

Tina, here at the top of Mount Kinabalu, enjoys staying fit and active

"The change in legislation allowing partial retirement was a game-changer. It afforded some stability while releasing time to spend with my children"

My cancer diagnosis made me wonder if I should take early retirement and do all the things I hadn't had time to do, but as my health improved, I realised I needed a plan B. With the support of my department, I gradually shifted my focus to retain some clinical work alongside leadership roles, which allowed me to still feel valued and have a fulfilling work life. The change in legislation allowing partial retirement was a game-changer. It afforded me some degree of job stability while releasing time to spend with my children who, despite being grown up, I felt needed me more rather than less.

I now work an 8PA week, allowing me to support my department and have a satisfying career, which includes my volunteer work for the examinations department of the RCPCH – I am also enjoying having more time for challenging roles such as Chair of the Clinical exam. I also have some time to pursue hobbies such as photography, walking and remaining fit and active to maintain my health, recognising that age catches up with all of us. While the term 'work-life balance' has become a mantra for younger generations, my generation could learn from that and recognise that life has moved on and priorities are different.

Medicine has been a vocation and a way of life for me, and I wouldn't have it any other way. Being in the thick of things means retirement kind of creeps up on you, so think ahead from about 10 years before you plan to retire. That said, I've learnt that you can plan all you like, but sometimes, life will throw you a curveball.

Instead of thinking of what might have been, the ability to adapt can still allow fulfilment. Now things are not better or worse, just different. I celebrate each day and think of how lucky I've been along the way and how my career in paediatrics was the best decision I made.

We'll feature a range of retirement stories in upcoming issues, showcasing the many ways paediatricians are navigating life after or alongside clinical practice. We'd love to hear yours, so email the team: milestones@rcpch.ac.uk

Clinical guidelines: How to run a workshop

In response to member demand, hands-on training is helping clinicians develop the skills to create high-quality, evidence-based guidelines

Thank you to the faculty (pictured, from left): Harshna Ravindran, Nish Talawila, Michaela Lazner, Sue Protheroe, Jan Dudley (who conceived the idea), Jo McCormack, Rosa Nieto and Manjith Narayanan

Sue Protheroe
- *RCPCH Officer for Clinical Standards and Quality Improvement*

Michaela Lazner
- *RCPCH Clinical Co-lead Evidence-Based Clinical Practice*

Manjith Narayanan
- *RCPCH Clinical Co-lead Evidence-Based Clinical Practice*

Following the 2024 RCPCH members' survey – where 92% of respondents agreed that access to guideline development training was necessary, and 85% felt the College should provide it – the research and education team designed and delivered a workshop to meet this clear demand.

The aim was to equip clinicians with skills to support the creation of high-quality, evidence-based guidelines that reduce variation in care, improve safety and enhance outcomes for children and young people. The workshop covered the principles of guideline development: how to carry out a systematic review; how to critically appraise clinical evidence; and how to use the Delphi method to develop a consensus on a specific topic.

Planning the workshop

Preparation for the workshop started almost a year in advance. The first step was to agree on how we would achieve the learning outcomes. A well-paced, structured and engaging agenda aligned to the learning objectives was important so that participants knew what to expect from the workshop before they registered. We decided on a free face-to-face meeting to facilitate interaction between delegates and faculty joining each table.

The next step was to advertise the workshop via a newsletter, social media and targeted emails to specialty groups. Places filled up rapidly and we reviewed attendees' skill sets to tailor our content so it was relevant to consultants, doctors in training and established leaders in quality.

We shared links to the guidelines hub and RCPCH Learning platform, so delegates could complete the pre-course e-learning module and have a baseline knowledge. The next step was to rehearse the content and test the group practice activities (within tables) and the interactive voting using Mentimeter.

We wanted to create an inclusive, welcoming atmosphere where participants felt valued and respected so that they were comfortable participating and interacting with colleagues. We also planned for the unexpected with a back-up date for the workshop due to an unforeseen tube strike.

Post-course evaluation and subsequent team reflection were crucial to take on learning opportunities for the next course.

What attendees enjoyed

The workshop received overwhelmingly positive feedback, with an impressive overall satisfaction rating of 4.7 out of 5.

Participants appreciated the clarity and enthusiasm of the presenters, with one noting it "made a difficult topic accessible and understandable". The blend of direct teaching and practical tasks was especially valued, helping clinicians immediately apply their new knowledge. The face-to-face format offered valuable opportunities to engage directly with experts. "I felt energised about this field at the end of the day," one attendee reflected.

For further resources, visit our guideline hub: rcpch.ac.uk/resources/developing-a-clinical-guideline

Scan to participate in guideline development and register to hear about future workshops

Scan to visit the guideline development hub

The social network

Volunteering roles within resident doctor-led organisations gave this international medical graduate paediatrician a home away from home

Dr Neelakshi Ghosh

- *Paediatric Oncology GRID Trainee*
- *University College London Hospitals NHS Foundation Trust*
- *Trainee Representative, RCPCH Workforce Planning Board and RCPCH Global*

It was almost a year after moving to the UK that I truly felt I was away from home. I found myself sitting at the edge of the bed, exasperated because a button had come off the dress I was going to wear. I didn't have a needle and thread and the nearest shop was a mile away. As tears welled in my eyes, I recalled the bottom left drawer in my cupboard back home in Kolkata that had the 'essentials' – a box of safety pins, a sewing kit and a stapler. Things you collect over the years. Things that help you fix yourself when you come home broken. And there I was, away from home. Broken.

In the first few weeks of starting my first NHS job, I had a mental checklist of priorities. It resembled the pyramid of Maslow's Hierarchy of Needs – but upside down. Exams, acquiring competencies and career hoops to jump through surpassed the need for friends. As a career migrant, your human interactions seldom stretch beyond the workplace. In a hospital job, you're with your workmates on 12-hour shifts, sharing ready meals and supporting each other through life-and-death-defining decisions. But that closeness ends with the end of the shift, not knowing when the rota will bring you together again and, with rotational placements in NHS training jobs, you'll probably never see each other after the six-month stint. And that matters for overseas doctors who depend on workplace-based social networks and friendships.

Finding a lifeline

My pyramid was wobbling on its pinnacle when I found my lifeline. Volunteering with Soft Landing happened by chance. An email introduced me to this wonderful group of people who are committed to helping new doctors who have joined the NHS. Attending virtual meetings and arranging induction workshops and webinars for international medical graduates (IMGs) soon evolved into exploring each other's cuisines. We were from all over the world, joined by a common thread of being away from home and trying to find that 'soft landing' in the NHS. I found some of my best friends here.

Over time, my volunteering role expanded – organising RIPPLE (a London-based regional teaching programme for the MRCPCH clinical exam), joining the London School of Paediatrics Trainees' Committee and becoming a part of REACH, the resident doctor-led research network in London. The leadership and management skills gained from these roles are indispensable, but the most cherished gain is being a part of a community. Connections beyond the workplace that brought me friends for life.

Resident doctor-led networks allow a group of us to come together with a shared purpose. There are team socials, a team check-in before meetings and a chance to find commonality, which could lead to a trip to the cinema or a museum visit. Although unpaid and likely to involve non-working hours, volunteering provides that much-needed sense of belonging for IMG doctors, and it refines communication skills and offers wider opportunities. Resident doctor-led organisations should uphold their spirit of inclusivity, opening their roles for IMG doctors and championing their participation.

I do own a sewing kit now. But in those moments of exasperation, I also have these wonderful friends on speed dial who would instantly agree to sweat with me on a Parkrun, pull me up if I stumble and thread the needle if I fail. They have helped build me a home away from home.

Neelakshi (second from left) with Team REACH at this year's RCPCH Conference

▶ ***Find out more: Soft Landing (soft-landing.org) is run by IMG paediatricians and supports IMG paediatricians arriving to work in the NHS from overseas. The RCPCH has guidance for doctors who are thinking of coming to work in the UK: rcpch.ac.uk/resources/opportunities-uk-international-doctors***

L-EAP across the channel

The European Academy of Paediatrics is a win-win for paediatrics and child health in the UK and Europe, and for the individuals who contribute

The European Academy of Paediatrics (EAP) and the European Paediatric Association (EPA) are two organisations that bring together paediatricians from across Europe. RCPCH is represented on both.

Focusing on the EAP is one way that UK paediatricians can be involved with European colleagues. Established as a section of the European Union of Medical Specialists (UEMS), EAP represents over 50,000 paediatricians across Europe. It serves as an umbrella organisation bringing together 53 national paediatric societies, 14 sub-specialty societies and trainee representatives with the aim of improving the health of children and young people in Europe.

The EAP works on standards in training, service and research, and advocates for evidence-based practices and policies at an EU level. Within EAP, the European Board of Paediatrics (EBP) is aimed at harmonising training in paediatrics and has recently established a new European exam, as many other medical specialties already have.

Young EAP (yEAP) is the paediatric trainee branch of the organisation and national resident representatives. Residents contribute to many projects, including Choosing Wisely, comparison of training programmes, and the conference scientific organisation.

"yEAP brings together individuals who see paediatrics not just as patient care but as an opportunity to influence the wider child health landscape"

A trainee perspective

Dr Debora Calderoni

- *ST4 Paediatric Registrar*
- *Southampton*
- *yEAP RCPCH Representative*

Dr Francesca Seregni

- *ST8 Paediatric Neurodisability*
- *Cambridge*
- *EAP Fellow*

Becoming involved with the yEAP has been an invaluable part of our paediatric training and an incredible leadership experience. It's provided the opportunity to contribute to projects that influence child health at an EU level, something we had not imagined being part of so early in our career. Having first-hand experience as international medical graduates, we appreciate the importance of harmonising training and creating common standards for paediatrics in Europe.

Being interested in education, we contributed to the Core knowledge in paediatrics (CKP) course and question writing for the European exam. We had the opportunity to work alongside committed colleagues from across Europe, gaining insight into medical education development, project coordination and international teamwork.

What stands out is the collaborative spirit and shared motivation among trainees. yEAP brings together individuals who are eager to contribute beyond their clinical roles – who see paediatrics not just as patient care but as an opportunity to influence education, policy and the wider child health landscape across Europe. If you're a trainee looking to broaden your impact, we highly recommend getting involved.

A consultant perspective

Dr Sian Copley

- *Consultant Paediatric Gastroenterologist*
- *Manchester*
- *yEAP Vice Chair*

I first got involved with yEAP as an ST3, when I was the North East representative on the Trainee Committee. Being involved in developing the yEAP to where we are today has been one of the proudest parts of my career. We now have representatives from most European countries and are involved in all activities of the EAP, contributing to working groups, research and projects, including on an EU level.

I couldn't recommend getting involved with EAP more, for the experience, connections and friendships, plus the chance to influence children's health opportunities.

Dr Jonathan Darling

- *Consultant Paediatrician*
- *Leeds*
- *RCPCH VP for Education and Professional Development*

Isn't paediatrics in the UK quite separate from the EU? What is there to be gained by working together? It's part of our mission to improve child health. Working together leads to beneficial harmonisation (especially relevant when trainees from Europe move to the UK), improved standards and sharing of best practice. It also means a voice in the European decision-making body that oversees training and certification, and achieving goals that are difficult to reach in isolation. Finally, working with paediatricians from across Europe brings new insights, perspectives and opportunities, and is, of course, very enjoyable.

Members

The latest member news and views

KEEP IN TOUCH

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

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

Research Awards 2025

Celebrating outstanding contributions to paediatric research, winners were announced at this year's RCPCH Conference

◀ *Scan to learn more about our awards and to apply*

RCPCH-GOSH Dr Simon Newell Early Independent Researcher Award

With support from the Great Ormond Street Hospital Charity, this award recognises an outstanding young medically qualified researcher in British paediatrics. The winner is **Dr Claire Wood** for her research in paediatric endocrinology.

Dr Claire Wood

Claire says: "Winning this award is a huge honour and I would like to thank all my academic supervisors. I certainly would not have won this without their unwavering guidance and support. I look forward to continuing to establish my career in academic paediatric endocrinology."

RCPCH Outstanding Publication Award

Awarded for the best scientific paper(s) on any subject related to paediatrics, the winners are **Dr Ceri Evans** for *Inflammation and cytomegalovirus viremia during pregnancy drive sex-differentiated differences in mortality and immune development in HIV-exposed infants* and **Dr Sarah Leiter** and **Dr Angus Hodder** for *Benefits for children with suspected cancer from routine whole-genome sequencing.*

Dr Ceri Evans

Ceri says: "I was thrilled to receive this award for my work exploring how the immune environment in women with HIV during pregnancy drives immune development and mortality in their children, highlighting potential new intervention strategies. This was the culmination of years of research with a large team at the Zvitambo Institute in Zimbabwe, and I'm grateful to my funders, collaborators and all the mothers, children and families who participated."

Dr Sarah Leiter

Dr Angus Hodder

Sarah and Angus say: "This was a truly collaborative project, and we'd like to thank the whole team for their dedication and hard work. We particularly thank all the senior authors for their guidance and ongoing mentorship. We hope that more children with cancer worldwide will benefit from improved diagnostic and targeted treatments."

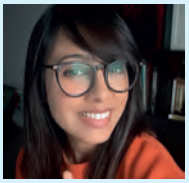
RCPCH-NIHR Paediatric Involvement and Engagement in Research Prize

Recognising significant contributions to excellent patient engagement for NIHR CRN Portfolio studies, this prize is awarded to the Born in Bradford: Age of Wonder (BiB: AoW) team, who are **Dr David Ryan**, **Jennie Ellul**, **Zarina Mirza** and **Professor John Wright**.

The team says: "We are delighted to win this award. Co-production and public involvement are hugely important to us at Born In Bradford (BiB) and central to BiB: AoW. This has only been made possible by the many young people, parents and teachers who gave their time, thoughts and perspectives. Huge thank you to Emma Holmes, Penny Wild and the Young Dynamos, Michael Davis, Julie Whiting, Isha Ali and the Healthy Minds Apprentices, our BiB Parent Governors and BiB Young Ambassadors (to name just a few)."

Dr David Ryan

Jennie Ellul



Zarina Mirza

Professor John Wright

Williams Syndrome Cooper Bursary

Introduced in 2024 to recognise the best scientific paper related to paediatric learning disability, the inaugural bursary winner is **Dr Thomas Isaac**, for *Measuring the impact of deprivation on learning difficulties and behaviour among infants born preterm: A cohort study.*

Dr Thomas Isaac

Thomas says: "I'm incredibly honoured and humbled to be the first recipient of this bursary. It's deeply exciting to have my work recognised by the College, and attending the RCPCH Conference as a prize winner was a truly inspiring opportunity. This award and the bursary are a brilliant platform to help further develop my research career."

Book review: *An acquaintance with death: Memoirs of a paediatrician* by Dr Richard G. Wilson

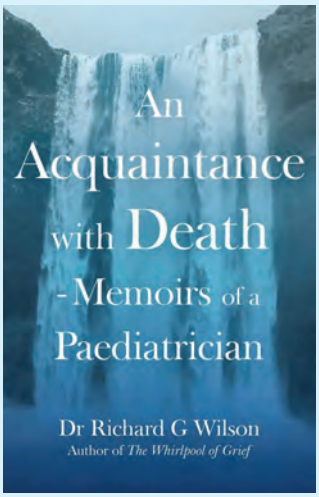
Professor David Hall

- *Honorary Professor of Paediatrics, School of Child and Adolescent Health, University of Cape Town*
- *University of Sheffield, SCHARR & the Department of Family Medicine and General Practice (retired 2005)*
- *RCPCH President (2000-03)*

Fifty years ago, most district general hospitals had only one or two full-time paediatricians – indeed, one early aim of the British Paediatric Association, long before the formation of our College, was to ensure that no paediatrician would be single-handed. When Dr Richard G. Wilson was appointed at Kingston Hospital, he was its first full-time consultant paediatrician. I worked with him as a senior registrar in 1976-8 and, many years later, I valued his wisdom when the College was confronted with public anger and professional controversies, firstly over the misuse of statistics regarding the probability of two 'cot deaths' occurring in one family and subsequently on the role of covert video surveillance in demonstrating that some parents deliberately harm their children.

For much of his 30-year career as a consultant, he took the lead in ensuring a thorough investigation of all child deaths, whatever the actual or suspected cause, and in supporting and counselling the whole family, including the siblings of the child who had died. He had a particular interest in what we used to call 'cot death' and contributed in many ways to research programmes on child deaths, often supported by parent organisations. These have spawned a veritable salad of abbreviations and projects – FSID, SUDI, SIDS, CESDI, CONI.

An acquaintance with death: Memoirs of a paediatrician is more than a memoir; all child health professionals – not only doctors – would benefit from his historical perspective on the scientific background as well as his compassionate approach to the tragedy of a child's death, as it evolved over his 30 years at Kingston. It is unlikely that any paediatrician in the 21st century would be able to acquire such a broad experience. *An acquaintance with death* invites us all, whatever our age and discipline, to reflect on our professional response to the death of a child.



History taking: The antihaemorrhagic vitamin of the chick

Dr Richard Daniels

- *Paediatric Registrar*
- *St Mary's Hospital*

@DrRDaniels

There are columns where the hardest part is to find a catchy title to draw your attention. It's a different skill from writing prose, and not one that everyone has. You know who else struggled with this? Henrik Dam.

Henrik was a Danish scientist who had some chickens. See, that's a good first line. You're enthralled. What happened to Henrik? What happened to his chickens? Henrik took away their fat, that's what. In 1929, he fed them denuded feed and noticed they started bleeding. He added back pure cholesterol, but to no avail. So Henrik suggested the existence of a second agent with an impact on 'koagulation'. Vitamin K had arrived. For this discovery, Dam and his colleague, Doisy, were awarded the Nobel Prize in 1943.

This was only half the story. In 1894, Charles Townsend, a Boston haematologist, published a case series of infants who sustained haemorrhages in the first week of life. He distinguished them from other children believed to have haemophilia. William Wirt Waddell Jr connected the dots. In 1939, he started experimenting with Vitamin K supplements for babies, showing a reduction in the number of haemorrhages (although a rise in kernicterus due to high doses). The premise was proven.

How to translate this to clinical practice? Nobody worked this out until surprisingly recently. Before national guidance on universal Vit K administration, the most common offer was 1mg to babies 'at risk' of haemorrhage with regimens determined locally. The BPSU were key in getting the evidence base to where we are today, with the current guidance only being rolled out in 2008.

So, what was Henrik's catchy title that caught Waddell's eye? See above. It's eggscellent.

ASH'S BAKING SCHOOL

Chocolate hobnobs

Dr Ashish Patel
- *Consultant Paediatric Nephrologist*
- *Leeds Children's Hospital*

@DrKidneyAsh

This issue I'm heading back to basics. I am a strong believer that basic bakes are the best! You don't need to be fancy with your decoration, it shouldn't become a chore to make and, at the end of the day, it's all about the flavour and spreading the love.

I decided to poll my team on their favourite biscuit. I was expecting the beloved bourbon or classic custard cream to come out top, but surprisingly, the chocolate hobnob was many colleagues' highlight. I needed to understand the hype and I'm now a convert!

This is the easiest biscuit I have ever made. In addition to the ingredients, you just need a bowl and spoon, so it's an accessible bake for any family. The hardest part for me was finding wholemeal flour, which is key to getting the correct flavour and consistency. Apart from that, let the ingredients do their magic and enjoy a hobnob with your next afternoon brew.

Ingredients
- 100g soft unsalted butter
- 100g light brown sugar
- 50g golden syrup
- 125g rolled oats
- ½ teaspoon bicarbonate of soda
- ½ teaspoon salt
- 150g plain wholemeal flour
- 100g milk chocolate (melted, can also use dark chocolate)

1. Preheat your oven to 180°C/160°C (fan-assisted) and line two baking trays with non-stick baking paper.
2. Add the butter, brown sugar and golden syrup to a bowl and beat together until combined (you can use a mixer or beat by hand).
3. Then add the oats, bicarbonate of soda, salt and wholemeal flour, and mix again until combined.
4. Take heaped tablespoons or use an ice cream scoop to make balls of the mixture and spread them out on the baking trays. Push each ball down until almost flat.
5. Bake for 12-15 minutes, depending on how crunchy you want the hobnobs to be, and allow to cool completely.
6. Turn over each of the biscuits so the flat surface faces up.

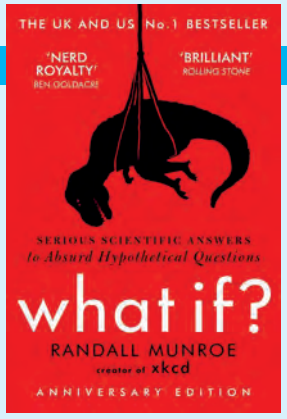
7. Melt the chocolate in bursts in a bowl in the microwave or on the hob in a small saucepan. Then add a teaspoon of melted chocolate onto each flat biscuit surface and spread to the edges.
8. Leave the chocolate to set or speed up the process by placing the biscuits into the fridge. Enjoy!

CYP Book review: *What if?* by Randall Munroe

Toby
- *Aged 20*

This popular science book provides scientific explanations to many absurd and wacky questions, including: 'How many printers would you need to keep up to date with printing the entirety of Wikipedia?' and 'What if you tried to collect physical samples of the entirety of the periodic table of elements?'

I really enjoyed going through this book and getting answers to some of the questions I've thought about before, in both an efficient and amusing way. This kind of book is great for curious people, but also for anybody who wants to learn more about science and the world in general. Five stars!



A day in the life

“The clinical voice is powerful, shaping strategies and improving care”

Dr Chris Dewhurst
Medical Director and Neonatologist
Liverpool Women’s NHS Foundation Trust

Most mornings start the same way: a podcast or audiobook on my drive to work. I gravitate toward historical or catastrophic themes – human history, serious crime, nuclear war. It might sound grim, but I find that zooming out and reflecting on the bigger picture helps put the daily pressures of working in the NHS into perspective.

Once a week, I return to clinical work in neonatology – a specialty I love for its complexity, pace and hands-on nature. I work alongside a team of brilliant consultants, and these shifts are often the highlight of my week. Being on the front line keeps me grounded in the reality of the care we provide. It’s also a vital way to stay current in a fast-evolving field.

The rest of my week is spent in my role as medical director. My path into leadership began with being the named doctor for safeguarding, then progressed through roles like trainee programme director and clinical director for neonatal and maternity services. Each step brought new challenges and insights – supporting individuals, understanding regulatory compliance, strategic planning and NHS finances.

I’ve also completed several leadership programmes, including the NHS Leadership Academy’s Nye Bevan programme. One of the most valuable lessons I’ve learned is the importance of self-awareness and how you ‘show up’ in work. Sometimes this is second nature but on other days, I need to make a purposeful change to be my ‘best self’. Leadership isn’t just about decisions; it’s about understanding your impact on others.

When I finish work

Evenings are for family dinners and spending time with the children. Twice a week, I head to brass band practice, where I play the BBb tuba. It’s loud, immersive and the perfect way for me to unwind.

No two days are the same. My schedule includes board meetings, one-to-ones with consultants, writing papers and responding to unpredictable events, such as urgent safety issues, concerns about consultant colleagues, press enquiries or requests from external bodies like NHSE or the GMC. I’ve realised not every request can be fulfilled. My core responsibility is ensuring patient safety and clinical quality. That has to come first. Supporting my medical colleagues and making sure their voices are heard in decision-making is my next priority. The clinical voice is powerful, shaping healthcare strategies and improving care for our populations.

The hardest part of the job is the sheer volume. With 200-300 emails a day and constant demands on time, it’s a challenge to stay on top of everything. There’s also the emotional weight of leadership – making tough calls, managing crises and knowing that not every decision will please everyone. Balancing compassion with accountability is a daily test.

The best part of the job is shaping services to better meet the needs of our population. Recently, we analysed our local demographics; only 10% of the population we serve resemble the typical NHS senior leader – white British and among the least deprived. That statistic is a powerful tool in advocating for more diverse leadership. I’m aware of the irony, as a white male in a senior role, but I believe it’s our responsibility to use our platform to amplify underrepresented voices.