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

PROGRESS+ KICKS OFF

SUMMER 2023

INSIDE

RCPCH Child Protection Portal

Child Protection and Safeguarding in the UK

Our Child Protection Portal is your essential resource to help inform clinical practice, child protection procedures, and professional and expert opinion in the legal system.

Now more than ever it is important for paediatricians and the wider child health team to be prepared to be equipped with the best child protection and safeguarding skills and knowledge.

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

The Child Protection Portal offers access to six vital sections:

Child Protection Companion

Evidence & Reviews

Standards & Resources

Safeguarding Legislation

Child Protection Advocacy

Educational Opportunities

Find out more: **childprotection.rcpch.ac.uk**

Take a look at our online book shop! We have textbooks for the MRCPCH and Diploma of Child Health exams, evidence-based reviews and reference books. Log on and shop today...

RCPCH Publications

www.rcpch.ac.uk/shop-publications

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

Editor's pick

On behalf of the *Milestones* crew, welcome to this summer edition, another vibrant read brought to you by our wonderful editor-in-chief Aisling.

Dr Griffin's experience of the same world through a very different lens demonstrates so beautifully how personal adversity can profoundly shape your professional development. Sharing these deep reflections and role modelling a change in practice, can positively influence the compassion and understanding of many others.

Fabulous youth friendly initiatives challenge us to shift our mindset from asking what ailment a person has come with, to being curious about what else might be going on for them. This is echoed by public health colleagues encouraging promotion of national health rather than national treatment, and looking at the bigger picture.

It's great to see the flexibility and opportunity that Progress+ brings. I'm hopeful that retention will improve.

And to add to my to do list: 'test whether condensed milk does make a biscuit more crispy'!

Dr Dita Aswani
Consultant Paediatrician specialising in Diabetes and Weight Management Sheffield Children's NHS Foundation Trust, @DrDita

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

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Leading the way in Children's Health

jamespembroke media

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Update

The latest news and views

KEEP IN TOUCH

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

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

PRESIDENT'S UPDATE

Dr Camilla Kingdon
RCPCH President
@CamillaKingdon

I LOVE THE SUMMER EDITION OF *MILESTONES* as it's exactly the kind of magazine to have next to the sun lounger or under the umbrella! Here's hoping we have plenty of sunshine and each of us gets the opportunity to relax and unwind.

As paediatricians, we have always been accustomed and conditioned to busy winters. Until a few years ago, the reward for all the grit and determination that allows us to survive during the winters was a few months of relative calm in the summer to catch up on audit and quality improvement work, personal professional development and taking a break. The truth now, though, is that we seem to have lost the rhythm of the seasons and the pace of work, and the demands on each of us continues relentlessly for 12 months of every year.

This year is no exception. After a truly eye-wateringly busy winter, there is no sign of a let up. This year is a particularly important one for paediatric training with the roll out of Progress+ from August/September. The changes to our training programme have been meticulously planned over many years and this is the year it will finally happen. You can read much more about it in this edition, and I commend our trainees and educational supervisors across all four nations who are working hard to make Progress+ work to our overall advantage as paediatricians.

When the demands of work are so challenging, taking time to acknowledge excellence, to celebrate both individuals and teams who have gone above and beyond, and to stop and say thank you, are very important. I love our paediatric awards – the PAFTAs – because they are an idea that came from our College Trainees' Committee a few years ago and are unashamedly an opportunity to celebrate the very best of training. Over time the awards have widened to include our nursing and allied health colleagues, as well as non-clinical members of the team who fulfil such important roles in our working lives. For me, the PAFTAs epitomise everything I love and treasure about being a paediatrician and I am certain you will enjoy reading about them.

My thanks, again, to our editorial team. Your optimism and sense of humour is a tonic to us all!

With my very best wishes
Camilla

Staff Spotlight

Anna Rossiter
Medicines for Children Project Manager

@AnnaRossiterL

SINCE STARTING AT THE COLLEGE in 2015, I've managed our parent information resource, 'Medicines for Children', providing paediatric medicines information for families. During this time, I've seen our modest website grow into a new-look, mobile-enabled, fully accessible site approaching four million users annually.

I've been lucky to meet some wonderful people – both College staff and our brilliant paediatrician members, whose energy and enthusiasm never fails to amaze me! Our fantastic Programme Board, made up of the College, Neonatal and Paediatric Pharmacists Group (NPPG) and WellChild representatives, have an encyclopaedic knowledge of medicines, but are also a constant source of joy, as one of the kindest and most enthusiastic groups I've ever had the pleasure to work with.

One of the most fulfilling aspects of my work is hearing from parents who've found our information helpful during some really tough times for their family. Knowing that we are making a difference to families makes the work feel very meaningful. Following feedback from families, we're now in the final stages of developing a new medicines management app for parents/carers. Following a few months of user testing over the summer, the app will be ready for release this autumn.

In my free time I enjoy running – in any weather, frequent unsuccessful experiments with vegan-baking (any tips welcome!) and preparing 'fun' historical walks for friends and family around London or wherever we are visiting. I once accidentally gained some extra people while doing a tour in Rome with friends and had to awkwardly explain that I wasn't a guide!

If you'd like to get involved or share ideas for how we can reach more families, please get in touch: www.medicinesforchildren.org.uk/resources

Every child has a right to breathe clean air

Dr Katie Knight
- *Paediatric Emergency Medicine Consultant*
- *North Middlesex University Hospital NHS Trust*

@ _katieknight_

IT'S SHOCKING THAT THIS NEEDS SAYING IN 2023: clean air is a human right. Yet the majority of children worldwide (yes, including in the UK) breathe air that is making them ill.

As paediatricians, we are all aware of the death of nine year old Ella Adoo Kissi Debrah, the first child to have air pollution stated as a cause of death on her death certificate. Tragically, Ella is only one of many thousands of children whose lives are cut short by toxic air; globally, air pollution is responsible for 16% of deaths of children under five years old.

Air pollution is a mixture of toxic chemicals, gases, liquid droplets and solid particulate matter suspended in the air. The particles can be so fine that they enter the bloodstream and are carried to every organ in the body, causing damage wherever they are found. Air pollution is proven to be linked to premature birth, intrauterine growth restriction, and impaired lung development in childhood. Because children breathe faster, they inhale a higher proportion of toxic pollutants compared to adults. Their developing organs are also more vulnerable to irreversible damage that has life-long consequences.

You might not be aware that climate change and air pollution are two sides of the same coin. When fossil fuels are burnt, greenhouse gases are released (hydrofluorocarbons, methane, ozone and dozens of other side products) that not only trap heat on our planet but are also toxic to breathe. Stop air pollution at the source, and you mitigate climate change and improve health in one go; the ultimate win–win.

This is why the RCPCH Climate Change Working Group (CCWG) 'Advocating for Change' workstream has decided to focus on calling for action on air pollution in its first major strategy for action. We are delighted that 140 RCPCH members took part in our e-action, writing to their MP asking them to support the Clean Air (Human Rights) Bill (known as 'Ella's Law').

Katie and members of the CCWG at COP26, experiencing what air pollution might be like in 2040

Although the Bill is struggling to progress through the House of Commons, there is still plenty for us to be getting on with. We're turning our focus to the intersection between health inequalities and air pollution, and will be releasing a new position statement and toolkit later in the year. We're also really excited about a new partnership starting soon with the Clean Air Fund, on safeguarding a clean air future for children and young people. In the meantime, check out our five top tips on what you can do to help us clean up our air – both current and future generations of children need our help!

Five things you can do about air pollution as a paediatrician

1. Check the pollution in your local area via **addresspollution.org**
2. Write to your MP about **#EllasLaw**
3. Download our handy toolkit and speak to your council about air pollution locally
4. Sign up to our bimonthly climate change ebulletin to keep up to date with our work
5. Get cycling! Join in with **Ride for Their Lives 2023**

▶ ***Visit:*** ***www.rcpch.ac.uk/get-involved-climate-change***

RCPCH FACTS

#SHIFTTHEDIAL CAMPAIGN – CHILD HEALTH INEQUALITIES

1,019
PAEDIATRICIANS SIGNED OUR PARLIAMENTARY CAMPAIGN

80k
IMPRESSIONS FOR THE LAUNCH TWEET

3,930
WEBPAGE VIEWS

1,051
PODCAST DOWNLOADS

160
BROADCAST AND PRESS MENTIONS

500
CHILDREN AND THEIR FAMILIES ATTENDED RCPCH &US #SHIFTTHEDIAL WORKSHOPS

14
TOWNS & CITIES VISITED BY RCPCH &US WORKSHOPS

Introducing our new Officer for Child Protection

Professor Andrew Rowland

- *Honorary Professor of Children's Rights, Law, and Advocacy*
- *School of Health & Society, University of Salford*
- *RCPCH Officer for Child Protection*

@DrAndrewRowland

IT IS AN ABSOLUTE PRIVILEGE to be taking over from Dr Alison Steele as the new Officer for Child Protection. Alison's legacy is something I'm looking forward to building on. As I start my new role, I'd like to pay tribute to Alison's steadfast advocacy for children and young people over the past five years in office.

I have a hugely enjoyable, and very varied, portfolio career as a consultant paediatrician, Honorary Professor (children's rights, law, and advocacy), non-executive director of an international non-governmental organisation (M'Lop Tapang), chair of the board of trustees of a registered charity in England and Wales (SicKids), and medical director of the largest lead employer of doctors, dentists and public health trainees in the NHS in England. I'm a registered medical practitioner in both the UK and in Cambodia, where I work with a fantastic team caring for vulnerable street- and beach-living and working young people.

I worked for over 12 years as a consultant in children's emergency medicine before moving my clinical work into the community, where I now focus exclusively on safeguarding vulnerable children, initial health assessments for 'Our Children' (looked after children), and initial health assessments of unaccompanied asylum-seeking children. My role, as the new Officer for Child Protection, involves working with the outstanding health policy team at the College, and with key stakeholders, to provide leadership and strategic direction in all aspects of child protection, safeguarding children and looked after children. This fits so well with my honorary academic appointment, my leadership experience and my clinical work, that I can't wait to get started.

One of the first things I intend to do is to review the workplan for the RCPCH Child Protection Standing Committee for the next 12 months, to build upon the work undertaken by my predecessor. I envisage that over the coming months, we will be considering things including the College's position on mandatory reporting of child abuse; how to ensure the health needs of unaccompanied asylum-seeking children and refugees are best protected; and what changes may be needed to inter-agency guidance to better protect children and young people.

I'm passionate about promoting and protecting the rights of children as well as supporting our children's workforce and I am committed to doing everything possible to build child-safe communities with happy, healthy and safe children and young people firmly at their hearts.

Safeguarding is at the heart of the role

LAYING THE FOUNDATIONS – LEVELLING UP FOR CHILDREN

Dr Cara Cochrane

- *Consultant Paediatrician*
- *Royal United Hospitals Bath NHS Foundation Trust*

TO UNDERSTAND HEALTH INEQUITIES we need to know where the biggest problems lie. How do paediatricians help to level up?

We are hugely fortunate in Bath and North-East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB) to have Dr Steve Jones as our local RCPCH Ambassador. He brought together 30 colleagues from our three acute trusts, community paediatric services, the BSW Children and Young People's Programme as well as RCPCH for a one-day conference to discuss health inequities. Topics included asthma, diabetes mellitus and obesity as well as thinking broadly about how legislation affects poverty and health. We heard about transformation projects to help tackle the high volume of referrals for neurodevelopmental concerns and how our ICB coordinates care needs for young asylum seekers. Ideas were sparked and conversations flowed, from sharing how one team had worked with a local food bank to how another had seen huge benefit from having a general paediatric psychology service. Group discussions were met with enthusiasm and inspired us to share best practice. Many more conversations will follow and this has laid the foundations for levelling up our workstreams.

▶ ***Find out more about RCPCH Ambassadors:***
www.rcpch.ac.uk/ambassadors

ICS Paediatric Conference

WORKING FOR CHANGE: TWO YEARS ON

Dr Rashmi Mehta
- *Clinical Research Fellow (OOPR)*
- *Sheffield Children's Hospital*

@RRMehta24

TWO YEARS AGO, RCPCH launched its Working for Change programme, which looked at how the College could position itself to address wider issues across protected characteristics, beyond its volunteer roles. Over the past two years, work has been carried out across four workstreams – working lives of paediatricians; health outcomes of children and young people; volunteers and awards; and our College – with the support of dedicated member and staff reference groups, and members of RCPCH &Us.

Entering this process was challenging, but under an affectionate, responsible and accountable leadership, we took small steps to complete many of the actions that were laid out in the original Working for Change report. Some of the examples include:

- equality, diversity and inclusion (EDI) and unconscious bias training for College volunteers
- sharing information with Health Education England (HEE) and the GMC to triangulate data in an effort to reduce differential attainment
- supporting the Workforce Race Equality Standard (WRES) to increase member reporting about EDI characteristics
- actively encouraging underrepresented groups to apply for volunteering roles

We also ran a successful pilot reciprocal mentoring project, which aimed to share experiences of members of underrepresented groups with College Officers, who shared their own routes into leadership. I was pleased to be part of its pilot run, sharing my experience as an international medical graduate, and I'd encourage anyone interested to join future iterations of the scheme.

Although this is our final Working for Change report, our work on EDI is not a finite project – we remain dedicated to working for change. This is a long-standing area of focus for us and the following underscore the College's commitments to ensure the ethos of this work is embedded at all levels and in everything we do.

- We will be accountable
- We will be a voice for change
- We will continue to engage deeply and widely

A key part of this is our continued focus on data, which remains a pivotal tool in bench-marking any change. As challenging as it proves to be, a great deal of effort has been put in to improve data collection. Did you know there is a dedicated diversity form for RCPCH members? If you haven't already, please take a few minutes to share your data so the College has a better understanding of its member representation!

▶ ***Visit:*** ***edi.rcpch.ac.uk***

Supporting SAS doctors

Dr Kumar Swamy
- *Specialist in Neonatology*
- *Nottingham University Hospitals NHS Trust*
- *RCPCH Co-Chair SAS Committee*

SAS STANDS FOR Specialty and Specialist grade doctors. SAS doctors are a diverse group with a wide range of skills, lots of experience and knowledge. I am a proud SAS doctor and my passion is to support fellow SAS doctors both locally and nationally. I have been involved in the College's SAS Committee for six years and am currently the Co-Chair alongside Dr Jamil Khan. I am also the SAS Tutor for Nottingham University Hospitals.

The SAS Committee meets three times a year to discuss the issues of SAS doctors in general. We have representatives from each region in the UK, College officers, workforce team, British Association for Community Child Health (BACCH) and British Medical Association (BMA) representatives. SAS Committee members have representations in various other committees. I represent at the Academy of Medical Royal Colleges and Jamil at the College's Council.

The committee addresses the needs and issues of SAS doctors in paediatrics; signposts for Certificate of Eligibility for Specialist Registration (CESR) applications; helps identify opportunities for continuing professional development; and supports education, training and career progression. The committee has also been involved in the shape of training, Diploma in Child Health (DCH) examination and membership exams, and is currently working on helping NHS trusts in the appointment process of specialists (previously called associate specialists). The College have always been supportive of SAS doctors in paediatrics, with the committee always allocated a dedicated session at the RCPCH annual conference.

I've been pleased to see increased recognition by the GMC, NHS employers and the Academy of Medical Royal Colleges for contributions made by SAS doctors to the NHS. There is a lot of work going on to provide support in their personal and professional development.

Thrive Paediatrics – share your stories!

Dr Jess Morgan
- *Dinwoodie Clinical Fellow*
- *RCPCH*

THE CURRENT PRESSURES on paediatricians are relentless. Overwhelming workloads and excessive demands on our time and resources can leave us feeling powerless in a complex system where change takes time. Yet fundamentally, in order to thrive at work, what we need is to feel safe, valued and respected. A sense of belonging. A community.

I'm one of the new clinical fellows working on the College's Thrive Paediatrics project. I have experienced first-hand the daily challenges we face as doctors, be it unsurmountable workloads; inadequate staffing; access to teaching, hot food, parking, emotional support, culture... I understand. But I can also speak of some incredible individuals who have supported me along the way, departments that have listened and organisations that have made changes. Over the past few years, I have developed an ever-growing passion for wellbeing and I'm excited that the College are also prioritising this.

Thrive Paediatrics is, at its core, a journey towards a thriving, enjoyable career for all, with funding from the Dinwoodie Charitable Company. It starts with a commitment to listen to our collective lived experiences in order to develop a better understanding of the numerous, often interconnected, multidimensional and multi-layered challenges that we face as paediatricians. We then hope to tap into the spirit, the energy, the will of individuals, teams and leaders across the country, who are already doing amazing work in this area. We wish to showcase their work and support them to amplify and spread these great initiatives across the country. In this project, no effort, no idea is too small. If you have personally contributed, positively influenced your own wellbeing or the wellbeing of others, started departmental or organisational initiatives to improve the working lives of doctors, we want to hear about it.

▶ ***Please do send us your stories to thrive@rcpch.ac.uk, join the conversation and help create change.***

JOURNAL: ADC UPDATE

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

@ADC_BMJ

THINK BACK TO the last time you came home after a clinical day not having prescribed any drugs? For many of us, this has, literally, never happened. Knowledge of clinical pharmacology is arguably the most important (certainly the most pervasive) requirement (aside from the ability to communicate) in paediatrics.

It feels good, therefore, to have had such a wide range of therapeutics papers recently, both in Dan Hawcutt's erudite Drugs and Therapeutics section and in the main journal. Just to give you a flavour (and show I'm not exaggerating), Archives has covered these themes in the past couple of months alone:

Intravenous treatment (infusion concentrations, lapses in flow from occlusions, salbutamol in acute asthma); de-labelling penicillin (non) 'allergy'; a minitablet randomised controlled trial; monoclonal antibody treatment in X linked hypophosphatasia; and polypharmacy in low- and middle-income countries. Add to this a reminder from Jonathan Coutts in Glasgow that e-cigarettes are still flying (and selling) under the radar – even being endorsed by organisations (who should know far better now) to appear, speciously, as 'health conscious'. Now, there's an irony! If you'd rather listen to the discussion around this stubborn controversy, plug in your earphones and listen to Rachel Agbeko's (as always, wonderful) Spotlight podcast interview.

JOURNAL: BMJ PAEDIATRICS OPEN UPDATE

Imti Choonara
- *BMJ Paediatrics Open Editor-in-Chief*

@BMJ_PO

THE USA IS the only country in the world that hasn't ratified the UN Convention on the Rights of the Child (CRC). The United Nations launched the CRC in 1989. It says a lot for the importance of children and young people, in both the USA and the UK, that this is not mentioned by either the media or politicians. An editorial in *BMJ Paediatrics Open* by two American health professionals gives reasons why the USA is frightened to ratify the CRC.

The authors point out that the USA is excellent in research in child health, but poor in delivering healthcare and health outcomes. They highlight how young people's rights in the USA are being eroded (alongside women's rights). Unfortunately, children and young people are unlikely to be seen as a priority in the USA in the near future.

What we know, and more importantly what we don't know about e-cigarettes

Dr Mike McKean

- *Consultant in Respiratory Paediatrics*
- *Great North Children's Hospital*
- *RCPCH Vice President for Health Policy*

@ DrMikeMckean

AS A RESPIRATORY PAEDIATRICIAN, I am deeply disturbed about the rise of children and young people picking up e-cigarettes. E-cigarettes remain a relatively new product and their long-term effects are still unknown. Vaping is far from risk-free and in many cases can be very addictive. It is even more concerning to hear that there is an increase in unregulated e-cigarettes hitting the UK market. In the north-east of England, more than 1.4 tonnes of illegal e-cigarettes were seized from shops in the second half of last year. It's impossible to know what these products contain or how they might impact young people's health. The thought that these products are ending up in the hands of children is terrifying.

We know for a fact that vaping among secondary school children is rising, with nearly one in five 15 year olds using e-cigarettes in 2021, according to NHS Digital. Among 11 to 15 year olds, 9% say they are vapers – this is up from 6% in 2018. It's clear that children and young people are being targeted by e-cigarette companies with bright packaging, exotic flavours and enticing names. These products are affordable, appealing and clearly very accessible for children and young people.

I have worked as a respiratory consultant for 21 years, so it is not lost on me that smoking remains the single biggest cause of preventable illness and disease in the UK. But the research and data around widespread e-cigarette use is still very much in its infancy. We simply don't know enough.

In addition to potential health issues, these products have serious environmental concerns, especially disposable e-cigarettes – which we know are increasingly popular with children and young people. The charity Material Focus, which campaigns for better recycling of electrical waste, published a report showing that at least 1.3 million disposable vapes are thrown away every week in the UK. That is two every second. A single-use vape contains on average 0.15g of lithium – the mining of which has led to water loss, ground destabilisation, biodiversity loss, increased salinity of rivers, contaminated soil and toxic waste.

We must make every effort to stop children and young people picking up and using these products. As paediatricians, I believe we should start using our voice to call on the Government to make real change to current policies around disposable e-cigarettes across the UK for children and for society. We're seeing a solid decline in smoking rates among children and young people, we cannot let vaping undo this good work. If action is not taken soon, we run the risk of having generations of children addicted to nicotine.

LEADING ASPIRING PAEDIATRICIANS

Dr Joanne Martin

- *FY2 Academic Foundation Trainee*
- *Great North Children's Hospital, Newcastle*

@UKAPStweets

I AM DELIGHTED to introduce myself as this year's UK Aspiring Paediatricians Society (UKAPS) President! UKAPS is a group of medical students and junior doctors who are passionate about child health and interested in paediatrics as a career. We have representatives from all over the UK, working together to provide advice, support and events for those interested in pursuing a career in paediatrics.

As a regional representative previously, I was inspired by the work of UKAPS nationally and wanted to become more involved in steering the future direction of our work. During my time as president, I hope to increase the awareness of UKAPS among students and doctors, increase the educational content on our website and get as many involved as possible in our future activities and events.

There are a number of exciting activities lined up for the year ahead and all are welcome. We hope to re-launch our mentorship scheme and our teaching series soon to support junior doctors preparing for the RCPCH theory exams. Keep your eyes peeled!

UKAPS United Kingdom Aspiring Paediatricians Society

If you or anyone you know is interested in a career in paediatrics, you can get in touch via Twitter, Instagram or email contact.ukaps@gmail.com

Providing medical aid following the earthquake in northern Syria
Dr Rana Zoualghina describes the realities of working in a resource-deprived area

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Diary Dates

Listed below are some of the up and coming online courses and events. We will continue to add to this list over the coming months, so don't forget to keep an eye on our website.

- **How to Manage: Refugee and asylum-seeking children and young people**
  7 June
- **Sustainable Child Health Course**
  8 June
- **Safeguarding in the digital world (Level 3)**
  19 June
- **Effective Educational Supervision**
  3 July
- **Supporting new named and designated doctors for safeguarding children**
  4 – 5 July
- **Statement and report writing – England/Wales**
  6 July
- **MRCPCH Applied Knowledge in Practice exam preparation**
  30 August
- **How to Manage: Common Dermatological Problems**
  2 October
- **How to Manage: FASD in community paediatric services**
  5 October

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

PODCASTS

- **A young person's experience of living with epilepsy**
- **Our voices: young people and climate change**
- **Shining a light on children's mental health**
- **Child health inequalities part 1 – talking with families**
- **Our voices: engagement done well**
- **Child health research matters to medicine**

▶ ***See the College's podcasts***
www.rcpch.ac.uk/podcasts

RCPCH LEARNING

- **Introduction to paediatric antimicrobial stewardship: how the rational use of antibiotics can improve the overall quality of paediatric care**
- **Paediatric GeNotes: facilitating genomics mainstreaming for paediatric clinicians**
- **Rare diseases webinar: juvenile-onset Systemic Lupus Erythematosus**
- **Whole genome sequencing: developments and future perspectives**

▶ ***See RCPCH Learning***
learning.rcpch.ac.uk

An MDT about young people's care by young people

At the Adolescent Health Conference, young people from RCPCH &Us shared what matters to them when creating services for young people

HI! WE'RE DEMI, MAX AND SREE and we're volunteers with RCPCH &Us and came together to think about what is important to young people with health needs and hopes and aspirations for your life as a young adult. For some, they will be managing long-term conditions like asthma and eczema, learning about who they are and their identity, worrying about the impact future heatwaves might have on their conditions during exam time and having their paediatric team talking about the other doctors in adult services who will be helping you soon. It can all get too much. Areas that need to be thought about are:

Communication: it can be difficult for young people to open up to their doctors when their parents are in the room. Clinical teams need to think about giving them the best opportunity possible to be able to share, being respectful, kind, approachable and aware of different identities and cultures.
Take home point: create a safe space, ask the parent/carer to leave for a bit, go off topic and ask about hobbies to create rapport.

Mental health: it can be hard when you have conditions that leave scars behind emotionally and physically that can lead to you feeling self-conscious and different. If preferred pronouns are not seen as a priority, this can lead to feeling uncomfortable and that this isn't a safe space, especially when having to move to a new team and rebuild trust with new workers.
Take home point: talk about mental health and mood and share information about services that understand about mental health and long-term conditions and give tips on self-care and referral options.

Transition: it can be confusing if there is no step-by-step plan on what is happening with transition, and can be overwhelming to meet new teams, especially when things like pronouns are not being understood or used.

Meds can change too and who is in charge of them, so learning to do your own injections for asthma for example can be scary.
Take home point: introduce the new doctor to all the information e.g. pronouns, have joint meetings that are informal about family, identity, hobbies.


Demi, aged 18


Max, aged 17


Sree, aged 19

We hope this gives you some ideas to talk about with your teams and your adult services colleagues. You can watch our full MDT video at youtube.com/watch?v=rubBUN8fRrw.

ABOUT

RCPCH &Us: The Children and Young People's Engagement Team delivers projects and programmes across the UK to support patients, siblings, families and under 25s, and gives them a voice in shaping services, health policy and practice. RCPCH &Us is a network of young voices who work with the College, providing information and advice on children's rights and engagement.

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

KEEP IN TOUCH @RCPCH_and_Us @rcpch_and_us @RCPCHandUs and_us@rcpch.ac.uk

Life on the other side

Dr Julia Griffin shares the lessons she learnt as a parent and paediatrician on the neonatal unit

Dr Julia Griffin
- *SAS doctor*
- *Gloucester Royal Hospital*

Two years have passed since I phoned the on-call neonatal consultant in the early hours of the morning from maternity triage to inform him I was calling in sick for my long day shift. No, it was unlikely I would be in for my shift the next day either. And please could he arrange locum cover? It was likely my own baby would be requiring their services!

Sure enough, the following morning, just after the post-ward round tea break, our daughter Rose abruptly entered the world. Delivered by caesarian section at 28+1 weeks, birth weight 1.11kg, her appearance was the source of some consternation to my non-medical husband: "she's very tiny, very red, and why have they wrapped her in plastic?!" For the 60 days and nights that followed, Rose was cared for by the wonderful medical and nursing staff at the local neonatal unit (LNU) where I work. Though I trust my colleagues, leaving my baby behind in the hospital each night to go home to my husband and 18 month old toddler is one of the hardest things I have ever had to do. Looking back, I appreciate we were lucky, our daughter did well, one of that rare breed of premature babies who has 'read the textbook', progressing through her neonatal journey as expected, with blessedly few bumps in the road. She even earned herself the enviable discharge summary strapline: "an uncomplicated NICU stay" (to us as parents it was anything but!).

Neonatal nurses provide invaluable support – and regular photo updates

With Rose now two years old, I have settled back working in the hospital where I spent those first two surreal months of my maternity leave, and keen to share a few of the lessons I learnt during that unique time, an experience that has forever changed me, both personally and professionally. A paediatrician parent's perspective of 'life on the other side':

Preterm birth can be a positive experience

As neonatal doctors and nurses it is within our gift to make this a reality. It is in our approach to antenatal counselling when preterm birth is anticipated, our efforts to work in partnership with midwives and obstetricians, involving and informing parents at every stage. It is in the atmosphere in the delivery room, the language we use, tone of our voices, the words we greet the new arrival with, and ensuring no baby is ever transferred without first meeting their mother (delivery room cuddles written into trust policy since my maternity leave). In our case the stars aligned, so that what could have been a very frightening situation (Rose was delivered due to placental abruption) became an incredibly positive birth experience, more so than the term delivery of my first-born!

Neonatal nurses are the heart of the LNU

Before I had Rose, I had no idea just how much neonatal nurses do to support and care for the families of their tiny patients. We were taught how to hold our daughter in her incubator and on our chests skin-to-skin, how to perform her 'cares', change her nappy, record her observations, administer medications, give NG feeds,

the list goes on... We received daily photos and video updates online, phone calls when unexpected changes occurred (oh the heart-stopping dread when 'NICU calling' flashes up on your phone screen!), presents and handmade cards to mark key events. I was even serenaded by a choir of nurses on my birthday! Competing work/life/family commitments can mean it is easy to feel disconnected from what is happening to your baby medically – ward rounds may be missed, decisions made in your absence. Nursing staff are a constant and reassuring presence. Now I am back in work I am trying to emulate these inspirational figures, to make myself more available to parents emotionally, and outside of routine ward round times, to learn their names and take an interest in their lives beyond the four walls of the LNU. I have a lot to learn, but it's a step in the right direction, towards kindness.

Milk matters

We all know the science: breastmilk is the nutrition of choice for premature babies. Most mothers of preterm infants are fully aware of this too, and want the best for their babies, dutifully expressing their milk every two-three hours, night and day, week after week, for the duration of their hospital stay. Be very careful what you say on the matter of milk: the combination of sleep deprivation, heightened hormones, and the poignant personal sense of failure having given birth prematurely can be explosive... I still vividly recall the hot tears of frustration I shed after tipping over a whole bottle of freshly expressed breastmilk (crying over spilt milk!), and the green-eyed envy I felt each morning watching other mothers arrive on the unit with vast quantities of expressed breastmilk in comparison to my own meagre supply. Breastmilk madness is real!

Enabling cuddles is a must for happy parents and babies

Parents and procedures

Being present for procedures, even if invasive or painful, can be a positive experience for parents and their baby (or older child if on the paediatric ward), when approached pragmatically. Paint an honest picture of what to expect, whether parents can be involved (skin-to-skin contact or breastfeeding their baby during heel-prick blood sampling, cuddling or distracting an older child), and schedule a time that is mutually convenient (emergencies notwithstanding). It is important to also be mindful to 'release' parents to be absent, without judgement, again scheduling a time is helpful. A preterm baby's fortnightly ophthalmology examinations (routine screening for retinopathy of prematurity) can be particularly distressing for parents to witness – after missing my daughter's first, I vowed to stay for all subsequent examinations, a decision I came to regret.

The flipside of screens

Screens are a useful piece of kit for the premmie parent, preserving a mother's modesty when expressing, and helping to create a calm, soothing atmosphere for skin-to-skin contact time. However, they are in no way sound-proof, and may act as an inadvertent barrier to seeking assistance. I will never forget the distress I experienced isolated behind a screen with my daughter on my chest suffering repeated bradycardias and desaturations while a medical emergency occupied staff at the opposite end of the ITU room. I know I should have shouted for help, but in my panic I was mute. Since my return to practice, screens have taken on a new significance: a visual prompt there are parents and babies hidden from view who may need checking up on, especially if the unit becomes busy or noisy. Out of sight is not out of mind...

Julia and her husband with their early arrival, Rose

Never SBAR a parent

Lastly, when informing parents of an acute deterioration or change in their baby or child's condition, whether you work on a neonatal unit or paediatric ward, please avoid using SBAR (Situation, Background, Assessment, Recommendation). I experienced this information-sharing strategy from a (very well-intentioned) registrar upon being wheeled back to the unit following a short rest on the postnatal ward. Whilst I appreciate in the right context, when used between clinical staff, this succinct communication tool can be extremely effective, especially in an emergency situation, it is not appropriate to use with parents!

So, half a dozen practice-changing learning points later, I hope I have conveyed a sense of what it feels like to be a parent on the neonatal unit. The experience has made me determined to be a better, kinder, more holistic doctor, to put into action the lessons I learnt on the other side, and to share these with others. For Rose. Thank you for reading.

Preparing for Progress+

Our new two-level training programme is almost here. What are the changes, what's staying the same and what does it mean for you? Our VP for Training and Assessment and Chair of the Trainees Committee are here to reassure you

Dr Cathryn Chadwick

- *Consultant Paediatrician*
- *Northampton General Hospital*
- *RCPCH VP for Training and Assessment*

@cathrynchadwic1

WITH LESS THAN a few weeks before Progress+ is implemented, we are here to remind you of the key changes and to reassure you that all will be well. Importantly, Progress+ should result in much improved flexibility in training, more thought given to capability-based progression and wider training opportunities during core training.

The headline change is that we are moving from a three-level, eight-year programme to a two-level, seven-year programme. This has required a lot of thought from local schools and the College implementation team to make sure that trainees fit smoothly into the new pathway. For the majority, the transition will be smooth. The newly named specialty level is very similar to current level 3; a trainee at that stage or about to start that stage will notice little difference. Trainees in level 1 training currently will continue seamlessly through core training. Trainees who have started but not finished level 2 training by this summer can choose to remain in core or proceed to specialty level. It is important that everyone understands where a trainee is in the Progress+ pathway. I hope that most trainees have already agreed with their TPDs and supervisors and know which pathway they will follow and will be able to identify themselves on e-portfolio.

For some, who are out of sync, LTFT or out of programme, it may be more complicated. There is a lot of information on the Progress+ pages of the website and we are very happy to answer specific questions via the Progress+ inbox (**progress-plus@rcpch.ac.uk**) so please ask if you are not sure.

Flexible training

Training will be an indicative seven years. Our experience is that most trainees will want and need seven years' training to be ready for consultant working. Out of programme opportunities will allow people to extend and personalise their pathways. Some trainees will come into the programme with pre-existing experience that will mean they can progress quicker. Realistically life has ups and downs and trainees progress at different rates over time. Introducing longitudinal supervision will allow a good overview of the acquisition of capabilities over the course of a level and moving on when ready rather than trying to tick boxes every six months.

The broadening of capabilities during core training is an exciting change. Supervisors and trainees can already find plenty of learning opportunities around child mental health and public health in day-to-day patient encounters but might need to think creatively about how to make the most of these encounters. Many schools are introducing new placements and formal learning, initiatives include joint teaching with psychiatry trainees, learning together clinics with primary care and integrated care posts which include community paediatrics, mental health and public health. Within the College, child mental health is a high priority and we have made good links with RCPsych, which will help with joined up policy and training.

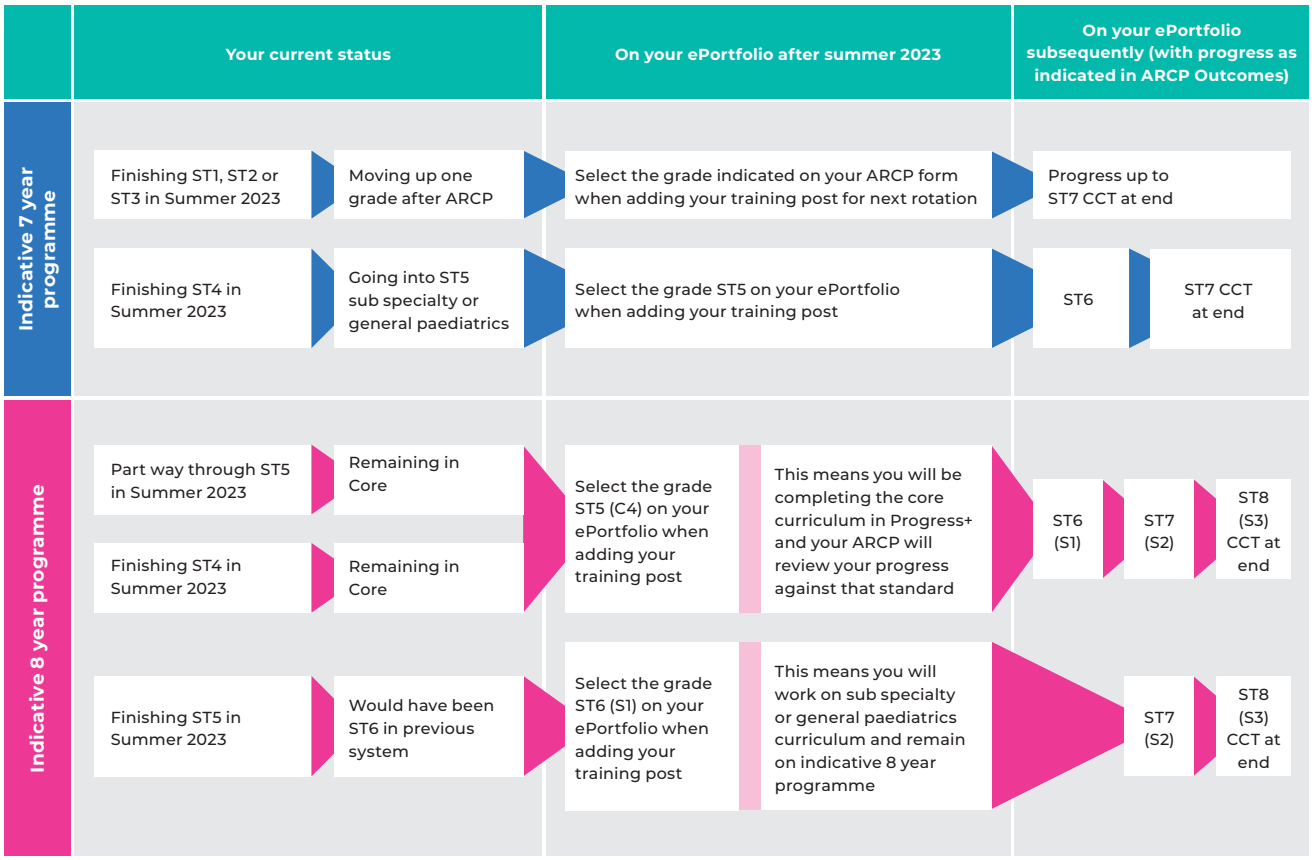
August 2023 is not a cliff edge. It is just the beginning of Progress+ and continued evolution of the curriculum.

Dr Emma Dyer

- *ST6 Paediatric Emergency*
- *Evelina London Children's Hospital*
- *RCPCH Chair of the Trainees Committee*

@EmmaMDyer

THE TRANSITION TO Progress+ is almost upon us, and hopefully by now everyone has worked out what that means for them and their specific circumstances. Basically – don't panic! The changes are not a complete overhaul of paediatric training, just streamlining and modernising what already exists. The curriculum is broadly the same, re-structured into two rather than three levels, and the principles of



a competency-based training with high-level professional capabilities are remaining. Evidence you are already collecting and tagging to the current key capabilities will be mapped to the Progress+ curriculum and pulled across so that nothing is lost. Progress+ embraces more flexibility and more opportunity to tailor training to an individual's interests and career plans.

I really hope that Progress+ is also an opportunity for us all to rethink paediatric training and to think a bit more "outside of the box" when training our future paediatricians. We know that healthcare is changing, new challenges are constantly emerging, and we need to equip our paediatricians for this so that we can continue to provide the best possible care for our children and young people. The Paediatrician of the Future document outlines what great training could look like with a focus on learning across the wider MDT, more experience in integrated care and child and adolescent mental health, and examples of innovative and aspirational training. If you are a trainer or a supervisor, I encourage you to read this document and see how you can start implementing these principles locally. If you are a trainee, have a read and think about what opportunities there may already be that you can tap into to enhance your training.

New naming system

One aspect of Progress+ that I know people have been concerned about is how the naming of grades will work for those transitioning between the two systems, particularly in relation to pay progression. The College were clear that they wanted to find a solution to ensure that no trainee missed out on their pay progression, and I'm pleased to say that the details have now been finalised. It is explained in the diagram above, and for those trainees who are LTFT or out of sync, the same principles can be extrapolated.

As you can see, for HR, contractual and pay progression purposes, the trainees on an indicative eight year programme will continue to be named as they progress chronologically through eight years, but for portfolio and supervision purposes there will be an additional descriptor to indicate their position in the Progress+ pathway, which they will need to select on their ePortfolio. These trainees will be in core level training as ST4 (c4) or ST5 (c4) and in specialty level training as ST6 (s5), ST7 (s6) and ST8 (s7).

If you are unsure what Progress+ means for you or have any questions or concerns please have a look at the resources and FAQs on the Progress+ landing page, speak to your educational supervisor or TPD or get in touch with the Progress+ team on **progress-plus@rcpch.ac.uk**.

▶ ***Visit:*** *www.rcpch.ac.uk/progressplus*

Youth friendly services – exploring new ways of collaborative working

The last few years has seen more discussion about 'youth friendly' services, to help support both the physical and mental health of young adults seeking access to medical care

Dr Hannah Baynes

- *General Paediatric Consultant*
- *King's College Hospital NHS Foundation Trust*
- *RCPCH Milestones Editor*

@HLB27

CONVERSATION AND COLLABORATION

between health and other organisations has led to the creation of some exciting and innovative models of care where youth workers, health and wellbeing practitioners and youth practitioners are working alongside medical teams to support young adults in a more holistic manner. There are many great examples of such work in hospitals (KAOS at King's College Hospital in London, Youth Navigators in Scotland, No Limits in Southampton and Young Devon in – you've guessed it! – Devon, to name but a few; all to be found on Google!).

Importantly, more recently there has been a rise in the number of these types of services for young adults based in primary care. In this article, we'll hear from Helen and Steph about the great work that is happening in their areas and how collaborative working between hospitals, primary care and voluntary sector organisations (VSOs) is having a positive impact. Hopefully, this will give you some food for thought about how you can make services local to you more youth friendly!

Dr Stephanie Lamb

- *GP Partner/Clinical Director*
- *The Well Centre*

THE WELL CENTRE

THE WELL CENTRE is a young person's health hub working across Lambeth and Wandsworth in South London, open since October 2011. It was created with the ambition of improving access to both physical and mental health support for young people aged 11-20, particularly those young people who may find it challenging to access support. The Well Centre team comprises GPs, a senior mental health practitioner from CAMHS and Health and Wellbeing Practitioners (HWPs) who provide counselling, social prescribing, advocacy and mentoring.

Each young person accessing the Well Centre for the first time gets a holistic biopsychosocial assessment (The Teen Health Chat) either with a GP or, if less complex, one of the HWPs. This is based on the HEADSSS assessment but is broader and includes enquiries regarding possible adverse childhood experiences, risk and unmet need. The young person has an opportunity to discuss any concerns they may have and a plan is made about their ongoing care with the young person.

The majority of support and engagement at the Well Centre is provided by the HWPs – they are the heart of the service. They combine the talents of youth work and engagement with training in counselling skills and social prescribing. They will see young people at the hub, in local schools, in local VSOs, GP practices and in their own homes. They will 'walk and talk' if the preference is to meet in the park or have a hot drink in a local café. They liaise with parents, schools and social services/early help where appropriate or needed providing support for the young person however and wherever it is needed. They also set up and run groups within the Well Centre for example running groups on empowering girls/non-binary young people – and each HWP champions a particular area of health. These range from neurodiversity to one HWP being embedded in the local Youth Offending Service, depending on the skills and training of the individual HWP. They can then support and educate other HWPs within the team about their champion area. In addition, we have two HWPs who specialise in supporting young people with diabetes, working across two local hospital trusts in paediatrics and young adult services. The HWP skills are very transferable across primary and secondary care and the community – the Well Centre has a record of supporting more than 4,500 young people in this way over the years.

Dr Helen Jones
- *CCG Clinical Lead for CYP MH*
- *Healthspot*
- @natmilesmac

HEALTHSPOT – WHAT IS IT?

HEALTHSPOT IS A bespoke GP clinic (enhanced access hub) for adolescents, delivered twice a week in the evening in an amazing youth provision called Spotlight in Tower Hamlets in East London.

It is delivered alongside VSO mental health support, public health commissioned substance misuse, sexual health service and youth worker practitioners as an integrated offer brought into a space and place where young people feel comfortable to be.

According to the young people's wants and needs, the youth practitioner can be involved in the Healthspot consultations acting as an advocate and support for the young people, providing ongoing trusted and relational support outside of the appointments, plugging them into the incredible in-house creative and active offer eg boxing, dance, creative workshops, music etc or sourcing the right help and opportunities according to the young person's needs.

Why was healthspot set up?

Young people have told us about the challenges they face in accessing primary care, expressing concerns about confidentiality (in particular, their parents being informed), timing of appointments, not being able to access online consultation platforms directly and not feeling confident, or comfortable to express their health concerns.

Equally, as clinicians, we face challenges when supporting young people within the confines of our current health setting, especially those facing multiple challenges (vulnerable). We often come across young people who need ongoing holistic health support yet they may or may not meet criteria for traditional services within health and the wider system, and even if they do then struggle to engage with the offer.

Kenny (GP), Delso (MH practitioner), Treaser (youth practitioner), Helen and Diane (sexual health nurse)

"It is helping shine a light and call for change in our wider system, both locally and nationally"

At Healthspot, we bring the integrated offer to the young person and the youth practitioner is available to help them engage at a pace and in a manner that the young person feels at ease with. We also closely liaise with the wider systems including education, social care, secondary care, CAMHS, NSPCC and others.

Healthspot is an offer in line with the College's report 'State of Child Health': "Holistic, one-stop shop... a youth-friendly service that is accessible... co-produced and absolutely born out of young people's voice". It is helping shine a light and call for change in our wider system, both locally and nationally.

If there was one report I would like to highlight that mandates an offer like Healthspot, it is the 'Hidden in Plain Sight' report by the Commission on Young Lives published last November. It is a national plan of action to support vulnerable teenagers to succeed and to protect them from adversity, exploitation, and harm.

Ask yourself this: how have we tolerated a system for so long that puts so much emphasis on box-ticking, and that is so reluctant to take a chance on doing things differently? How have we ended up with so many multi-agency meetings about a vulnerable child which last longer than the amount of time any of the professionals in the room will have ever spent with the child concerned? Why are we surrounding some vulnerable children with 10 or more different professionals, none of them taking a lead or building a trusted relationship with the child? Why does the system do so much to stifle relationship-building and hold back innovation, and why is it so risk averse? The contrast with those who exploit children could hardly be starker.

▶ ***Visit:*** ***wearespotlight.com***

National PAFTA Winners 2023

Celebrating the best in paediatric training achievements around the UK

JUNIOR TRAINEE OF THE YEAR – JOINT WINNER

Dr Kamla Pillay

- *Clinical Research Fellow*
- *Centre for Neonatal and Paediatric Infection, St George's University, London*

Kamla has demonstrated a holistic approach, showing initiative when managing wards, is always reliable in completing tasks and ensuring clear and prompt communication with families. She took on the role of a trust representative and provided a reliable and insightful connection between the College Tutors and trainees. She was vocal when voicing various issues without being negative or accusatory. She understood the importance of team spirit and wellbeing and took on the role of social secretary, organising a well-received outing to Regent's Park. She also provided pastoral support to her fellow trainees when needed.

JUNIOR TRAINEE OF THE YEAR – JOINT WINNER

Dr Qasim Malik

- *Education Fellow*
- *Birmingham Women's and Children's NHS Foundation Trust*

Qasim strives to improve the care of patients and the working conditions for his colleagues by contributing to multiple audit and quality improvement projects. He is active in his role as ST1-3 West Midlands trainee representative. He listens to fellow trainees and advocates for them and their wellbeing. He has organised Welcome to Paediatrics days and portfolio support days for paediatric trainees across the region. His innovative technical skills have enabled the trainees' committee to share educational and wellbeing information with a wider audience.

SENIOR TRAINEE OF THE YEAR

Dr Saba Hussain

- *ST8 Paediatric Grid Trainee in Community Child Health*
- *Sirona Care and Health, Bristol*

Saba is an empathetic advocate for children, excellently capturing their voices in her letters and reports. Saba is a great team player who organised safeguarding rotas for her team efficiently and supported her peers with specific leave plans. She has supported a junior trainee with a quality improvement project, as part of her LEAD project. Saba has completed a peer review for the RCPCH purple book, involving intense analysis and review. She is currently involved in completing a parent/carer and children/young people's patient information leaflet for a sensitive child protection medical examination.

EDUCATIONAL SUPERVISOR OF THE YEAR – JOINT WINNER

Dr Najette Ayadi O'Donnell

- *Consultant General Paediatrician in Adolescent Health and Complex safeguarding*
- *University College London Hospitals NHS Foundation Trust*

Najette goes above and beyond to help trainees. She thinks outside of the box, taking action on their behalf, sending emails, coming in on her days off to attend meetings and using her incredible interpersonal skills to create connections, which has resulted in additional support from the trust. Najette combines her detailed knowledge of the curriculum and the training needs of those she supervises to ensure they are able to obtain all their competencies in creative and bespoke ways. She inspires trainees to value themselves and is a strong advocate for the College's commitment to equality, diversity and inclusion.

EDUCATIONAL SUPERVISOR OF THE YEAR – JOINT WINNER

Dr Rachel Howells

- *Consultant Paediatrician*
- *Royal Devon University Hospitals NHS Foundation Trust*

Rachel shares her decision making and thought processes regularly with the team using every patient as a learning opportunity. She discusses complex issues as equals, asking pertinent questions to develop self-reflection. She takes the time to have lunch and coffee with the team, taking an interest in individuals, and is very supportive in suggesting projects for career development. Her work as a national lead in the area of childhood headaches sets an excellent standard for others to aspire to. Along with colleagues she has developed an effective and pragmatic teaching course in this area, which has benefitted trainees throughout the country.

What's the point of public health?

Dr Alice Willson gives a paediatric trainee's perspective on being involved in public health as a HEE Population Health Fellow

Dr Alice Willson
- *ST6 Paediatrics*
- *Royal Manchester Children's Hospital*

@dralicewillson

AT THE START of my fellowship journey Prof Val Barker said: "We work in the National Health Service, not the National Treatment Service." This has stuck with me as I try to get my head around population health. As an acute medic it is easy for the job to become about the quick wins – the antibiotics, the salbutamol inhalers – getting kids out of hospital as quickly as possible. But, as several high-profile cases show, our efforts are futile if we don't confront the bigger problems in society: poor quality housing, the environment, a cost-of-living crisis. Keeping children well is the ultimate preventive medicine into adulthood – Sir Michael Marmot talks about getting 'the best start in life' – and it's why taking a population health approach to paediatrics is vital.

I am lucky to be among a group of five paediatric trainees across the country who were selected for the 2022/23 HEE Population Health Fellowship. This is a national programme available to applicants from a variety of backgrounds which aims to upskill the wider healthcare workforce, enabling better working across systems. As part of this we've received formal teaching from an array of inspirational speakers on topics from health inequality, to creating behaviour change to data use. Alongside this curriculum we're all embedded in a local organisation (e.g. public health team) one day per week to gain practical experience, and to participate in a project which allows us to use our newfound population health skills.

My project is about taking a population health approach to an Asthma Friendly Schools pilot – looking at the data, thinking about what other public health measures can run alongside the initiative such as School Streets, Healthy Schools, getting children active, smoking cessation and improving the environment (both indoor and outdoor). I've had to learn how to project plan, how to use local and national data and how to work over longer time frames in an iterative process that is not always clear cut or immediate. It is also an immense privilege to get to co-produce solutions with local populations, whilst being the voice of a frontline medic in the boardroom.

The fellowship has provided lots of opportunities beyond its formal parameters. I have met my wonderful paediatric colleagues and as a collective we have started to share ideas, plan regional teaching and lobby for better integration of population health into national paediatric training. Our shared aim is for all paediatric trainees to see themselves as population health practitioners, which I know can feel overwhelming, so here are some practical tips for how you can get involved:

Children at an Asthma Friendly Schools workshop

1. Educate yourself: there are great courses on e-LfH and The King's Fund has lots of easy to read blogs/videos.
2. Use the RCPCH Health Inequalities Toolkit.
3. NHS Futures website is a useful forum to find out what's going on in your area.
4. Practice population health day-to-day; be guided by Progress+ curriculum domain 5 and keep an eye out for potential future SPIN modules.
5. Visit the British Association of Child and Adolescent Public Health (BACAPH) website.
6. Consider applying for future HEE population health and other leadership fellowships.

Meet the other paediatricians in public health

Dr Katrina Roberts *(Derby city council) has been responding to the government's Serious Violence Duty as a multiprofessional collaborative, adopting a public health approach to tackling serious violence.*

Dr Jo O'Sullivan *(City & Hackney Public Health Team) is working to improve uptake of Long Acting Reversible Contraception (LARC) across the borough.*

Dr Tom Siese *(Somerset ICS) is developing an integrated care pathway for health visiting teams and community midwives supporting new parents in the first 1,001 days.*

Dr Sanjana Kattera *(Alder Hey Academy) has been understanding the lived experiences of young people with physical and mental health challenges; advocating for improved quality of life and social wellbeing by creating volunteering opportunities within the NHS.*

My time in northern Syria

After hearing about the earthquake in February, Dr Rana Zoualghina and her husband knew they needed to go back to Syria and help as best they could

Dr Rana Zoualghina
- *Paediatric Consultant*
- *Manor Hospital Walsall*

@ZoualghinaRana

I KNOW I WILL STRUGGLE TO SUMMARISE WHAT I WITNESSED DURING MY TIME IN SYRIA. I have been overwhelmed with contrasting emotions of despair and gratefulness since returning to the UK. Yet still, what I feel dulls in comparison to the magnitude of suffering the citizens in northern Syria and southern Turkey have experienced.

On the morning of the earthquake, I remember waking up to my husband already calling countless contacts to ensure his family in the area were safe. We met in a hospital in Damascus 25 years ago and medicine remains a key feature of our marriage. After dropping my youngest to school, stuck in traffic, I realised I had to do something.

Within a week, myself, my husband and a few doctors we knew travelled to Turkey. But due to bureaucratic permit delays, we only managed to enter Syria from its northern border after 48 hours. For the past decade, Syria has been stuck in a hopeless political proxy war. Each year brings more deprivation and complications. So I had never considered myself useful in anyway; yet here I was, on the ground, walking amongst flattened buildings – albeit due to missiles or a 7.8 earthquake.

I knew the situation was bad, but witnessing the complete deprivation of resources was heart breaking. Hydrocephalus was rampant amongst newborns; with no access to labs, infections were treated blindly; mothers and toddlers malnourished to the point of cachexia. I came across many toddlers at the weight of a six month old; infections swamped the tents; hospitals were rife with premature infant deaths; ventilators are nothing short of a miracle to come across and sanitation was non-existent. It is like the Syrian people have unwittingly signed a DNACPR form, in which the ceiling of care has been deigned at the meagre level allowed into Syria by misaligned politics and corrupt authorities – the result being a cascade of avoidable deaths and suffering. The standard of care is so belittled, to perform thus in the UK would be deemed the grossest form of negligence. Millions of children are living below the threshold for basic needs.

I came across a young girl who was suffering from a crush injury after being rescued from the rubble. She was in need of dialysis and amputations to her left arm and leg, the physical pain unimaginable yet wholly disregarded having lost her whole family to the earthquake. I put everything medical aside and gave her as much comfort as I could.

As despairing as the physical reality is, the hard-working and resilient medical staff completely stunned me in the most admirable way possible. Every day they showed up despite the limitations and severity facing them. With the resources we supplied from MIAT (Midland International Aid Trust) we managed to build tents, provide food baskets and other medical equipment – improving the situation somewhat for the people there. However, what we did is insignificant in comparison to the work required, just as what I have written pales in comparison to the true picture of hardship I witnessed first-hand. It is imperative that, as paediatricians, we advocate incessantly for the right of all children to access healthcare and nutritional support. Moreover, as people in a position of privilege, we must not forget those in need of our help.

British Ukrainian Refugee Children's Clinic

As the war in Ukraine unfolded, Professor Alastair Sutcliffe established a clinic for Ukrainian children arriving in the UK

Professor Alastair Sutcliffe

- *Professor of General Paediatrics*
- *UCL Great Ormond Street Institute of Child Health*

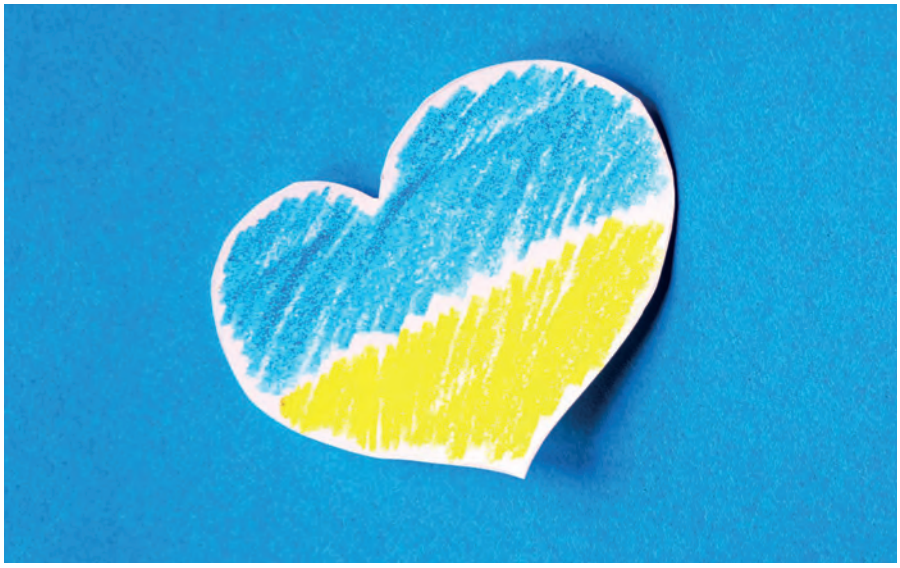
A TERRIBLE HUMAN TRAGEDY HAS EMERGED IN UKRAINE. On television, we could see children being pulled out of their homes and taken abroad with or without their parents. I found this upsetting and wanted to help. My friend Daniel Klusmann, who runs a web-based patient management system called FreddieMed, suggested that I set up a clinic for these children. They say that the first supporter in a new initiative is the most important supporter. Within days of 'putting it out there' via an article in *The Telegraph*, a number of volunteers came forward, beginning with Professor Mike Thomson. We then had others join us including Dr Vita Radchenko-Subych, who is a Ukrainian paediatrician. She unfortunately had to leave Odessa where she had a 3,000-patient private list and re-start her career in the UK. Vita helps communicate with the families and book in the patients. A translator volunteer also came and joined us. In reality, we don't need that person very often. We have free use of FreddieMed but also the choice of seeing children face to face in a private practice setting. We are seeing these children mainly using telemedicine. This has been an interesting experience and I was very surprised to be recognised by the Prime Minister regarding this clinic, which really came out of the blue.

There have been challenges in this work. First of all, it is done on top of our day jobs. Secondly, we are a small group. We are presently preparing to register as a charity and I have also been offered a sponsored polo match to help raise funds.

We may have done things a little differently with the benefit of hindsight, for example I have had difficulty getting paediatricians engaged with this initiative, although it has been almost uniformly positively received. I decided to personally put time and money into a promotional campaign. This has resulted in a useful number of volunteer consultants which is fabulous. Whilst the clinic is run by consultants only, we are seeking a volunteer to work on our website, and this might be a role for a tech savvy paediatric trainee.

Every child we see has their story (and their tragedy) and yet children have great vitality. We tend to see them once, do some signposting and we have prescribing software as required. I hope that eventually we will be able to expand the clinic to offer a service that acts as a one stop shop for child refugees coming to the UK. At the moment, we are helping families, one child at a time.

There are significant differences between some local and prescribing expectations and our own accepted practice here in the UK, which can be a challenge. There is a contrast in practice between Ukrainian medicine (as inferred by these families) and our medicine, particularly that Ukraine has primary care paediatricians. Some aspects of our meetings are educational and of course the children are delightful. With matters as grave as an ill child, inevitably families prefer their own doctors and culture and some perceive the NHS as remote. We also see young people as well and I am hoping the clinic will continue to grow, progress and be more successful. Should you wish to volunteer, do contact me **professorsutcliffe@ukraineclinic.co.uk**.



Visit: ***www.ukraineclinic.co.uk***

Members

The latest member news and views

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- **milestones@rcpch.ac.uk**

Elevating the adolescent health agenda

Dr Najette Ayadi O'Donnell

- *Consultant Paediatrician*
- *University College London Hospitals NHS Foundation Trust*

@yphsig

THE YOUNG PERSON'S HEALTH SPECIAL INTEREST GROUP (YPHSIG) brings all things adolescent health into one organisational space for the field. Formed as an association of the College, its foundation over 15 years ago paved the way for elevating the agenda for young people's health.

With its membership spanning the country and made up of medical students, trainees, consultants and allied health professionals, it works with partner organisations; for example, the Association for Young People's Health, to develop and promote high quality healthcare for young people.

YPHSIG's commitment has led the way in arranging internationally attended conferences. In building on the success of the 'Coming of Age' conference in 2019, last year YPHSIG held a two-day conference, jointly with the College, in Birmingham with a programme dedicated to emerging themes impacting young people. Topics on the programme included young people's mental health, functional disorders, contextual safeguarding and climate change anxiety. The conference also recognised the retirement of former YPHSIG convener, Dr Janet McDonagh, with the impact she leaves on adolescent medicine felt by many.

YPHSIG believes strongly in promoting adolescent medicine amongst medical students and has an annual essay prize. Last year's winner, Barbara Chow, a fourth year medical student at King's College London, won with an essay on the impact chronic illness has on adolescent development. The YPHSIG judges were impressed by her ability to navigate the biopsychosocial model at such an early stage of her medical career.

With a very proactive steering group, currently led by convener Dr Hannah Baynes, YPHSIG believes in representation from across the UK and Northern Ireland ensuring training and resources are developed with a national steer. Members also receive monthly ebulletins packed with useful information on resources, publications and guidance relevant for professionals working with young people.

In short, if you think young people matter and are interested in the growing and dynamic field of adolescent medicine then joining YPHSIG is for you. Joining is easy: visit **www.yphsig.org.uk**

Making progress with undergraduate paediatrics

PAEDIATRICS IS A popular choice for medical students at entry to medical school but this drops significantly by the time students graduate. A strong influencing factor is their experience of paediatric placements in medical school. This varies widely between medical schools, so how can we address this?

The Single Undergraduate Curriculum for Paediatrics was published in 2015. The aim was to standardise the paediatric experience of medical students across the country. It was the first attempt to set a standard of paediatric knowledge for medical students as they graduate.

Since then, there have been important changes in the medical education landscape. Progress+ is launching this summer. At the same time, the GMC is introducing the Medical Licensing Assessment (MLA). This exam will be taken by all undergraduates at the end of medical school. This is the first time that medical schools will have a standardised assessment.

In view of these new changes, I've been working with Chloe Macaulay, Hannah Jacob and the Paediatric GEMS group to bring together medical schools, medical students, patients and paediatricians to review and update the curriculum. Our aim was to map the undergraduate curriculum to Progress+ whilst also reviewing the content to ensure it aligned with the MLA requirements and content map. We have also updated the content to ensure a focus on key topics such as social determinants of health, the impact of climate change and health inequality.

Dr Alice Roueché

- *General Paediatric Consultant*
- *Nottingham Children's Hospital*

@qualityknitting

Importantly, the undergraduate curriculum differs from Progress+ in that it is only a guide. Medical schools can choose to use as much as they like. We hope, however, that this work will improve the quality of paediatric placements for medical students and will ultimately encourage more into paediatrics as a career. It will also ensure that all future doctors will have achieved a holistic paediatric grounding that enables them to do the best for children and young people.

HISTORY TAKING: HOT DOGS AND WARM KIDS

Dr Richard Daniels
- *Paediatric Registrar (OOP)*
- *Radish*

@DrRDaniels

WHEN I WAS 18, I spent some time on an agricultural commune. There was a shed full of chickens, and one of my unenjoyable tasks was to go into this loud, smelly building and collect the eggs. I'm not a bird guy in general. I like my chicken in soup or on my plate. I can hand on heart say I've never thought, "How can this delicious fowl help my medical practice?"

That is one of many differences between me and Dr Étienne Stéphane Tarnier, a French obstetrician who was not fully engaged with his children on a trip to Paris Zoo in 1871. Whilst les petits Tarniers ran around looking at giraffes, Étienne looked at some newborn chicks under a heat lamp and wondered whether this might be a solution to the national population decline in France, driven by war and famine. Me? I'd have gone to see the penguins.

Tarnier had some warming boxes made up for his practice at the Paris maternity hospital and showed excellent results in reducing preemie mortality. Whilst not the first to look at the problem of thermoregulation, he was the first to add a lid to the cot. Publishing his work in 1888 did not impress the medical world, so, together with colleagues Pierre Budin and Martin Couney, they took the proto-incubator to the 1896 World Expo in Berlin where having 'borrowed' six premature babies from a local hospital, they demonstrated 100% survival of infants dismissed as having no chance.

This travelling circus of neonatal care eventually settled in the Coney Island Amusement Park in New York, where for 25 cents, the public could view the Infantorium, providing a novel funding model for service delivery. Couney estimated over 6,500 babies were saved via these travelling NICUs before the practice ended in the 1940s.

ASH'S BAKING SCHOOL

Dr Ashish Patel
- *ST8 Paediatric Nephrology & Sim Fellow*
- *Birmingham Children's Hospital*

@DrKidneyAsh

I CANNOT WAIT for summer to arrive and with it all the refreshing bakes I can take to barbeques and garden parties. I get asked a lot what my favourite flavour is and my reply is always the same – lemon. The sharpness of the citrus lemon compliments the sugar and butter in biscuits and cakes perfectly. Lemon drizzle was also the first bake I ever made and began my journey to The Great Paediatric Baker I am today. Lemon bakes are a firm favourite in our household and at the recent junior doctors' strikes these crispy lemon creams went down a treat on the picket lines. The secret – condensed milk! It makes the biscuits delightfully crispy. Sandwiched with the mascarpone/ lemon curd, these lemon creams are irresistible.

Crispy Lemon Creams

INGREDIENTS

Biscuits
110g unsalted butter (soft)
50g light muscovado sugar
65g caster sugar
175g self-raising flour
50g condensed milk

Filling
150g mascarpone
150g lemon curd

Instructions
1. Line 2-3 oven trays with parchment paper.
2. Beat the sugars and butter together in an electric mixer until light and creamy.
3. Add the flour and condensed milk and combine until a thick dough has formed.
4. Wrap the dough in cling film and leave in the fridge for 30 minutes.
5. Preheat your oven to 180˚C fan assisted or gas mark 4.
6. Tear off small pieces of dough and roll into small balls – roughly 30 balls, 15g each to be precise.
7. Places the balls onto the baking paper and flatten each ball slightly with the back of a spoon.
8. Bake the cookies for 10-12 minutes until they are pale gold. Leave to cool completely to solidify.
9. Combine the mascarpone and lemon curd in a bowel. Distribute the mixture on top of half your biscuits and then sandwich together with the other biscuits on top. ***Voila!***

Getting started on a new project

Dr Tessa Davis
- *Consultant in Paediatric Emergency Medicine / Senior Lecturer*
- *The Royal London Hospital*

@TessaRDavis

WHEN I FIRST SET OUT to create the PEM MSc at Queen Mary University of London (QMUL) along with Dani Hall and Becky Platt, we knew we wanted to offer an innovative, online programme that would incorporate some of Don't Forget the Bubbles' (DFTB) flair along with some brand new assignment methods.

But...where do you even start?

Here are five tips we learned along the way to help anyone starting a new project:

1. Start with a clear vision. Before you start, you need to have a clear vision of what you want to achieve. What are your goals? What is your end game? If you don't know where you're going, you'll end up lost in the middle of nowhere.

2. Build a strong team. No one can do it alone. Build a team of people who share your vision, are committed, and are fun to worth with. Each person brings a unique set of skills and experiences.

3. Be flexible. Flexibility is key when it comes to starting a new project. You never know what obstacles or challenges you'll face. I promise it's more than you expect. Just like a yoga pose, flexibility is essential to avoid getting stuck in a rigid position.

4. Embrace new ideas. Don't be afraid to try new things. Innovation is what sets new projects apart from old ones. Who knows, maybe the next big thing is just around the corner.

5. Celebrate small wins. Celebrating small wins along the way can help you stay motivated and focused on your end goal. Each small win is a step closer to achieving your overall vision. And it's an excuse to bust out the bubbles.

With QMUL and DFTB, we've put these tips into practice with our PEM MSc programme. We've created an innovative, online, and distance-learning programme that incorporates new assignment methods like infographics, oral presentations, and blog post writing. We're proud to be halfway through our second year of running it and look forward to many more successful years ahead.

Starting a new project can be daunting, but it can also be one of the most rewarding experiences of your life. By staying focused, building a strong team, being flexible, embracing new ideas, and celebrating small wins along the way, you can achieve your goals and create something truly innovative and unique.

Plus, who said work can't be a little fun and quirky along the way?

▶ ***Visit: mastersinpem.com***

WHAT PAEDIATRICS MEANS TO ME

AS THE CONFERENCE CHAIR for the Imperial Paediatrics Society, I had the exciting opportunity of arranging our annual conference in collaboration with the United Kingdom Aspiring Paediatricians Society (UKAPS).

The theme I chose was 'diversity in paediatrics' which explored variety in the field, identifying and tackling child health inequalities and increasing diversity and inclusion. We had four keynote talks and five workshops.

Our first talk, by Dr Tom Lissauer, discussed child health inequalities in the UK. He also highlighted inequality globally through his work in Rwanda. Dr Rathi Guhadasan spoke of her diverse humanitarian experiences, sharing insight into child health abroad. Dr Chantal Ellis discussed breastfeeding and Alex Pinto focused on how medical students can gain research in paediatrics.

Yasmin Baker
- *Third Year Medical Student*
- *Imperial College London*

@yazz_b9

During the lunch break, we held our poster presentations with the winning poster being awarded to Aamina Mahmood et al for 'integrating diversity into paediatric medical education'. In the afternoon, we held a number of working groups from art therapy in paediatrics to paediatric medical ethics conundrums.

We concluded with our awards ceremony and then a video from young people sharing their view on paediatric care. Seeing the delegates focus on the video and some tearing up from hearing what these young people have gone through hammered home what a privilege paediatrics is. By listening, believing and advocating for young people, it helps them feel empowered to take ownership and responsibility of their healthcare and allows us to co-productively create better services to improve outcomes and experiences.

As an aspiring paediatrician, I found the conference incredibly inspiring. It was a fantastic opportunity to learn from experts and gain a deeper understanding of the importance of diversity. Thank you to RCPCH, UKAPS and all our sponsors!

STARTER FOR TEN

We put 10 questions to a consultant paediatrician and her paediatric trainee

Dr Catherine Penrose

Consultant in Paediatric Intensive Care
Leeds Children's Hospital

1) Describe your job in three words.
Exhilarating, exhausting, collaborative.

2) After a hard day at work, what is your guilty pleasure? Indulging in Nordic noir on Netflix.

3) What two things do you find particularly challenging? a) Seeing the huge growth in 'box ticking' paperwork over the past 20 years, taking both nurses and doctors away from the patient. b) Seeing health inequalities on a daily basis and witnessing that gulf getting bigger.

4) What is the best part of your working day? Evening handover because it never ceases to amaze me how much a critically ill child can improve in just one day.

5) What is the one piece of advice you wish you could impart to yourself as a junior trainee? Listen to your patient's family. They are the expert on their child and you can get some valuable information if you truly collaborate and have effective communication. The secret is active listening.

6) Who is the best fictional character of all time, and why?
Elizabeth Bennet from Pride and Prejudice. She was intelligent, witty, strong willed, and not afraid to change her opinion when presented with further information (Mr Darcy you're not so bad).

7) What three medications would you like with you if you were marooned on a desert island filled with paediatric patients?
Augmentin, dioralyte and salbutamol. Not paracetamol as fever is amazing and engages T cells in fighting infection. Viva la fiebre!

8) What would you like your superpower to be, and why?
Teleportation... I'm thinking of the extra lie-ins I could have as a sleep deprived intensivist. When I'm on a 24 hour shift I could zoom back to see family and never miss kissing them goodnight.

9) What is the single most encouraging thing that one of your colleagues can do to make your day? Tell me about a visit from an ex-patient who was incredibly ill but survived. There is always a buzz on the PICU after such a visit and we know we were all part of something truly amazing.

10) How can you and your colleagues inspire the next generation of paediatricians? By being enthusiastic and being honest about the pros and cons. Acknowledging that cons exist allows strategies for dealing with them. Ours has to be the best discipline as we have the health of tomorrow's nation in our hands.

Dr Emma Hubbard

Paediatric Intensive Care Trainee
Leeds Children's Hospital
@emmakatie11

1) Describe your job in three words.
Intense, exciting and rewarding.

2) After a hard day at work, what is your guilty pleasure?
Singing along to Disney/musical soundtracks, sometimes very loudly. (My poor neighbours)

3) What two things do you find particularly challenging?
Delegation. As a PIC trainee I've been advised to delegate some tasks to the rotating trainees so that I can step up on some shifts. I've always been a team player so I feel bad delegating some of the rubbish jobs! And switching off after a shift. I'm getting better, I try not to take my work home – that's what a handover is for.

4) What is the best part of your working day? Working with a fantastic team, especially the nursing staff. They are so knowledgeable and supportive, and have made me feel welcome.

5) What is the best advice you have received as a trainee?
If you can't answer a question, don't fumble your way through it. Tell the patient/parents you will find out and get back to them.

6) Who is the best fictional character of all time, and why?
Sherlock Holmes is pretty awesome. Medicine involves a lot of detective work, especially in paediatrics as the children can't always tell you what is wrong, so I can relate to the character.

7) What three medications would you like with you if you were marooned on a desert island filled with paediatric patients? IV fluids, Ceftriaxone and Oxygen.

8) What would you like your superpower to be, and why? I love to travel, so my ideal superpower would be teleportation. If I could nip over to another continent for a weekend, I'd be the happiest person in the world!

9) What is the single, most encouraging thing that one of your colleagues can do to make your day? Positive feedback or taking the time to tell you that you've done something worthwhile for a patient or their family.

10) How can you and your colleagues inspire the next generation of paediatricians? Every paediatric trainee should spend some time on a PICU. It will help you to make referral calls and understand the advice we give to the ward doctors. Having ward doctors who can recognise deterioration quickly could help to avoid some of our admissions.

BOOK: EYE CAN WRITE - A MEMOIR OF A CHILD'S SILENT SOUL EMERGING

by Jonathan Bryan

Dr Rebecca Rhodes

- *Paediatric Registrar*
- *Nottingham University Hospitals*

@RebecRhodes

EVER WONDERED WHAT life is like as a child with 'profound and multiple learning disabilities'? How do they see the world around them? What do they think of 'us'? Jonathan Bryan – a young man with cerebral palsy – felt isolated, lonely and trapped as he couldn't communicate verbally for the first part of his childhood. With much perseverance, he and his family found a way, using a spelling board and directing his eyes... and the reflections he documents are amazing. He describes his experiences of seizures, admissions and PICU as well as family life, faith, holidays and education. He has a love for creative writing and a passion for others to be able to be understood and communicate too. He subsequently founded 'Teach Us Too' to advocate for every child to have the opportunity to learn to read and write. To say I was inspired by his book is an understatement; I'd recommend it to any paediatric doctor or team who has the privilege of journeying even for a short time with amazing young people like Jonathan.

AN 'AAC', WHAT IS THAT?

Dr Tony Hulse

- *Retired Consultant Paediatrician*
- *RCPCH AAC Clinical Lead*

THE PAINT ON your portfolio is gleaming, your 360 assessment is water-tight, your CCT date in sight – you're ready to become a consultant. You are likely to face an AAC – an Advisory Appointments Committee – the process which appoints substantive consultants (but not locums) in the UK. Foundation trusts are not legally bound to follow the AAC process but many do.

The AAC is an interview with maybe 10 scary people who have perfected 'management speak' and yet only two from your specialty! But there will be someone on your side – the RCPCH AAC Assessor – the only person on the AAC from outside the employing trust. An experienced, trained consultant paediatrician whose official role is to ensure that candidates are ready. But they do so much more – they also see fair play and help with difficult decisions. There is a team at RCPCH whose job it is to make this process work smoothly, with Dr Rajiv Mittal and I working as clinical leads.

So 'growing up' – becoming a consultant is as difficult as it is for teenagers! It's a different world from being a trainee. But when you have been a consultant for four years, consider volunteering as an AAC advisor. You will be eligible for a small payment, but there are many other benefits – you see how things are done elsewhere and can steal their good ideas! And you are making a huge contribution to the future of paediatrics. Contact us on **aac@rcpch.ac.uk**.

Why study history?

Dr Robert Scott-Jupp

- *Retired Consultant Paediatrician*
- *Salisbury*

@scott_jupp

"THOSE WHO CANNOT REMEMBER THE PAST ARE CONDEMNED TO REPEAT IT." (GEORGE SANTAYANA, 1905)

To really understand why we practise as we do today, we need to look at where we came from. After RCPCH was formed in 1996, our specialty came of age, and it seemed fitting that its history should be acknowledged. Thus in 2002, the late Professor Peter Dunn founded the British Society for the History of Paediatrics and Child Health (BSHPCH), the name reflecting that of the new College. It has since thrived, with national meetings twice a year.

Meetings are enjoyable social events, with associated informal receptions and dinners. All are welcome. Anyone can submit an abstract, and no special historian skills are required. A £300 prize is offered annually for an essay on a relevant topic. A number of articles arising from our meetings have been published in ADC and elsewhere, and several members have had books published on relevant topics.

Members are predominantly, but not exclusively, paediatricians. We also include surgeons, child psychiatrists, archivists, academic historians and others. We share a passion for history, sometimes kindled by realising the lack of knowledge amongst younger colleagues about how much practice has changed, even within our working lifetimes. But our interests are not confined to the origins of current practice. Some presentations concern wider aspects of child health, including global issues, and some go back much further than the modern era.

Join us in Preston on 15-16 September for our next meeting and sign up to find out how fascinating our history can be.

▶ ***Visit:*** ***www.bshpch.com***

A one stop guide to living and working in the UK

Dr Jaspreet Kaur Sokhi along with **Soft Landing** have developed a guide to help international medical graduates settle into life in paediatrics in the UK

Dr Jaspreet Kaur Sokhi

- *Speciality Doctor in Developmental Paediatrics*
- *St George's Hospital, London*

@Paedsoftlanding

I am a paediatric international medical graduate (IMG) who, like many others, struggled to find my way both in the personal and professional world in the UK. My circumstances may be slightly different in the sense that I married someone who was settled in the UK, so at least I did not have to worry about having a roof above my head. Apart from that, my journey has been just as interesting as any other IMGs. There were several times at the beginning when I wanted to go back home to my family and the career that I had. It can get quite trying but if you have the right guidance and support network, it can be a much smoother journey.

I really wished someone had just given me a handbook or a one stop shop where I could have got a checklist of all the things I needed to do without having to figure it out myself through days of researching on various websites and talking to strangers, who unfortunately all gave different advice, making the situation so much more complex.

When I eventually found my way into the professional world, I met an amazing person, our college tutor at St George's, who suggested I write a local handbook for paediatric IMGs for the trust. This seemed like a brilliant idea and was the starting point of this journey.

The book produced by Jaspreet and her co-editors aims to be a one stop shop for IMGs looking for help when they arrive in the UK

He then introduced me to the Soft Landing Team, which I joined. This was a relief for me. Soft Landing is a group of mostly IMG paediatricians who have survived and thrived after the transition and want to make it easier for others. The group is entirely voluntary and dedicates its time to easing the transition for all IMGs aspiring to work in paediatrics in the UK. It holds regular mock interviews, webinars and induction workshops as well as local WhatsApp support groups to assist paediatric IMGs. It is a home away from home!

They were excited to see our trust handbook and encouraged me to publish it, so that it could be beneficial to a wider audience of IMGs. We brainstormed on the main topics that we felt would be most important to an IMG starting afresh in the UK and then searched for volunteers who would be willing to write different chapters. The idea was received with a lot of enthusiasm, and we had eager volunteers who took time out of their busy schedules to write various chapters which we then edited and combined into one book that is currently available as an online publication both on Amazon and Apple stores.

Our hope is that no IMG feels alone in their journey while settling into life in the paediatric world in the UK and I am hoping this guide will accomplish that. I hope we have created that one stop shop that I wished I had when I started my journey in the UK. This is our first edition and we hope to improve it further as we gather the experience of more IMGs and what they would have liked to know when they initially came into the country. In addition, we hope to include some personal stories as inspiration in future editions. Look out for our book and do share your ideas with us on anything you feel could improve this guide.

Wellbeing

Laughter pays dividends

Paediatricians tend to be a jovial bunch and whilst a smile costs nothing, laughter pays dividends. Research has shown that there are numerous health benefits to justify that laughter is indeed the best medicine

Dr Seb Gray

- *General Paediatric Consultant*
- *Salisbury NHS Foundation Trust*
- *RCPCH Milestones Editor*

@SebJGray

FROM ANALGESIA TO anti-inflammatory, anti-depressant to increased blood flow, there's a lot to be said for a good belly laugh. Often, the bleaker the situation, the darker the humour and we've all been in situations where if you don't laugh, you'll probably cry. Laughter doesn't always come as the first instinct in difficult environments. For example, some of the humour on intensive care units toes the line of acceptability whilst blindfolded, wearing flippers after a few beers. An intensive care version of '24 Hours in A&E' would have to come with so many warnings that I can't see a genuine 'reality' form ever making it to screen. At least not without the number of complaints sky rocketing. Using laughter as a forcefield to fend off deeper feelings isn't sustainable. Having safety mechanisms in place to reflect and process the whole range of emotions is essential.

"You treat a disease, you win, you lose. You treat a person, I guarantee you, you'll win, no matter what the outcome."

Patch Adams was based on the real life of Hunter Doherty Adams and portrayed by the brilliant Robin Williams. Both suffered from mental health problems and whilst sadly, Robin Williams died from suicide, Hunter Adams continues his charitable work and ethos of accessible healthcare. Interestingly, whilst Adams felt Williams did a "fabulous job" playing him he was disappointed with how he was portrayed, stating, "I would become a funny doctor. Imagine how shallow that is relative to who I am." With all his philanthropy, humour is part of his personal arsenal but not his only weapon. Laughter and being funny is a wonderful quality but it is not a mask or defence mechanism to hide other feelings.

Ethics and our conscience dictate that we should remain professional and respectful throughout. The GMC's ears would prick up if they heard stories being regaled at dinner parties or in the pub for light relief. When you've been involved in a funny situation that you're unable to share more widely, it forms a bond so unique and many great relationships with the multidisciplinary team grow their roots through these unique experiences. It's important in this context to maintain patient trust and confidentiality.

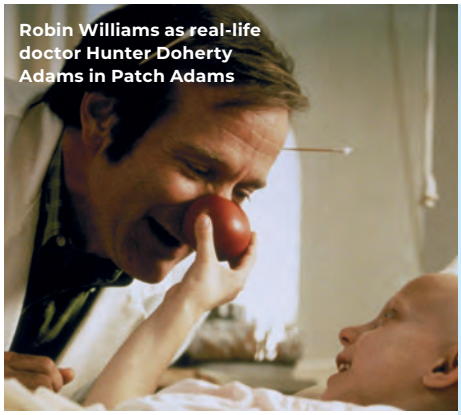
"Having safety mechanisms in place to reflect and process the whole range of emotions is essential"

However, not all anecdotes and stories are unique enough to identify patients and GMC guidance suggests that anonymised stories would be OK if you "Ensure that appropriate controls are in place to minimise the risk of individual patients being re-identified." By not mentioning details about time, location or any other identifying factors, the risk of re-identification becomes negligible.

The anecdote below is an example: When deep in concentration my mouth stops being a mouth. It becomes ajar. This has risks as a paediatrician. We concentrate a lot and sometimes the thing we're concentrating on might be a baby capable of producing bodily fluids. Whilst focusing on seeing if an anus was patent on a newborn, having your mouth ajar is not the preferred stance if you discover with some force, it was patent. MECC, making every contact count, took a different meaning for me from then on.

Most people seeking healthcare have a heightened sense of anxiety and being able to alleviate that with humour is a wonderful skill. Too soon without developing a rapport, you risk causing offence. For example, if you were seeing someone with burns to their groin you wouldn't start with, "So you must be liar, liar?"

Likewise, you need to be able to judge a situation and adapt jokes



Robin Williams as real-life doctor Hunter Doherty Adams in Patch Adams

Image: MCA\UNIVERSAL

for that age group and parental approval. One of my own child's favourites is a perfect example that will have divided opinions.

"Knock knock"
"Who's there?"
"Europe"
"Europe who?
"No, you're a poo!"

The safe approach is probably synonymous with 'dad jokes' defined as "an unoriginal or predictable joke, especially a pun". Generally, unoffensive, even an adolescent eye roll response helps build relationships and trust. The great news is that you don't have to be a dad to deliver these jokes (although it does make you a faux pa!).

Joking around at work is great but within the current NHS climate, sometimes it's no laughing matter and you need to find a way to induce your funny endorphins in your own time. Finding what really tickles you is individual and far from universal. Watching pranks and epic fails with your kids, reading a funny book, going to see a humorous play, film, or stand-up comedy, or just chatting with friends are all options. Whatever floats your boat, humour can alleviate that sinking feeling and boost your mood so jokes aside, it's time to take funny seriously.

Heard about the magic tractor? **It went down the lane and turned into a field.**

What do you get when you cross a sheep and a kangaroo? **A woolly jumper**

What you do you call a man with a spade in his head? **Doug**

And what about a man without a spade in his head? **Douglas**

Professor Steve Turner, RCPCH Registrar

What did the cheese say when it looked in the mirror? **Halloumi**

Dr Cathryn Chadwick, RCPCH VP for Training and Assessment

What do you call a sleeping dinosaur? **A dino-snore!**

Dr Mike McKean, RCPCH VP for Policy

What do you get if you cross a snowman with a vampire? **Frostbite**

What is a pirate's favourite letter in the alphabet? **Rrrrrrrrr**

Where do cows go to watch films? **The moooooovies**

Professor Andrew Rowland, RCPCH Officer for Child Protection

Why are paediatricians always grumpy? **Because they have very little patients.**

Dr Liz Marder
RCPCH Treasurer

How do you make an octopus laugh? **Give it ten tickles!**

Dr Simon Broughton
RCPCH Officer for Recruitment

I awoke to find a jumbo jet sitting at the top of our stairs. 'You left the landing light on again,' said my wife.

Dr Andrew Long, RCPCH Representative for Senior Members, Senior Fellows and Honorary Fellows

Why did the mushroom always get invited to the party? **Because he was a fungi.**

Doctor, Doctor! I've swallowed my pocket money. Take this and we'll see if there's any change in the morning.

Doctor, Doctor! I think I'm turning into a pony! **Don't worry; it's not as bad as you think. You're just a little hoarse.**

Professor Paul Dimitri
RCPCH VP for Science and Research

Person 1: How do you put an elephant into a refrigerator? **Person 2: That's not physically possible.** *Person 1: Wrong, you open the refrigerator door, put the elephant inside, and close the door!*

Person 1: How do you put a giraffe into a refrigerator? **Person 2: Open the refrigerator door, put the giraffe inside, and close the door.** *Person 1: Wrong, you open the refrigerator door, take the elephant out, put the giraffe in, and close the door!*

Dr Jonathan Darling
RCPCH VP for Education and Professional Development

Why did the squirrel swim on his back? **To keep his nuts dry.**

Why do giraffes have long necks? **Because they have smelly feet.**

Dr Karen Street
RCPCH Officer for Mental Health

Why did the scarecrow win an award? **He was out standing in his field.**

Dr Emma Dyer, RCPCH Chair of the Trainees Committee

A DAY IN THE LIFE

"A happy child is a happy family"

Dr Jamil Ahmad Khan

Clinical Lead Paediatric Emergency Department, Royal Oldham Hospital
RCPCH Co-Chair SAS Committee

Jamil (second from left) with his colleagues

I decided to become a paediatrician after doing my first rotation in a children's ward. I can still remember the day years later when I decided paediatrics was my tribe. An adorable eight month old started talking to me (of course he was only babbling), and I was so overjoyed that I took him in my arms for a cuddle. However, this ended abruptly when my scrub top suddenly went all wet, and I realised the cute little star wasn't wearing a nappy and had enjoyed a wee all over me. That's how I started my career in paediatrics and I haven't looked back. I love the pure, true and natural emotions children show when they're happy or recovering from an illness. A happy child is a happy family.

My typical working day involves waking up at 5am and getting myself a healthy but light breakfast. My commute is about 30 minutes and as with most NHS trusts, finding a car parking space is a task as difficult as conquering Mount Everest. The morning starts with a 20-minute handover and right after, I find myself surrounded by cute little babies, toddlers and of course school age children. Some are already fixed and ready to go home, while others need a little bit more fixing. My nursing colleagues are brilliant and are always friendly, polite and co-operative. With their kind assistance, I review several unwell children and devise management plans. Time flies until we are at lunch time. After lunch, I always feel like taking a little nap, but that's just a pipe dream!

Back to the second session of work and it is either again assessing poorly children and supervising junior doctors or making some follow-up calls to worried parents of children who are now home, to reassure them and ask of any changes in their conditions.

The most difficult part of my job is dealing with parental anxiety. The majority of the children are not seriously unwell (fortunately) and all that's needed is more reassurance. But I always encourage parents to seek medical assistance whenever they are worried and trust their parental instincts. As paediatricians, we not only manage children and young people but their parents and carers too (sometimes granny as well).

The best part of the job is receiving a compliment for a job well done, it makes my day. We do also get a lot of chocolates and treats from parents as a thank you gesture, which I enjoy!

My most memorable moment was when I joined RCPCH to advocate for paediatric SAS doctors in the UK. As Co-Chair of the SAS Committee, I can directly liaise with the College Council regarding issues faced by SAS grades. The College is keen to support and involve SAS doctors. College Fellowship is now open via election to SAS doctors and we are actively working towards enabling SAS doctors to become College examiners. We have also lobbied for a new specialist grade so NHS employers can recruit SAS doctors into senior level roles. I think our biggest achievement has been the release of the GMC workforce data, which shows SAS will be the UK's largest medical workforce by 2030. Interest in SAS posts has risen sharply over the past few years. Overall SAS is an extremely rewarding career with excellent work life balance and fairly good financial incentives.

When I'm finished work,

I like to watch cricket, I'm a big fan and never miss a moment. I also have a keen interest in astronomy and spend my spare time reading research articles. The recently launched James Webb telescope is a history-making project which is exploring unseen corners of the universe. I enjoy watching all the latest revelations.

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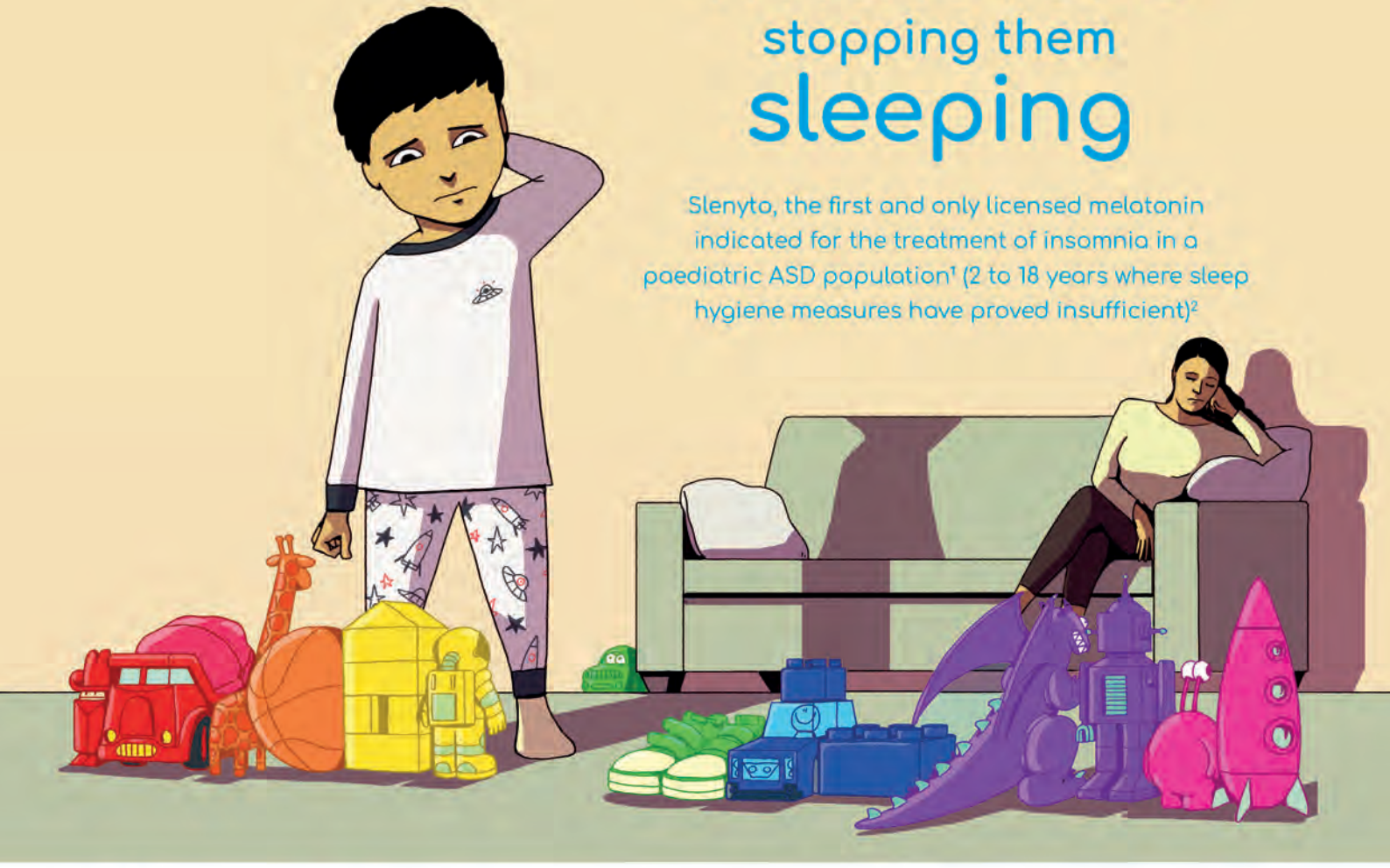

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Slenyto 1mg	£41.20	60 tablets	PLGB 52348/0003 EU/1/18/1318/001
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DATE OF REVISION OF PRESCRIBING INFORMATION: June 2021

References
1. *BNF for Children*. https://bnfc.nice.org.uk/drug/melatonin.html#indications AndDoses [Accessed January 2022]. **2.** Slenyto SmPC [Accessed January 2022].

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