The Top 10 Paediatric Guidance ...why and how

Dr Phil Thompson MBCHB (Hons) MRCGP DRCOG
Clinical Lead GP for Children, South Worcestershire CCG
The Top 10 conditions which children & young people present to urgent care with

1. Bronchiolitis
2. Croup
3. Fever
4. Gastroenteritis
5. Asthma
6. Limping child
7. Purpuric rashes
8. Crying baby
9. Mental health
10. Constipation
The challenge

- Rising admissions

Acute Paediatric admissions to Worcestershire Royal Hospital
The challenge

- Rising cost of admissions

Mean monthly cost of admissions

- **2014/15**: £474,244
- **2015/16**: £504,776
Admissions of less than 24 hours

- 2014/15: 1,875
- 2015/16: 2,299
Admissions of less than 24 hours

- Did they really need to be there?
- Were there any interventions that could only have been done as an admission to the ward?
Reasons for admissions of less than 24 hours

- Acute bronchiolitis unspecified
- Acute upper respiratory infection unspecified
- Viral infection unspecified

Why have paediatric admissions been rising?

- Children probably aren’t getting “sicker” than they used to
- Some children DEFINITELY need to be in hospital
- Many children probably don’t need to be in hospital
- Being in hospital when it’s not necessary creates more stress for children and parents and uses up limited resources
Workload crisis in Primary Care and A+E

Rising workload 'hits patient care', BMA survey finds

'Patients at risk' from length of GP consultations

A&E crisis: Four in 10 NHS hospitals declared a major alert in their A&E departments last week amid mounting pressure
Concerns over “missing” a diagnosis

Mother's 5-year fight for the truth after doctors missed signs of killer meningitis in her baby: 'Neglectful' medics said it was a virus and sent her home with Calpol

GP negligence claims: alarming rise revealed
Other possible reasons

- Increasing parent expectations
  - Wanting an “expert” opinion
- GP experience and confidence in the diagnosis and management of children
  - Paediatrics post is not a compulsory part of GP training
  - GPs who haven’t done a formal paediatrics job, admit more children to hospital and refer more children to outpatients
What did we do?

- We looked at a sample of admissions to Worcestershire Royal Hospital Paediatric Ward
- We found that many of the children admitted, could have potentially been managed without admission to the ward
- We found the same handful of conditions resulting in a number of admissions that were potentially avoidable
What did we do?

- We felt that we might be able to reduce admissions and improve care if we could:
  - Improve understanding
  - Provide guidance
  - Provide support
We developed “The top 10”
# Bronchiolitis

<table>
<thead>
<tr>
<th><strong>Clinical Assessment Tool</strong></th>
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<tbody>
<tr>
<td>Babies/Children under 2 years with</td>
<td></td>
</tr>
<tr>
<td><strong>Bronchiolitis</strong></td>
<td>Green – low risk</td>
</tr>
</tbody>
</table>

### Behaviour
- Alert
- Normal

### Circulation
- CRT < 2 secs

### Skin
- Normal colour skin, lips & tongue
- Moist mucous membranes

### Respiratory Rate
- Under 12mths < 50 breaths/minute
- Over 12 mths < 40 breaths/minute
- No respiratory distress

### SATS in air
- 95% or above

### Chest Recession
- None

### Nasal Flaring
- Absent

### Grunting
- Absent

### Feeding
- Normal – no vomiting

### Apnoeas
- Absent

### CRT: Capillary refill time
- *Apnoea – for 10-15 secs or chest depression by a sudden decrease in saturations/normal cyanosis or bradyarrhythmia

### SATS: Saturation in air
Clinical Assessment Tool

Babies/Children under 2 years with Suspected Bronchiolitis

Assess, look for:

- Green features
- Amber features
- Red features

If all green features and no amber or red

- Child can be managed at home with appropriate care and advice. Always provide verbal/written information about warning signs and when to seek further advice.

Con
- Provide a safety net for the parents/carers by using one or more of the following:
  - Written or verbal information on warning symptoms and accessing further healthcare
  - Arrange appropriate follow up
  - Liaise with other professionals to ensure parent/carer has direct access to further assessment
  - Referral to Community Nursing Service (if available)
How is your child?

Red:
- Blue lips
- Unresponsive and very irritable
- Finding it difficult to breathe
- Pauses in breathing or irregular breathing pattern

You need urgent help please phone 999 or go to the nearest Accident and Emergency Department.

Amber:
- Decreased feeding
- Passing less urine than normal
- Baby/child’s health gets worse or you are worried
- If your baby/child is vomiting
- Your baby/child’s temperature is above 39°C

You need to contact a doctor or nurse today please ring your GP surgery or call NHS 111 – dial 111.

Green:
- If none of the above factors are present

Self Care
Using the advice overleaf you can provide the care your child needs at home.
Management of the Unsettled Infant Where the Cause is Thought to be Related to Feeding

Consider the following:
- Age and sex of the child
- Birth history/developmental history
- Feeding history and technique
- Family history of allergy

Caregivers might report one or more of the following:
- Possetting (effortless vomiting) or back-arching
- Prolonged crying episodes
- Loose stools or unusual coloured stools
- Bloated abdomen or Constipation

Remember what is not abnormal (see Appendix 1 for further detail):
- Possetting alone is not abnormal. It can be abnormal if associated with distress
- Stool colour and frequency is highly variable depending on age of child/whether breast or bottle fed or whether being weaned
- Constipation and diarrhoea is often a subjective observation by caregivers. What they describe may not be abnormal

Consider Gastro-Oesophageal reflux:
- Tendency to back-arch during feeding, associated with distress
- Possetting with distress
- Distress when laid flat after feeds

Consider Infant Colic:
- Prolonged but intermittent periods of unexplained crying, often with unusual cry
- Infant pulls knees up to chest
- Well in between episodes

Consider Cow’s Milk Allergy (CMA):
- Persistent symptoms that do not improve well with treatment for GOR or colic
- Associated eczema or constipation
- That are not responding well to usual treatments

Consider Lactose Intolerance:
- Diarrhoea/posting/cramping following feeds
- Recent infectious GI illness
- Possible CMA history

See Page 30
See Page 31
See Page 32
See Page 33
Suspected Gastro-oesophageal Reflux

**Red Flags**
- Recurrent, forceful (projectile vomits) – might suggest PYLORIC STENOSIS
- Blood stained vomitus or stool
- Melaena
- Abdominal distension or bile-stained vomitus
- Weight loss

**Common Symptoms**

**Step 1**
- Bottle fed infants
  - Review the feeding
  - Consider reducing feed
  - Consider more frequent
  - Offer trial of thickened
  - Starchy/cream starchycereal

**Step 2**
- Trial of alginate tablets

**Step 3**
- Consider a 4 week trial
  - Verbal child with over
    - Distressed
    - Faltering growth
    - Unexplained
    - Feeds

**Step 4**
- Do not prescribe domperidone, metoclopramide or erythromycin
  - Without discussion with a specialist
  - Consider paediatric outpatient referral

Discuss with on-call paediatrician
<table>
<thead>
<tr>
<th>Type of milk</th>
<th>Indication</th>
<th>Preferred choices</th>
<th>Prescribe/ Purchase</th>
<th>Review/ stopping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extensively Hydrolysed Formula (eHF)</td>
<td>Cow’s milk allergy (CMA)</td>
<td>Lactose –free:</td>
<td>Prescribe*</td>
<td>See guideline</td>
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<tr>
<td></td>
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<td>Nutramigen Lipil 1° 0- 6 months</td>
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*In babies under 6 months due to high phyto-oestrogen content.

Refer to paediatrician if still not tolerated.

Stop at age 1 year – use lactose-free full fat cow’s milk.

N.B Infasoy was discontinued in April 2015.
Direct access to advice

Discuss with on-call paediatrician
Guidelines rolled out and supported

- Rolled out in weekly bulletins from the CCG
- Regular reminders about their use
- Local quality improvement schemes highlight their use
  - IQSP - Improving Quality and Supporting Practice
  - Mandatory to have the guidelines on each clinician in the CCG’s desktop
- Clinical Pharmacists across South Worcestershire
Quality improvement

- Consultants now take all referrals from GPs/A+E from 8am-8pm weekdays and 8am-5pm weekends.
- Consultant can offer advice to referring clinician over the phone.
- Development of “hot clinic slots”
  - Can be used for less unwell children who need seeing urgently but not necessarily admitting.
  - Better for parents and children.
  - Less cost than an admission.
An ongoing challenge

- Admissions continue to be a challenge
- Continuing to support GPs and the A+E teams surrounding best practice management of children
- Trying to keep children out of hospital who don’t absolutely need to be there
- Providing the best possible care to children in the community
Thank you for listening

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