BSPGHAN
working for children with digestive and liver disorders

British Society of Paediatric Gastroenterology Hepatology and Nutrition

Joint Meeting

Trainees in Paediatric Gastroenterology, Hepatology and Nutrition

and

Associate Members

29th and 30th September 2014

WIMAT Centre, 29th September 2014
Holiday Inn (evening 29th and all day 30th September 2014)
Cardiff

BSPGHAN thanks the following companies who have generously provided educational grants for this meeting

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Children's Liver Disease Foundation

BSPGHAN
working for children with digestive and liver disorders

British Society of Paediatric Gastroenterology Hepatology and Nutrition

Study Day – 29th September 2014
WIMAT, Cardiff Medicentre, Heath Park, Cardiff, CF14 4UJ

Monday 29th September 9.30 – 17.00

9.30 Registration desk opens, WIMAT Centre

10.45 – 11.00 **Welcome and Introduction**
Dr Fiona Cameron, Chair of Trainees' Group

11.00 – 11.30 **Update on START and specialty specific reviews; training – what you need to know**
Dr Sue Protheroe

11.35 – 12.15
Parallel Sessions

Senior Trainees:

How to write a good CV/interview tips for consultant interview and how to organise your paperwork

Dr Hemant Bhavsar
Consultant Paediatric Gastroenterologist
Leicester Royal Infirmary, Leicester

Junior Trainees:

How to prepare for grid interviews

12.15 – 13.30
Lunch

13.30 – 17.00 **Endoscopy workshop**

Trainers:

Dr Mike Thomson and Dr Priya Narula
Consultant Paediatric Gastroenterologists
Sheffield Children's Hospital
Sheffield

Dr David Rawat
Consultant Paediatric Gastroenterologist

Dr Hemant Bhavsar
Consultant Paediatric Gastroenterologist
Leicester Royal Infirmary, Leicester

Dr Venkatesh Krishnappa
Consultant Paediatric Gastroenterologist
Alder Hey Children's Hospital
Liverpool

Dr Patrick McKiernan
Consultant Paediatric Hepatologist
Liver Unit
Birmingham Children's Hospital, Birmingham

Mr Mick Cullen
Paediatric Gastro Nurse Specialist
Southampton General Hospital
Tremona Road
Southampton
SO16 6YD

Beginners	*Advanced*
Basic hands on OGD/ Colonoscopy	**Lesion recognition, advanced techniques**
Beginners:	**Advanced**
Endoscopy Workshop	**Endoscopy simulator training**
	Banding

17.00
Close of Meeting

18.00 – 19.00 **Associate Committee and Trainee Committee meetings - Holiday Inn Cardiff City Centre, Cardiff**

20.00 **Dinner, Holiday Inn, Cardiff City Centre**

Tuesday 30th September 2014

Holiday Inn, Cardiff

8.00 Registration

9.20 – 9.30 Welcome and introduction

Dr Fiona Cameron
Chair Trainees' Group

Mr Mick Cullen
Chair Associate Members' Group

9.30 – 10.45 – Session One, Upper GI

Chairs

Dr Protima Amon
Specialist Registrar
The Royal London Hospital
Whitechapel Road
London E1 1BB

Ms Claire Sadlier
Specialist Nurse
Children's Centre
University Hospital of Wales
Cardiff

9.30 – 10.00

How to develop a service? Including Commissioning

Dr Sue Protheroe
Consultant Paediatric Gastroenterologist
Birmingham Children's Hospital
Steelhouse Lane, Birmingham

10.00 – 10.20

Cyclical vomiting

Dr Sonny Chong
Consultant Paediatriic Gastroenterologist
QMHC, Wrythe Lane
Carshalton, Surrey

10.20 – 10.50

What should we feed children who can't feed themselves?

Introduction from Dr Huw Jenkins
Consultant Paediatric Gastroenterologist
Children's Centre
University Hospital of Wales, Cardiff

Ms Claire Sadlier, Specialist Nurse and Ms Kath Singleton, Paediatric Dietitian
Children's Centre
University Hospital of Wales, Cardiff

10.50 – 11.05
Coffee

11.05 – 12.20
Session Two: Parallel Sessions
Please check rooms on day

Chair:

Dr Paul Henderson
Paediatric Registrar and Honorary Clinical Fellow
Royal Hospital for Sick Children
Sciennes Road
Edinburgh EH9 1LS

11.05 – 11.45

How to interpret and carry out pH studies/impedance

Dr Priya Narula
Consultant Paediatric Gastroenterologist
Sheffield Children's Hospital
Western Bank
Sheffield, S10 2TH

11.45 – 12.20

How to make up a modular Feed

Ms Tracey Johnson
Dietitics Department
Birmingham Children's Hospital
Steelhouse Lane
Birmingham B4 6NH

And

Ms Viv Jones and Ms Sian Evans
Dept of Nutrition and Dietetics
SAC building level 2
University Hospital of Wales
Heath Park
Cardiff CF14 4XW

Panel:

Ms Kay Crook, St Mark's Hospital, Middlesex

Mr Chris Smith, Royal Alexandra Hospital, Brighton

Ms Anna-Kristina Skrapac, Chelsea and Westminster Hospital, London

11.05 – 11.45

Gastroenterology, hepatology and nutrition frustrations and fixes: Bring or send prior to the meeting

11.45 – 12.20

Transition: General gastroenterology and constipation not just bog standard transition

Templates and traps to transition

Ms Rachel Russell
Clinical Nurse Specialist
Southampton General Hospital
Tremona Road
Southampton

10 – 15 minutes discussion

12.25 – 12.45 Abstract presentations

Chairs:

Dr Lisa Whyte	**Ms Nicky Heather**
Specialist Registrar	**Nutrition and Dietetic Dept**
Birmingham Children' Hospital	**Southampton General Hospital**
Steelhouse Lane, Birmingham	**Tremona Road, Southampton**

12.25 – 12.35

Successful mercaptopurine usage following azathioprine intolerance in paediatric IBD: A Regional Cohort Study
Merrick, V; Henderson, P; Rogers, P; Gillett, P; Wilson D. Department of Paediatric Gastroenterology and Nutrition, Royal Hospital for Sick Children, Edinburgh, UK

12.35 – 12.45

Setting up a feeding clinic

Ms Nicky Heather
Nutrition and Dietetic Department
Southampton General Hospital
Tremona Road
Southampton
SO16 6YD

12.45 – 13.40

Lunch and visit exhibitor stands

13.40 – 14.50
Diagnostic approach to GI conditions

Chairs:	
Dr Anthony Wiskin **Specialist Registrar** **Southampton General Hospital** **Southampton**	**Ms Janis Maginnis** **Clinical Nurse Specialist** **University Hospital of** **North Staffordshire**

13.40 – 14.10

Motility Disorders: An overview of the spectrum, including pseudo obstruction

Dr David Rawat
Consultant Paediatric Gastroenterologist
Department of Paediatric Gastroenterology
4th Floor
Chelsea and Westminster Hospital
369 Fulham Road
London SW10 9NH

14.00 – 14.30

Pathology: interactive session. How to understand the pathologist's report

Dr Edgar Lazda
Consultant Histopathologist
University Hospital of Wales
Cardiff

14.30 – 14.50

GI Radiology for dummies – interpretation of x-rays/MRI/BariumCT/dexa

Dr Sara Harrison
Consultant Radiologist
University Hospital of Wales
Cardiff

14.50 – 15.30 Difficult case presentations

Chairs:

Dr Rafeeq Muhammed
Consultant Paediatric Gastroenterologist
Birmingham Children's Hospital
Steelhouse Lane
Birmingham

Dr Clarissa Martin
Consultant Clinical Psychologist
The Hayes
Stafford

14.50 – 15.02

Recurrent Acute Liver Failure and the Challenges it Presents to Transplantation

Dr Lauren Johansen
Specialist Registrar, Hepatology Grid Trainee
Liver Unit, Birmingham Children's Hospital
Steelhouse Lane, Birmingham

15.02 – 15.14

Challenging case:
presentation of 8 year old boy with neurodisability and intestinal failure.

Dr Lisa Whyte
Specialist Registrar
Department of Gastroenterology, Birmingham Children's Hospital
Steelhouse Lane, Birmingham

15.14 – 15.26

Case of child with extreme short gut and challenges of long term PN

Mr Chris Smith
Dietitian
Department of Nutrition and Dietetics
Royal Alexandra Children's Hospital
Eastern Road, Brighton

15.30 – 16.00

Coffee break

Opportunity to visit exhibitor stands

16.00 – 16.20

Chairs:	
Dr Lauren Johansen	**Ms Deepa Kamat**
Specialist Registrar	**Specialist Paediatric Hepatology Dietitian**
Liver Unit	**Liver Unit**
BCH	**King's College Hospital**
Steelhouse Lane	**Denmark Hill**
Birmingham	**London**

16.00 – 16.20

Non alcoholic fatty liver disease – how to manage

Dr Alastair Baker
Consultant Paediatric Hepatologist
King's College Hospital
Denmark Hill
London

16.20 - 16.30
End of meeting and Prize giving

2011. Best presentation winner: Digital Camera donated by Pentax

Ms Sarah Cunningham, Royal Victoria Infirmary
Presentation: ***Very low catheter infection rates are achievable in Paediatric Home Parenteral Nutrition Patients***

2012 Best presentation winner

Dr Johan van Limbergen, Royal Hospital for Sick Children, Edinburgh
Presentation: ***Hypothesis-free analysis of ATG16L1 demonstrates gene-wide extent of association with Crohn's disease susceptibility***

2013 Best presentation winner

Ms Nicola Laird, Dietitian, Royal Hospital for Sick Children, Glasgow
Presentation: ***An audit of patients diagnosed with Coeliac Disease on biopsy over a 3 year period compared with the new ESPGHAN and BSPGHAN guidelines.***

Abstracts and notes pages

Monday 29th September 2014

Update on assessment Sue Protheroe 2014

RCPCH is responsible for

- Monitoring postgraduate specialty training in paediatrics in the UK
- Sets and maintains standards of training and assessment in General Paediatrics and sub-specialties, in accordance with the requirements set by the General Medical Council (GMC)

CSAC is responsible for

- Developing curriculum (level 3 SPIN) and related assessment strategies and tools (eg JAG endoscopy certification).
- Providing advice to deaneries on the quality management of training in PGHAN as part of the GMC's Quality Framework.
- Recording and monitoring trainees' progress through their specialty training
- Assessing applications for Completion of Training (CCT) before recommendation to GMC for entry to the specialist register.

Enhanced ARCP required for revalidation by GMC

RCPCH SPIN module

provides the general paediatrician with the competencies necessary for practice with particular expertise in the relevant area of clinical practice to the standard appropriate for secondary level paediatric care.

Work based assessment pilot 2014 (Asset) *RCPCH.ac.uk/assess-exams*

- *Directly Observed Procedural Skills (DOPS) = summative Assessment of Progress (AoP) ie sign off*
- *Mini Clinical Evaluation Exercise (Mini-CEX) = SLE x4-6*
- *Case Based Discussion (CbD) = SLE (8-12 ; x1 safeguarding) then Reflect*
- *Discussion of Communication (DOC) SAIL = SLE x 5.*
- *Handover Assessment Tool (HAT) x 1*
- *Leader tool CBD x 1*
- *Paediatric specific Acute Care Assessment Tool (ACAT) x 1*

Feedback- Supervisor gives more formative constructive feedback on performance to develop learning outcomes with reflection and a learning plan.

Benefits the trainee by restructuring understanding, skills and builds on capability

Encourage aspiration to excellence, self-assessment, and self-esteem

Learner- what went well?
Observer- what you did well
Learner –what could be improved
Observer " " " and how to achieve it.

So that

- Learner is sure of progress and can use to change or improve
- Better evidence for the completion of the trainer's report.
- Better able to influence the ARCP with progression of training
- Feedback was limited with summative assessment
- Supervised Learning Events (SLEs) 20 / year (min 12)

Reflection-is used in decision making and judgment –provides insight into practice- an educational process

- Analyze actions, learn and apply to new situations
- Identify gaps and learning needs

Reflection in action – while solving a problem

Reflection on action- after a problem.

Target your training

- Acute cases MiniCEX, CbD, reflective
- Chronic case management
- Leading/contributing to MDT/discharge planning meeting

- Targeted outpatient experience
- Ethics, consent and law – ethical dilemma, clinical decision-making/ thought processes.
- consent, conflict over best interest of the child, withdrawal or withholding treatment.
- Conflict – absent colleague, poorly performing colleagues/juniors, complaints, critical incidents.
- Teaching – Skills in teaching technique, selection of appropriate facts and quality of information given.
- Safe prescribing – Practical exercises knowledge and skills in safe prescribing – looking at ability to complete prescription, understanding of pharmacology, advice/explanation and general management (http://www.rcpch.ac.uk/training-examinations- professional-development/quality-training/paediatric-prescribing-tool/paediatr) http://bnfc.org/bnfc
- Ward rounds & Handover & Clinics - priorities and decisions, quality of information, SBAR
- Logistics- coping with multiple demands decision making, prioritisation, planning and negotiation
- Protection issues- safeguarding, abuse, protection, management, multidisciplinary nature, external agencies, law (in any station), - attend multi-agency meetings

Specialty Training Assessment of Readiness for Tenure (START)

- Ability to utilize knowledge and experience around clinical decision-making
- Formal assessment of professional skills and readiness for consultant practice.

Educational Supervisors Trainers report

- The new 2 part forms consist of an Educational Supervisor Trainer's Report and a Clinical Supervisor Trainer's Report to be completed by your supervisor prior to the ARCP round.

Speciality Specific Appraisal (Regional)

- Face to face meeting, review of portfolio.
- Ensures that trainees are receiving high quality (endoscopy) training and achieving required competencies and informs CSAC Progression Form.

CSAC Progression form

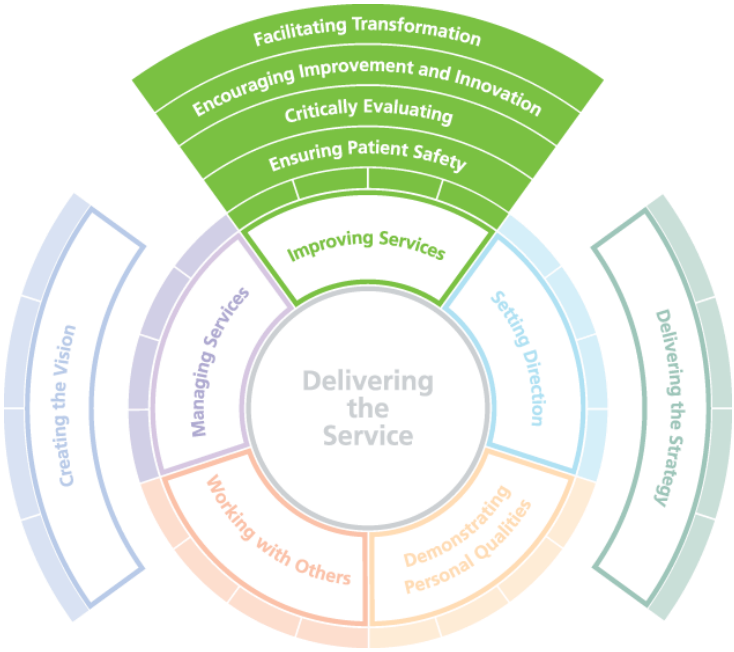
- Competencies
- Strengths
- Assessments
- Academic
- Targets

Tuesday 30th September 2014

Commissioning and developing a service 2014
Dr Sue Protheroe

Why talk about in commissioning?

We deliver care daily on an operational level but for every interaction with a patient there is a system of purchasing and planning, financing, and regulatory activity required to support it. We have responsibility to go beyond our clinical training and think strategically if we have a vision to manage and improve services. To do this we have to understand the system in which practice happens. Then we can respond to the changing health needs of children, the increasing need for health care to be evidence based and quality assured and the challenges of providing sufficient and appropriately qualified work force which needs planning, training, appraisal and revalidation. Commissioning is the process of ensuring that health services meet the needs of the population and are safe, effective, patient-centred and of high quality.



The shared goal with commissioners and clinicians is –

- The provision of high value specialized services –value being defined from both the patient's perspective and in terms of value for money;
- Ensuring that services deliver the highest quality, 7-day consultant led care in line with the ethos of "High quality care for all, now and for future generations" as close to the patient's home as is safe and cost effective;
- Ensures sustainable service and workforce planning for services provided by a small number of experts, particularly with regards to highly specialized services;
- Ensure equitable access to specialized services, regardless of geography;
- Enable promotion of specialized services to international partners;
- Respond to the UK rare diseases plan - Department of Health;
- Minimize barriers to access for specialized services that have impact across the whole patient pathway;
- Improve partnership working with patient groups, providers and commercial organizations.

The Clinical Reference Group (CRG) have developed the 2014/15 contract service specifications for all specialized services commissioned by NHS England for inclusion in provider contract. Previously, there were very few service specifications in place where commissioners had involved this level of consultation with clinicians.

Development of the consultation work included assessing patients needs and ensuring that services are safe, effective, patient-centred and of high quality and provide uniform, better care across the whole of England. This includes statements of the primary objectives and descriptors of our service, providing details of what will be provided, for and by whom, and is produced in conjunction with relevant quality requirements. Specifications will stretch services over time to provide excellence.
You can find the following service specifications by following this link **http://www.england.nhs.uk/resources/spec-comm-resources/npc-crg/group-e/e03/**
A short version is found in the NHS England Manual
http://www.england.nhs.uk/wp-content/uploads/2012/12/pss-manual.pdf

Quality Indicators, which have been taken from the national indicators and matched to the Children's Outcomes Forum document which will be included in the service specification and contracts for children's services. Some will be core (essential) and they will describe what might be aspirational.

Developing a service – the objectives
Eg build a nutrition support team

Developing a service – the plan

1. Setting the strategic context
2. Discussion – building the case for change
   A Framework for assessing the proposal against those standards to help management team in decision-making process

Set of key essential standards of safety and quality (Governance)

- Develop a capacity plan in line with existing guidance.
- Develop a Policy framework unifying existing policies and procedures.
- Develop clear accountabilities & responsibilities.
- Develop clear measures of process stability and capability as a basis for future monitoring.

3. Proposal
   Assurance- 4 tests
   Strong public and patient involvement, consistency with current and prospective need for patient choice, clear clinical evidence base, support for proposals from clinical commissioners
4. Consultation
5. Decision
6. Implementation

Developing a service- the Business case

- Describe the Impact in terms of outcome
- Explicit and numbers affected and resultant benefits, equality of opportunity
- How stakeholders and public involved
- Options affordable and clinically viable, VFM, -evaluate a set of options against set of criteria eg capital investment, deliverability on site,
- Planned savings are achievable
- How promote equality and tackle variation
- National guidance and strategic sense check

Cyclical Vomiting
Dr Sonny Chong

What should we feed our children who can't feed themselves?
Ms Claire Sadlier and Ms Kath Singleton

Parallel Session notes:

How to interpret and carry out pH studies/impendance
Dr Priya Narula

How to make up a modular feed
Ms Tracey Johnson

Templates and traps to transition
Ms Rachel Russell

Appropriate transition for successful transfer of adolescents from paediatric to adult care services has been recently highlighted as an area of increasing importance within gastroenterology. The number of young people in need of specialist health care services is growing, and the numbers of children diagnosed with IBD in particular is increasing, with the mean age at diagnosis becoming lower. Disengagement and non-concordance with recommended health care plans during the adolescent years brings significant mortality and morbidity risks in relation to acute as well as long-term health and well-being. The point of transfer to adult services is recognised as a potential risk escalator, and inadequate transition can lead to increased impacts upon health care resources through repeated non-attendance for planned care, increased use of urgent care and increased complexity of need through avoidable complications and adverse lifestyle choices.

This session will discuss the transition process, defining the concept and stating the aims that underpin the theory, such as empowerment, engagement and communication. The stages in the process will be presented, and the different gastroenterology sub-specialities will be reviewed. The transition process in paediatric gastroenterology at UHS will then be introduced, and the recent ongoing re-development of the service will be presented. The 'Ready Steady Go' concept programme of transition is used not only at UHS, but also by many other NHS health providers and it provides a clear, concise, progressive document for all health care professionals to use during the transition process. This provides an excellent template for providing a focus and structure to patient consultations, and generates discussion to ensure all areas of the patient's knowledge, self-advocacy, health, lifestyle, education, and psychosocial well being are covered. Examples of the paperwork and the website will be on hand to help demonstrate how the document fits so well within the transition pathway.

Traps and challenges to transition will then be considered, with some suggestions to overcome these issues being made. Case studies will help to demonstrate how this process works in reality, and considerations for future development, research, and audit will be explored.

Succesful mercaptopurine usage following azathioprine intolerance in paediatric IBD
Dr Victoria Merrick

Thiopurines are commonly used to maintain remission in paediatric inflammatory bowel disease (PIBD). Use can be limited by intolerable side effects necessitating drug withdrawal and use of other therapies. Adult data suggests that switching from azathioprine (AZA) to mercaptopurine (MP) may be an alternative and effective treatment strategy in some cases.

The aim of this study was to determine use, tolerance and safety of MP in PIBD patients who are intolerant of AZA

METHODS

AZA intolerance was evaluated within the cohort of all PIBD patients cared for in South East Scotland between August 1997 and December 2013. Case notes and laboratory records were reviewed for all cases switching from AZA to MP

RESULTS

Of 366 children in the PIBD cohort, 24 were switched to MP due to unacceptable AZA side effects. GI toxicity featured in 23 patients (96%) intolerant to AZA, with nausea/vomiting in 21, flu-like symptoms in 6 and transaminitis in 2 but no cases of hepatotoxicity, pancreatitis or persistent myelosuppression. MP was well tolerated in 15 (62%), but 9 patients (38%) were also intolerant of MP with a single case of myelosuppression; the remainder suffered repeat GI toxicity. 16 patients (67%) had a documented TPMT level, of which 2 were low; both patients tolerated MP

CONCLUSION

Mercaptopurine is tolerated in the majority of PIBD patients who have unacceptable side effects on azathioprine and so should be trialled prior to discontinuing thiopurines.

Setting up a feeding clinic
Ms Nicky Heather

Motility Disorders: An overview of the spectrum, including pseudo obstruction
Dr David Rawat

Pathology: an interactive session. How to understand the pathologist's report
Dr Edgar Lazda

GI Radiology for dummies – interpretation of x-rays/MRI/BariumCT/DEXA
Dr Sara Harrison

Recurrent acute liver failure and the challenges it presents to transplantation
Dr Lauren Johansen

It is a significant decision to list a child for liver transplantation. Although paediatric outcomes in the UK are good; 5 year survival of 85% for pre-planned liver transplantation, the child is committed to a lifetime of immunosuppression and at risk of a number of short and long term complications.

In this case report I will discuss the difficulties faced by the Birmingham Children's Hospital transplant team during their assessment of a 4 year old boy who recurrently presented with acute liver failure. His acute episodes were severe; characterized by hyperammoniaemia, hypoglycaemia, gross coagulopathy and encephalopathy. However, they were often short lived and resolved with intensive conservative management. He had 5 episodes of acute liver failure within a period of 2 ½ years and his case was repeatedly brought to the transplant meeting for a decision as to whether to transplant him, both within the emergency situations but also electively to improve his quality of life. Diagnostic uncertainty was also complicating the decision making process and his recent genetic diagnosis of RALFS syndrome has helped the team to make an informed decision.

Challenging case of 8 year old boy with neurodisability and intestinal failure
Dr Lisa Whyte

Brief summary of case:

We present the case of an 8 year old boy with neurodisability who develops intestinal failure. We discuss the challenges faced when managing these children and possible approaches that can be used to optimise enteral feeding, and at what stage PN should be considered. We will also discuss the timely role of palliative care in the management of this increasing group of patients.

Case of child with extreme short gut and challenges of long term PN
Mr Chris Smith

Case study of a long term parenteral nutrition patient with extreme short gut. The case tracks the patient over many years showing the main nutritional considerations of management of extended home PN. The case study highlights how over time the original aims of nutritional support can change dramatically.

Non Alcoholic fatty liver disease – how to manage
Dr Alastair Baker