Healthier Together

Healthier Together Pathways

Abdominal Pain Pathway
Clinical Assessment/Management tool for Children
Primary and Community Care Settings

Abdominal pain

Asthma Pathway
Clinical Assessment/Management tool for Children
Primary and Community Care Settings

Asthma

Bronchiolitis Pathway
Clinical Assessment/Management tool for Children
Primary and Community Care Settings

Bronchiolitis Pathway

Chest Infection (Pneumonia) Pathway
Clinical Assessment/Management tool for Children
Primary and Community Care Settings

Chest Infection

Constipation Pathway
Clinical Assessment/Management tool for Children
Primary and Community Care Settings

Constipation

Cough/breathlessness pathway for children ≥ 1 of year of age
Clinical Assessment/Management tool for Children
Primary and Community Care Settings

Cough and/or Breathlessness over 1 year

Healthier Together Pathways

Healthier Together

Cough and/or Breathlessness 1 year and under

Croup

Diarrhoea and/or Vomiting (Gastroenteritis)

Earache

Fever

Fits, Faints and Funny Turns

Healthier Together

Healthier Together Pathways

[Head Injury]

[Limping Child]

[Lymphadenopathy]

[Sore Throat]

[Sepsis]

[UTI]

Colic in Infants

Clinical support tool for remote clinical assessment

Colic in Infants

Colic is a name used by many to describe long frequent episodes of crying in an infant. People used to think colic was caused by problems with the baby's digestion/bowel, but there is no evidence this is true. It is a common problem that affects up to one in five babies.

At 6-8 weeks the average baby cries for 2-3 hours per day, usually more in the afternoon and evening. Every baby is different, but after about 8 weeks, babies start to cry less and less each week. Colic will go away on its own, in most by 6 months old.

Remember colic is crying in an **otherwise well** infant. If your baby has any of the below please speak to a doctor:

Fever
Difficulty breathing
Not able to feed/gain weight
Persistent vomiting/change in bowel habit
Strange sounding cry

Signs and symptoms of colic include:

Your baby often starts crying suddenly
The cry is high-pitched and nothing you do seems to help
The crying begins at the same time each day, often in the afternoon or evening
Your baby might draw their legs up when they cry
Your baby might clench their hands
Babies with colic are often gassy (because they take in air when crying), fussy and don't sleep well

What can you do to help?

Babies can cry if they are hungry, tired, wet/dirty or they are unwell, so first check these basic needs.
Try some simple calming techniques:

- Talk calmly or sing to your baby
- Let them hear a repeating sound like a vacuum cleaner/white noise
- Hold them close – skin to skin
- Go for a walk outside with your baby
- Give them a warm bath

Let your baby lie on his or her belly on your lap, and softly rub your baby's back.

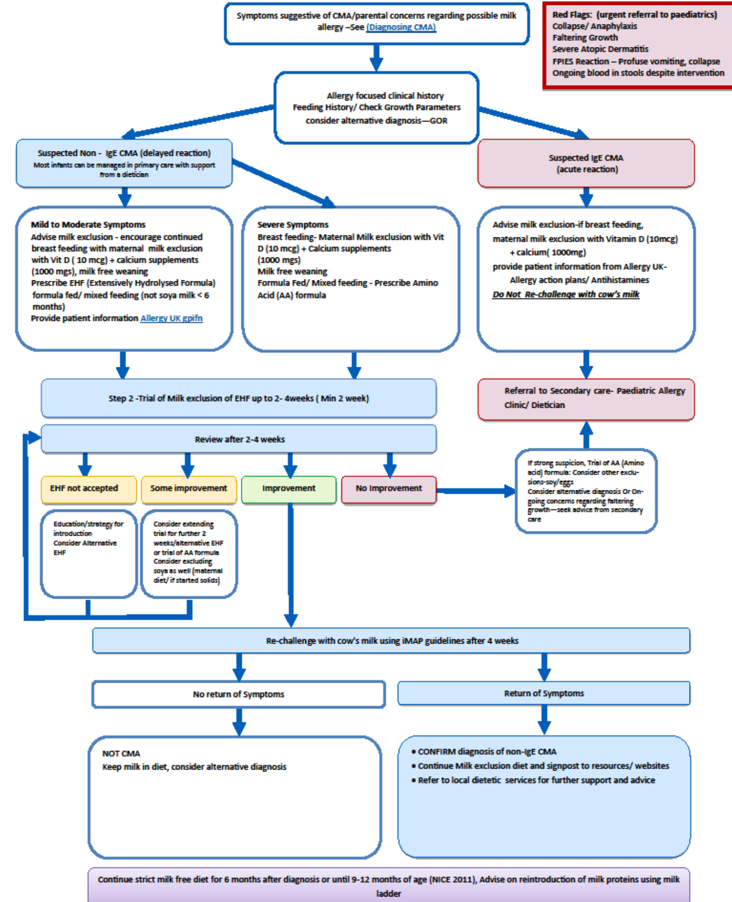
Don't get angry with your baby or yourself. Instead, put your baby in a safe place and walk away so that you can calm yourself down by doing something that takes your mind off the crying.

It's normal for parents to get stressed, especially by their baby crying. Remember *ICON*:

- I - Infant crying is normal
- C - Comforting methods can help
- O - It's OK to walk away
- N - Never, ever shake a baby

http://iconcope.org/parentsadvice

This guidance has been reviewed and adapted by healthcare professionals across North East and North Cumbria with consent from the Hampshire development groups



Cow's Milk Allergy (CMA) Pathway
Clinical Assessment/ Management tool for Children
Primary and Community Care Settings

Cow's Milk Allergy (CMA) Pathway

Symptoms suggestive of CMA/parental concerns regarding possible milk allergy –See (Diagnosing CMA)

Red Flags: (urgent referral to paediatrics)
Collapse/ Anaphylaxis
Faltering Growth
Severe Atopic Dermatitis
FPIES Reaction – Profuse vomiting, collapse
Ongoing blood in stools despite intervention

Allergy focused clinical history
Feeding History/ Check Growth Parameters
consider alternative diagnosis—GOR

Suspected Non - IgE CMA (delayed reaction)
Most infants can be managed in primary care with support from a dietician

Suspected IgE CMA (acute reaction)

Mild to Moderate Symptoms
Advise milk exclusion - encourage continued breast feeding with maternal milk exclusion with Vit D (10 mcg) + calcium supplements (1000 mgs), milk free weaning
Prescribe EHF (Extensively Hydrolysed Formula) formula fed/ mixed feeding (not soya milk < 6 months)
Provide patient information Allergy UK gpifn

Severe Symptoms
Breast feeding- Maternal Milk exclusion with Vit D (10 mcg) + Calcium supplements (1000 mgs)
Milk free weaning
Formula Fed/ Mixed feeding - Prescribe Amino Acid (AA) formula

Advise milk exclusion-if breast feeding, maternal milk exclusion with Vitamin D (10mcg) + calcium(1000mg)
provide patient information from Allergy UK-Allergy action plans/ Antihistamines
Do Not Re-challenge with cow's milk

Step 2 -Trial of Milk exclusion of EHF up to 2- 4weeks (Min 2 week)

Referral to Secondary care- Paediatric Allergy Clinic/ Dietician

Review after 2-4 weeks

EHF not accepted | Some improvement | Improvement | No improvement

Education/strategy for introduction
Consider Alternative EHF

Consider extending trial for further 2 weeks/alternative EHF or trial of AA formula
Consider excluding soya as well (maternal diet/ if started solids)

If strong suspicion, Trial of AA (Amino acid) formula: Consider other exclusions-soy/eggs
Consider alternative diagnosis Or Ongoing concerns regarding faltering growth—seek advice from secondary care

Re-challenge with cow's milk using iMAP guidelines after 4 weeks

No return of Symptoms | Return of Symptoms

NOT CMA
Keep milk in diet, consider alternative diagnosis

- CONFIRM diagnosis of non-IgE CMA
- Continue Milk exclusion diet and signpost to resources/ websites
- Refer to local dietetic services for further support and advice

Continue strict milk free diet for 6 months after diagnosis or until 9-12 months of age (NICE 2011), Advise on reintroduction of milk proteins using milk ladder

Developed by Tees Valley Cow's Milk Allergy Steering Group November 2021
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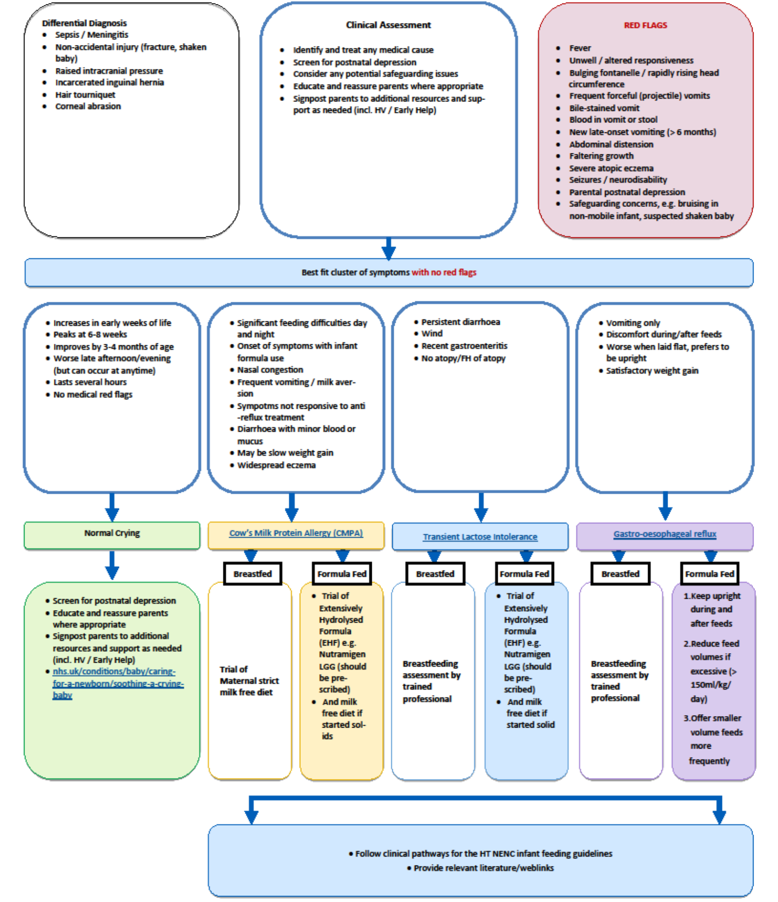

Unsettled Infant Pathway
Clinical Assessment/ Management tool for Children
Primary and Community Care Settings

Differential Diagnosis
- Sepsis / Meningitis
- Non-accidental injury (fracture, shaken baby)
- Raised intracranial pressure
- Incarcerated inguinal hernia
- Hair tourniquet
- Corneal abrasion

Clinical Assessment
- Identify and treat any medical cause
- Screen for postnatal depression
- Consider any potential safeguarding issues
- Educate and reassure parents where appropriate
- Signpost parents to additional resources and support as needed (incl. HV / Early Help)

RED FLAGS
- Fever
- Unwell / altered responsiveness
- Bulging fontanelle / rapidly rising head circumference
- Frequent forceful (projectile) vomits
- Bile-stained vomit
- Blood in vomit or stool
- New late-onset vomiting (> 6 months)
- Abdominal distension
- Faltering growth
- Severe atopic eczema
- Seizures / neurodisability
- Parental postnatal depression
- Safeguarding concerns, e.g. bruising in non-mobile infant, suspected shaken baby

Best fit cluster of symptoms with no red flags

- Increases in early weeks of life
- Peaks at 6-8 weeks
- Improves by 3-4 months of age
- Worse late afternoon/evening (but can occur at anytime)
- Lasts several hours
- No medical red flags

- Significant feeding difficulties day and night
- Onset of symptoms with infant formula use
- Nasal congestion
- Frequent vomiting / milk aversion
- Symptoms not responsive to anti-reflux treatment
- Diarrhoea with minor blood or mucus
- May be slow weight gain
- Widespread eczema

- Persistent diarrhoea
- Wind
- Recent gastroenteritis
- No atopy/FH of atopy

- Vomiting only
- Discomfort during/after feeds
- Worse when laid flat, prefers to be upright
- Satisfactory weight gain

Normal Crying | Cow's Milk Protein Allergy (CMPA) | Transient Lactose Intolerance | Gastro-oesophageal reflux

Normal Crying:
- Screen for postnatal depression
- Educate and reassure parents where appropriate
- Signpost parents to additional resources and support as needed (incl. HV / Early Help)
- nhs.uk/conditions/baby/caring-for-a-newborn/soothing-a-crying-baby

CMPA – Breastfed: Trial of Maternal strict milk free diet
CMPA – Formula Fed:
- Trial of Extensively Hydrolysed Formula (EHF) e.g. Nutramigen LGG (should be pre-scribed)
- And milk free diet if started solids

Transient Lactose Intolerance – Breastfed: Breastfeeding assessment by trained professional
Transient Lactose Intolerance – Formula Fed:
- Trial of Extensively Hydrolysed Formula (EHF) e.g. Nutramigen LGG (should be pre-scribed)
- And milk free diet if started solid

Gastro-oesophageal reflux – Breastfed: Breastfeeding assessment by trained professional
Gastro-oesophageal reflux – Formula Fed:
1. Keep upright during and after feeds
2. Reduce feed volumes if excessive (> 150ml/kg/day)
3. Offer smaller volume feeds more frequently

- Follow clinical pathways for the HT NENC infant feeding guidelines
- Provide relevant literature/weblinks

Colic in Infants | Cow's Milk Allergy (CMA) | Unsettled Baby

Paediatric Diabetes Referral Guidelines in Primary Care
Developed by North East and North Cumbria Diabetes Network

Clinical Signs and Symptoms

- Polydipsia
- Polyuria
- Nocturia, new onset Enuresis
- Weight loss
- Tiredness
- Glycosuria, Ketonuria
- Signs of DKA i.e. abdominal pain, nausea/vomiting, dehydration, respiratory distress, altered conscious state
- Symptoms may be more subtle (Candida infection or constipation) and mimic infection in under 5s

Action: Test capillary blood glucose level
If **Fasting sample ≥7 mmol/l or Random sample ≥ 11.1 mmol/l = Diabetes**
However regardless of blood glucose level or if unable to do glucose test please refer on clinical suspicion alone.

Please refer **immediately by telephone** to the local paediatrician on-call.
Do not send the child/young person to pathology or children's outpatients for a blood test; the paediatric team will take samples as required.
Do not refer as an outpatient
If any diagnostic doubt, discuss urgently with paediatrics
It is essential that all children and young people in whom you are considering a diagnosis of diabetes(any type) are referred the same day.

Send to local hospital as per local paediatric admission agreement
The child will be assessed and managed by the Paediatric Team on-call and referred to the specialist Paediatric Diabetes Team
The diagnosis of Type 1 diabetes is a medical emergency in order to prevent the development of Diabetic Ketoacidosis – the principle cause of mortality in children and young people with diabetes

Diabetes treatment and education will be initiated
Notification of treatment/medication and equipment requirements will be sent to GP within 24 hours of discharge

This document has been adapted for use by Dr Jude Reid, Associate Specialist, Queen Elizabeth Hospital, Gateshead, from those developed by the paediatric diabetes teams in The Ipswich Hospital NHS Trust, Calderdale & Huddersfield NHS Foundation Trust and the Children & Young People's Yorks. & Humber Diabetes

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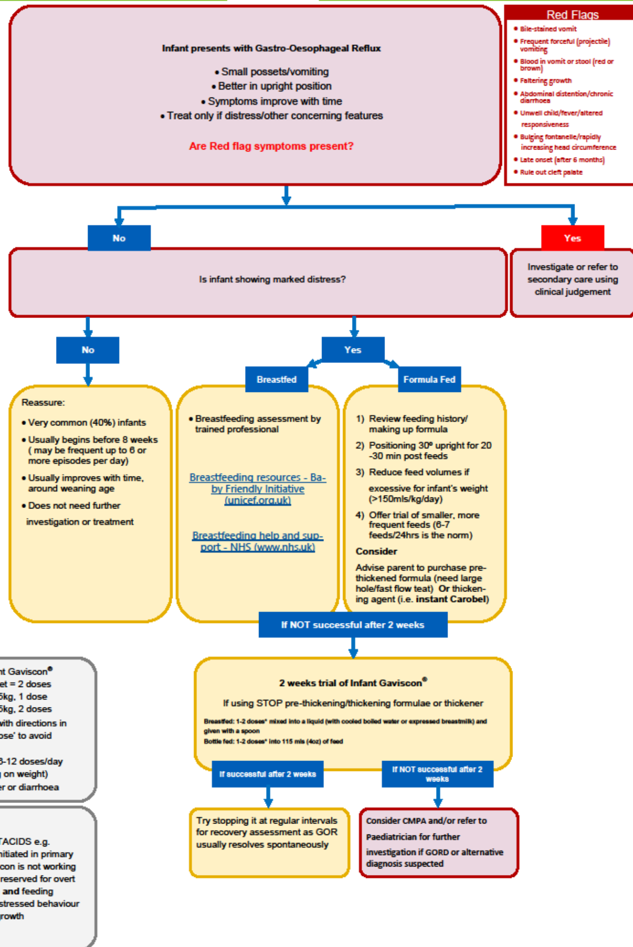
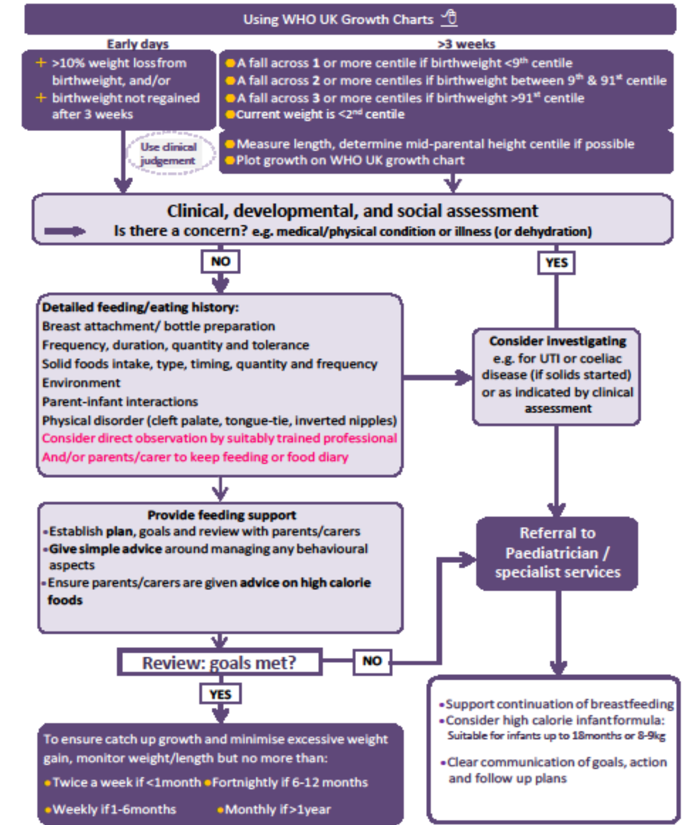


Managing Faltering Growth in infants and Young Children Pathway



[Paediatric Diabetes Referral Guidelines in Primary Care]

[Managing Gastro-Oesophageal Reflux]

Managing Faltering Growth in Infants and Young Children