



TARGET

Keep Antibiotics Working

# From guidance to practice: Managing paediatric respiratory tract infections through clinical scenarios

TARGET Antibiotics Webinar  
21 January 2026





# Introductions – TARGET and RCGP



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# Introductions – Speakers and Panellists



**Dr Graham Duce**  
GP, Audlem Medical  
Practice

Cheshire Place GP  
AMS Lead

Speaker and Panellist



**Dr Alicia Demirjian**  
Consultant in Paediatric  
Infectious Diseases and  
Immunology

Consultant Epidemiologist

Panellist



**Dr Sanjay Patel**  
Consultant in  
Paediatric Diseases  
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Panellist



**Dr Conor Jamieson**  
Regional  
Antimicrobial  
Stewardship Lead  
(Midlands)

Panellist



**Reena Barai**  
Community  
Pharmacist

Panellist



# Learning Objectives

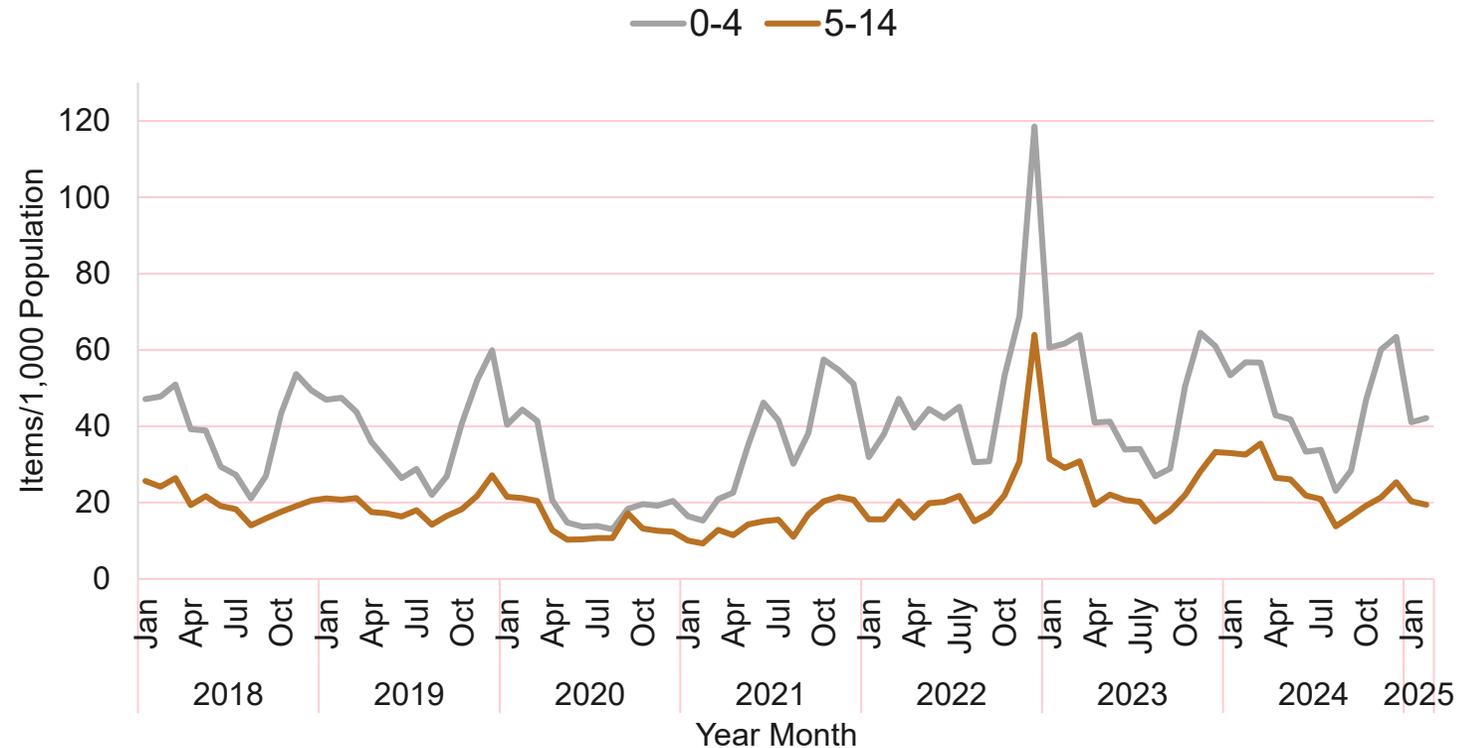
1. Implement current diagnostic and decision-making tools for managing acute otitis media, sore throat, and cough in children and young people.
2. Understand patient perspectives on antibiotic prescribing for RTIs in children and young people.
3. Use evidence-based strategies and resources to support discussions with patients and their carers in the context of paediatric RTIs, including how to address concerns and manage expectations.



# Paediatric prescribing

On average (2018-2024), each year 0-14 age group accounted for **12.2%** of antibiotic prescriptions in general practice in England  
That is **3.1 million** antibiotic prescriptions

Antibiotic use in GP Prescribing by Age Group





# Paediatric prescribing

Percentage of children aged 0-9 years who have been prescribed at least one antibiotic in primary care (latest 12 months to March 2025)

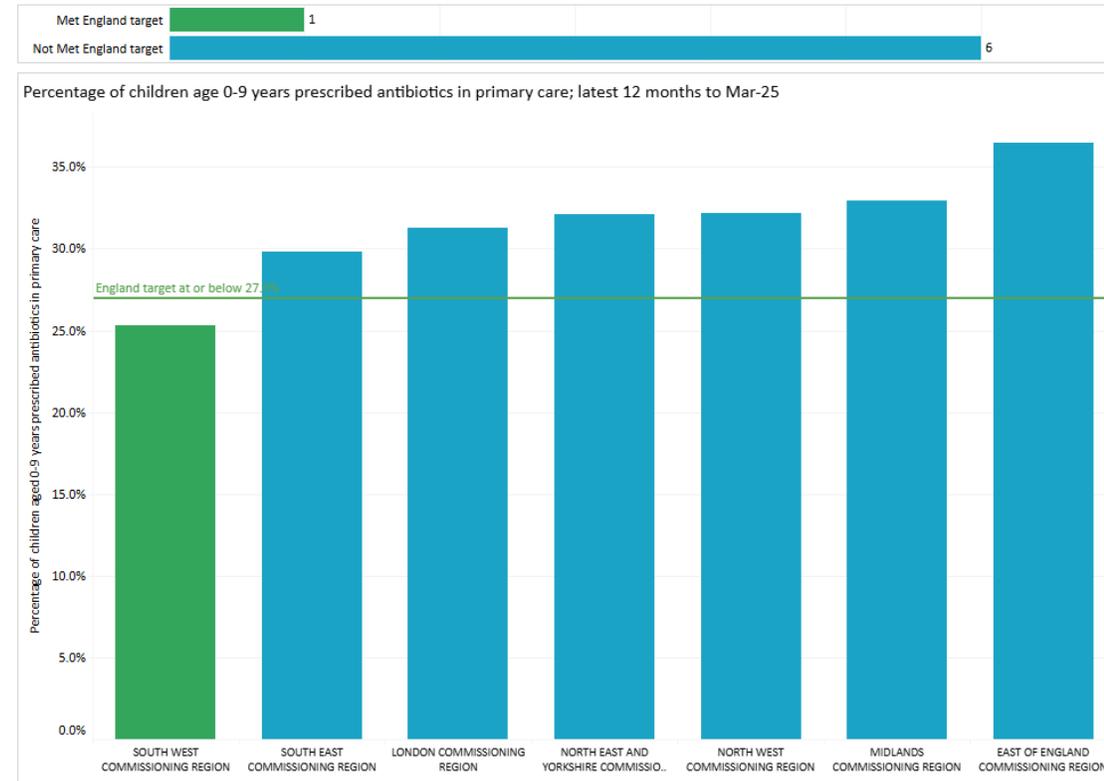
Regions/ICB performance assessed as Met or Not Met against a fixed nation England target: At or below 27%

# 31.7%

children under 10 were prescribed antibiotics in the last year



NHS Oversight Framework 2025-2026 ICB performance dashboard: Children prescribed antibiotics in primary care



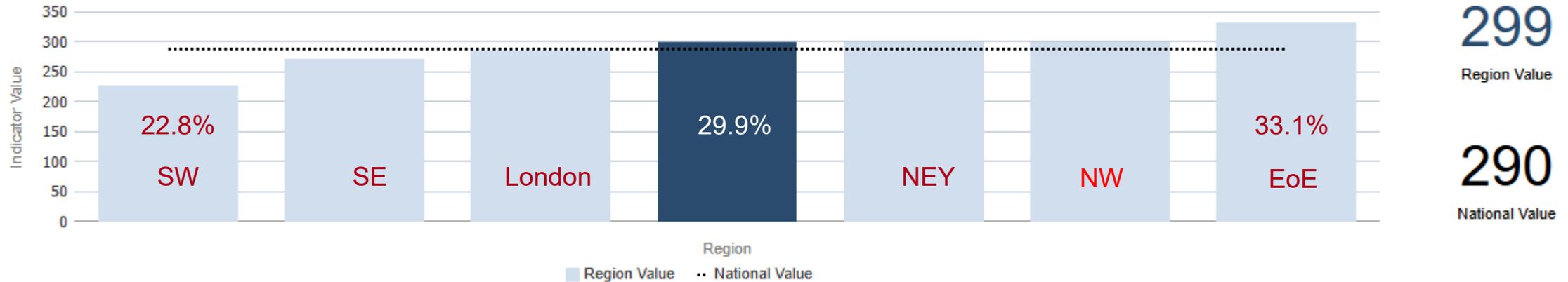
# Variation between regions in England (prescribing for children aged 0-9 years, 12 month rolling data)

ASC02 - Number of children prescribed antibiotics per 1,000 children

Children prescribed per 1,000 children on registered list size in the 0-9 years age band in the MIDLANDS region compared to all regions: 12 Months to Jul-25

Numerator Definition    Denominator Definition    Indicator Definition

Graph ▼

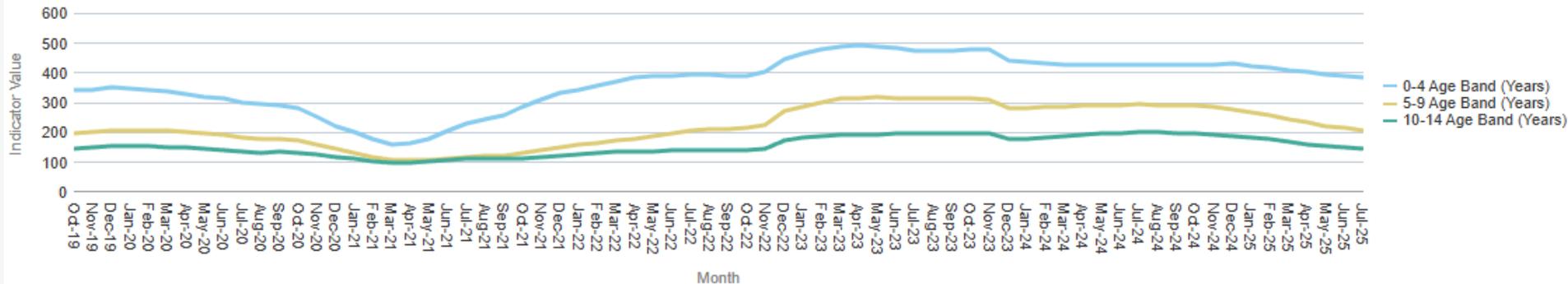


ASC02 - Number of children prescribed antibiotics per 1,000 children

12 Month Rolling trend over time for children prescribed per 1,000 children on registered list size for each age band at national level

Numerator Definition    Denominator Definition    Indicator Definition

Graph ▼



Source: [ePACT2](#)

# Volume of prescribing of antibiotics to children aged 0-14 in England 2022-23



# Why parents visit healthcare settings



Remove **health threat** through appropriate treatment.  
Seeking safety in the face of uncertainty



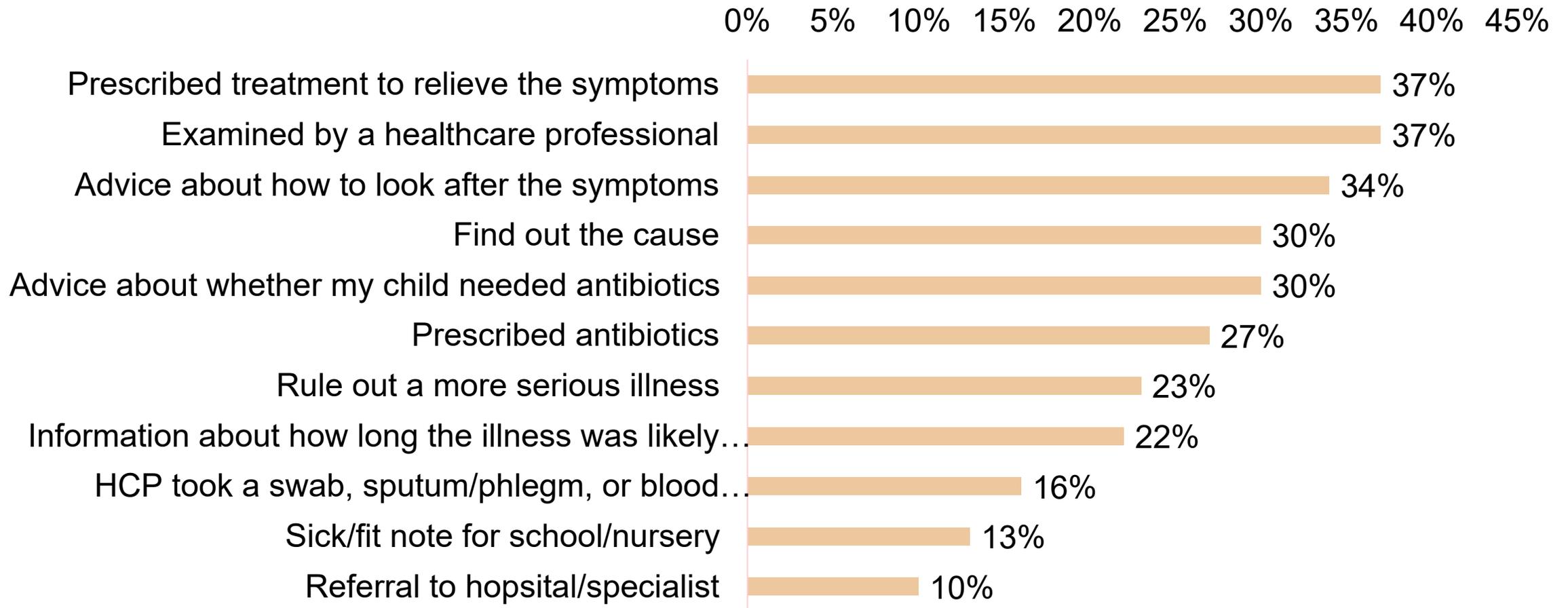
Want **reassurance**, parental anxiety is high



Parents cautious about antibiotics and wanted to be prescribed **only when necessary**  
Preference for natural remedies, need for clarity about what was wrong



# 2024 parent public survey findings highlight that antibiotic prescribing is **not** parents' main expectation when visiting the GP





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# Clinical Scenarios

# Clinical Scenario: Acute Otitis Media

Consider the following details:

- 5-year-old boy, screaming with pain in right ear.
- No history of fever, temp 37.4°C.
- Not vomiting.
- Paracetamol helps but pain returns before next dose due.
- Had AOM this time last year and was prescribed antibiotics.
- Right ear drum bulging and red.
- No penicillin allergy



# Clinical Scenario: Acute Otitis Media

What would you do?

1. Offer regular doses of paracetamol or ibuprofen for pain
2. Offer Phenazone and Lidocaine ear drops for pain
3. Offer a back-up antibiotic prescription (amoxicillin)
4. Offer an immediate course of amoxicillin



# Acute Otitis Media: Evidence

## Antibiotics

- Symptoms last between 3-7 days
  - Antibiotics do not reduce pain at 24 hours, modest effect at 2-3 days (NNTB 20), 4-7 days (NNTB 16) compared to placebo
  - No significant difference between watchful waiting/back-up or immediate antibiotics for pain at 3-6 days
- No antibiotic strategy or back-up antibiotic strategy



Clinical Scenario  
Acute Otitis Media

Otorrhoea (discharge after eardrum perforation) in any child or young person  
or  
Under 2 years with infection in both ears?

No

- Offer regular doses of paracetamol or ibuprofen for pain
- Consider eardrops containing an anaesthetic and an analgesic for pain
- Consider no antibiotic or a back-up antibiotic prescription

- Offer regular doses of paracetamol or ibuprofen for pain

given, advise:  
needed  
help if symptoms worsen  
antly, do not start to  
ays or the child or  
comes very unwell

Antibiotic prescription,  
rely  
if no improvement  
ptoms worsen  
help if symptoms worsen  
antly, or the child or  
comes very unwell

Antibiotic prescription,  
help if symptoms worsen

Reassess at any time if symptoms worsen rapidly or significantly, taking account of:

- other possible diagnoses
- any symptoms or signs suggesting a more serious illness or condition
- previous antibiotic use, which may lead to resistant organisms

If the child or young person:  
is systemically very unwell, or  
has symptoms and signs of a more serious illness or condition, or  
has high risk of complications

- Offer an immediate antibiotic prescription

**H**  
Refer to hospital if:

- severe systemic infection, or
- complications like mastoiditis

**i** Non-antimicrobial treatments

- Offer regular doses of paracetamol or ibuprofen for pain. Use the right dose for the age or weight of the child at the right time, and use maximum doses for severe pain
- Consider eardrops containing an anaesthetic and an analgesic for pain if an immediate antibiotic is not given, and there is no eardrum perforation or otorrhoea
- Evidence suggests that decongestants or antihistamines do not help symptoms

**i** Evidence on antibiotics

- Antibiotics make little difference to the number of children whose symptoms improve
- There is a small difference between children with short-term acute otitis media (not perforated eardrum) and children with acute otitis media (with perforated eardrum) but antibiotics do not help symptoms
- Complications include mastoiditis
- Antibiotics may be needed to benefit children with acute otitis media
- People with acute otitis media (discharge after eardrum perforation) with complications like mastoiditis

# Acute Otitis Media: Evidence

## Anaesthetic and analgesic ear drops

- Higher proportion of children with a 50% ( $p = 0.01$ ) and 25% ( $p = 0.02$ ) reduction in pain within 10 minutes compared to placebo.
- Decrease in proportion of children consuming antibiotics at day 8 compared to usual care (2.6% vs 29.0%,  $p = 0.009$ )
- Reduction in parent-reported pain scores at day 2 ( $p = 0.001$ ; 88% were on analgesia)





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# Otitis media (acute): antimicrobial prescribing NICE National Institute for Health and Care Excellence

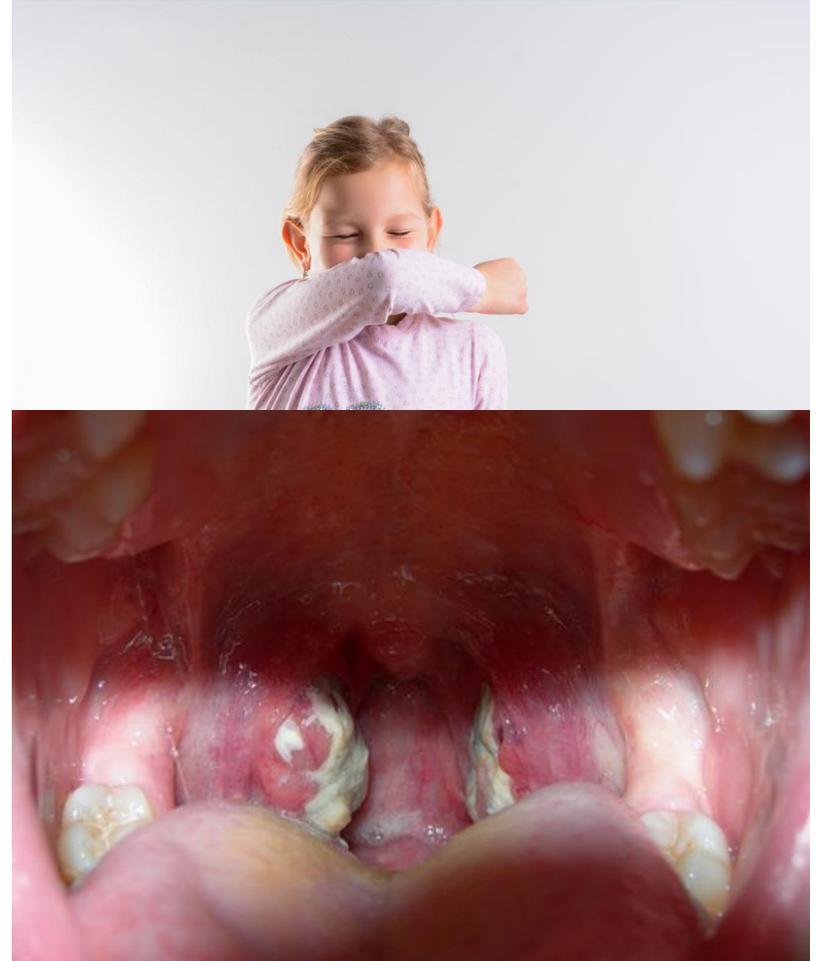
Choice of treatment: children and young people under 18 years

Treatment <sup>1</sup>	Dosage and course length <sup>2</sup>
Eardrops containing an anaesthetic and an analgesic	
Phenazone 40 mg/g with lidocaine 10 mg/g	Apply 4 drops two or three times a day for up to 7 days Use only if an immediate oral antibiotic prescription is not given, and there is no eardrum perforation or otorrhoea
First choice oral antibiotic	
Amoxicillin	1 to 11 months: 125 mg three times a day for 5 to 7 days 1 to 4 years: 250 mg three times a day for 5 to 7 days 5 to 17 years: 500 mg three times a day for 5 to 7 days
Alternative first choice oral antibiotic for penicillin allergy or intolerance (for people who are not pregnant)	
Clarithromycin	1 month to 11 years: Under 8 kg: 7.5 mg/kg twice a day for 5 to 7 days 8 to 11 kg: 62.5 mg twice a day for 5 to 7 days 12 to 19 kg: 125 mg twice a day for 5 to 7 days 20 to 29 kg: 187.5 mg twice a day for 5 to 7 days 30 to 40 kg: 250 mg twice a day for 5 to 7 days or 12 to 17 years: 250 mg to 500 mg twice a day for 5 to 7 days
Alternative first choice oral antibiotic for penicillin allergy in pregnancy	
Erythromycin	8 to 17 years: 250 mg to 500 mg four times a day or 500 mg to 1,000 mg twice a day for 5 to 7 days  Erythromycin is preferred if a macrolide is needed in pregnancy, for example, if there is true penicillin allergy and the benefits of antibiotic treatment outweigh the harms. See the <a href="#">Medicines and Healthcare products Regulatory Agency (MHRA) Public Assessment Report on the safety of macrolide antibiotics in pregnancy</a>
Second choice oral antibiotic (worsening symptoms on first choice taken for at least 2 to 3 days)	
Co-amoxiclav	1 to 11 months: 0.25 ml/kg of 125/31 suspension three times a day for 5 to 7 days 1 to 5 years: 5 ml of 125/31 suspension three times a day or 0.25 ml/kg of 125/31 suspension three times a day for 5 to 7 days 6 to 11 years: 5 ml of 250/62 suspension three times a day or 0.15 ml/kg of 250/62 suspension three times a day for 5 to 7 days 12 to 17 years: 250/125 mg three times a day or 500/125 mg three times a day for 5 to 7 days
Alternative second choice oral antibiotic for penicillin allergy or intolerance	
Consult local microbiologist	
<sup>1</sup> See the <a href="#">BNF for children</a> for appropriate use and dosing in specific populations, for example, hepatic impairment and renal impairment. <sup>2</sup> The age bands apply to children of average size. In practice, the prescriber will use age bands along with other factors such as the severity of the condition and the child's size in relation to the average size of children of the same age. Doses given are by mouth using immediate-release medicines, unless otherwise stated.	

# Clinical Scenario: Acute Sore Throat

## Consider the following details:

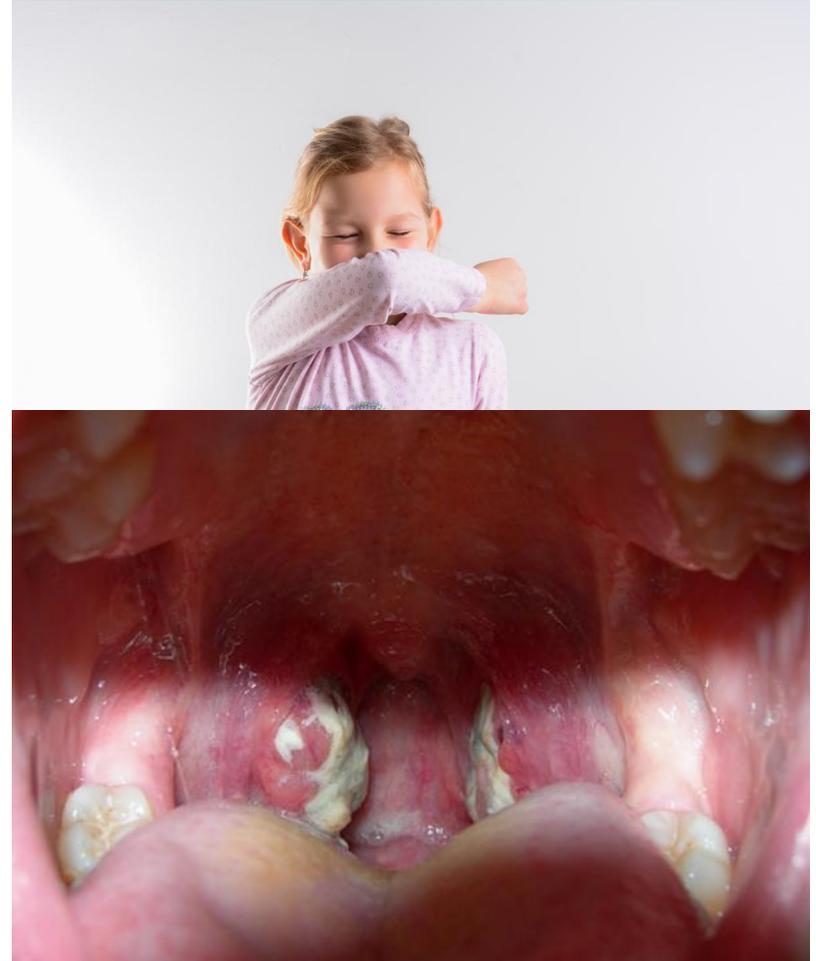
- 8-year-old girl
- 4/7 days sore throat, parents report high fever last night, tiredness, cough
- Difficulty swallowing
- Temp 37.5°C
- Slough on swollen tonsils, palatal petechiae
- Cervical and axillary lymphadenopathy
- 'Antibiotics helped' for tonsils last year



# Clinical Scenario: Acute Sore Throat

What would you do?

1. Consider 5 days of Pen V, with self care and safety netting advice
2. Consider no antibiotic with self care and safety netting advice
3. Consider delayed antibiotic with self care and safety netting advice
4. Consider 5 days of amoxicillin, with self care and safety netting advice

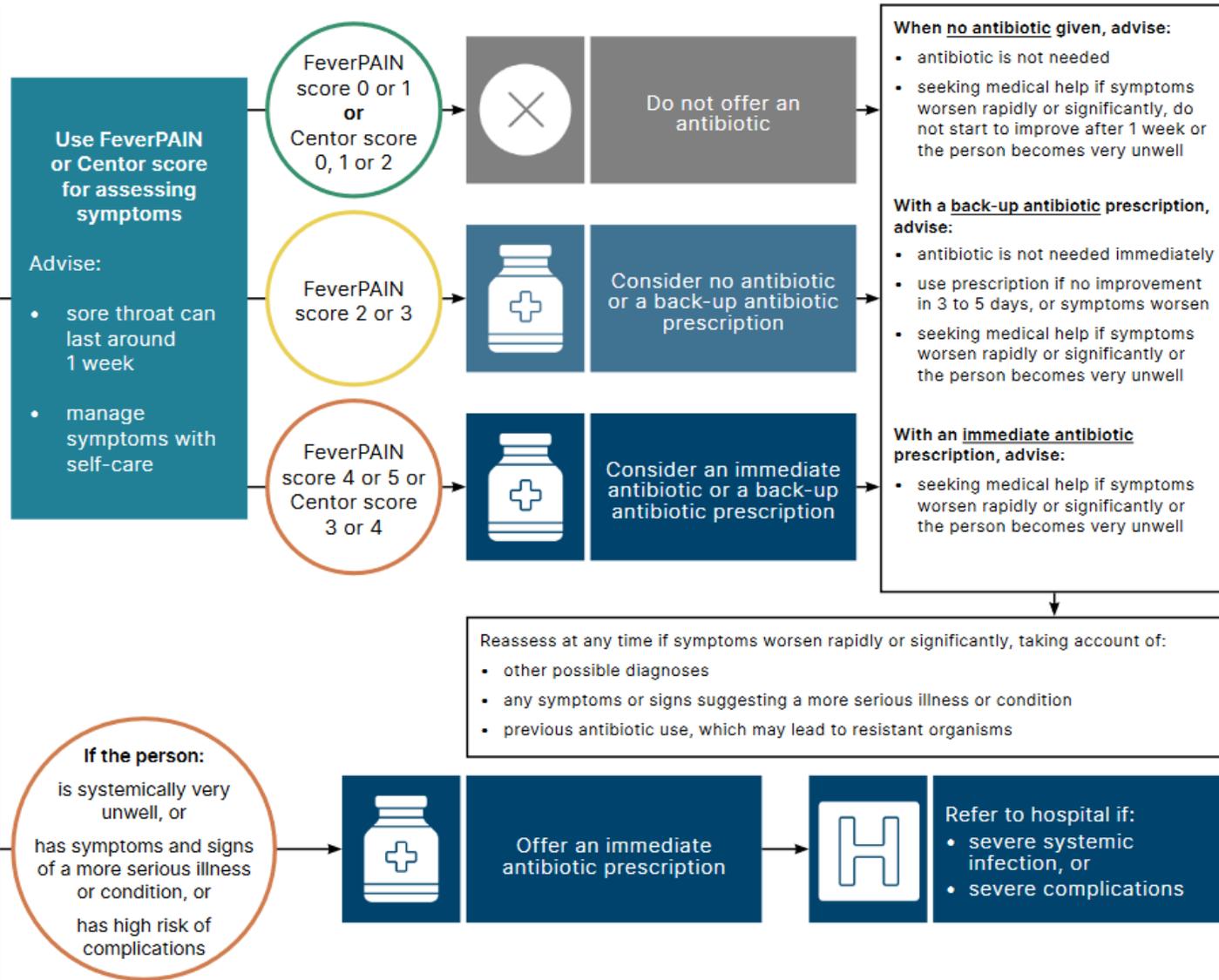


# Sore throat (acute): antimicrobial prescribing



Clinical Scenario  
Acute Sore Throat

Acute sore throat



**i Self-care**

- Consider paracetamol for pain or fever, or if preferred and suitable, ibuprofen
- Drink adequate fluids
- Some evidence that medicated lozenges can help reduce pain in adults
- No evidence was found for non-medicated lozenges, mouthwashes, or local anaesthetic mouth spray on its own

**Evidence on antibiotics**

- Antibiotics make little difference to how long symptoms last or the number of people whose symptoms improve
- Withholding antibiotics is unlikely to lead to complications
- Possible adverse effects include diarrhoea and nausea

**FeverPAIN score**

- Fever; purulence; attend within 3 days or less; severely inflamed tonsils; no cough or coryza  
1 point for each

**Centor score**

- Tonsillar exudate; tender anterior cervical lymphadenopathy or lymphadenitis; history of fever (>38°C); no cough  
1 point for each

**Updated February 2023**

**NICE** National Institute for Health and Care Excellence

# Clinical scoring systems

## FeverPAIN criteria (scores 0-5)

Designed and validated with patients aged 5 and above

- **Fever** (in last 24 hours)
- **Purulence** (pus on tonsils)
- **Attend rapidly** (within 3 days of symptom onset)
- (severely) **Inflamed tonsils**
- **No cough or coryza** (inflammation of mucus membranes in the nose)

## Centor criteria (scores 0-4)

Designed with patients over 16 \*\*\*

- Tonsillar exudate
- Tender anterior cervical lymphadenopathy or lymphadenitis
- History of fever (over 38 °C)
- Absence of cough

\*\*\* see presenter notes

# Clinical Scenario: Acute Sore Throat

## Feedback FeverPAIN

- 8 year old girl
- 4/7 days sore throat, “high” fever last night, tiredness, cough, difficulty swallowing
- Temp 37.5°C
- Slough on swollen tonsils, palatal petechiae
- Cervical and axillary lymphadenopathy
- ‘Antibiotics helped’ for tonsils last year

### FeverPAIN criteria (scores 0-5)

<b>Fever</b> (in last 24 hours)	✓
<b>Purulence</b> (pus on tonsils)	✓
<b>Attend rapidly</b> (within 3 days of symptom onset)	
<b>(severely) Inflamed tonsils</b>	✓
<b>No cough or coryza</b> (inflammation of mucus membranes in the nose)	

**Patient above scores 3**



# Clinical Scenario: Acute Sore Throat

## Feedback FeverPAIN

**FeverPAIN** is a five-item score based on **Fever**, **Purulence**, Attend rapidly (3 days or less), **severely Inflamed tonsils** and No cough or coryza

SCORE	PRESENCE OF STREPTOCOCCUS	SUGGESTED MANAGEMENT
0-1	13-18% have streptococcus	No antibiotic strategy
2-3	34-40% have streptococcus	Back-up antibiotic strategy
$\geq 4$	62-65% have streptococcus	Immediate antibiotics or short delayed prescribing strategy



# Clinical Scenario: Acute Sore Throat

## Feedback CENTOR

- 8 year old girl
- 4/7 days sore throat, “high” fever last night, tiredness, cough, difficulty swallowing
- Temp 37.5°C
- Slough on swollen tonsils, palatal petechiae
- Cervical and axillary lymphadenopathy
- ‘Antibiotics helped’ for tonsils last year

### Centor criteria (scores 0-4)

Tonsillar exudate



Tender anterior cervical lymphadenopathy or lymphadenitis



History of fever (over 38 °C)



Absence of cough

**Patient scores Centor criteria 3**



# Clinical Scenario: Acute Sore Throat

## Feedback CENTOR

**Centor Criteria:** History of fever; absence of cough; **tender anterior cervical lymphadenopathy** and **tonsillar exudates**.

- Centor score 0-2: has a high negative predictive value (80%) and indicates low chance of Group A Beta Haemolytic Streptococci (GABHS)  
→ **No antibiotic strategy**
- Centor score 3 or 4: suggests the chance of GABHS is 40%  
→ **Back up or immediate antibiotic strategy.**
- If a patient is unwell with a Centor score of 3 or 4 then the chance of developing Quinsy is 1:60.

# NICE antimicrobial prescribing guidelines for acute sore throat in children

Antibiotic <sup>1</sup>	Dosage and course length for children and young people under 18 <sup>2</sup>
<b>First choice</b>	
Phenoxymethylpenicillin	<p>1 to 11 months: 62.5 mg four times a day, or 125 mg twice a day for 5 to 10 days            1 to 5 years: 125 mg four times a day, or 250 mg twice a day for 5 to 10 days            6 to 11 years: 250 mg four times a day, or 500 mg twice a day for 5 to 10 days            12 to 17 years: 500 mg four times a day, or 1000 mg twice a day for 5 to 10 days</p> <p>Five days of phenoxymethylpenicillin may be enough for symptomatic cure, but a 10-day course may increase the chance of microbiological cure</p>
<b>Alternative first choice for penicillin allergy or intolerance (for people who are not pregnant)</b>	
Clarithromycin	<p>1 month to 11 years: Under 8 kg: 7.5 mg/kg twice a day for 5 days            8 to 11 kg: 62.5 mg twice a day for 5 days            12 to 19 kg: 125 mg twice a day for 5 days            20 to 29 kg: 187.5 mg twice a day for 5 days            30 to 40 kg: 250 mg twice a day for 5 days</p> <p>12 to 17 years: 250 mg to 500 mg twice a day for 5 days</p>
<b>Alternative first choice for penicillin allergy in pregnancy</b>	
Erythromycin	<p>8 to 17 years: 250 mg to 500 mg four times a day, or 500 mg to 1000 mg twice a day for 5 days</p> <p>Erythromycin is preferred if a macrolide is needed in pregnancy, for example, if there is true penicillin allergy and the benefits of antibiotic treatment outweigh the harms. See the <a href="#">Medicines and Healthcare products Regulatory Agency (MHRA) Public Assessment Report on the safety of macrolide antibiotics in pregnancy</a></p>

<sup>1</sup> Note: see the [BNF for children](#) for appropriate use and dosing in specific populations, for example, hepatic impairment or renal impairment.

<sup>2</sup> Note: the age bands given in the table apply to children of average size and, in practice, the prescriber will use the age bands in conjunction with other factors such as the severity of the condition and the child's size in relation to the average size of children of the same age.

# Acute cough: clinical scenario

## Consider the following details:

- 4-year-old with cough, yellowish sputum
- Temp 37.8°C
- Several previous episodes of lower respiratory tract infection and parents insist antibiotics 'always help'
- Respiratory rate within normal limits for age, no sign of significant work of breathing
- Scattered coarse crepitations and wheeze, vesicular breath sounds, no focal crepitations



# Acute cough: clinical scenario

What would you do?

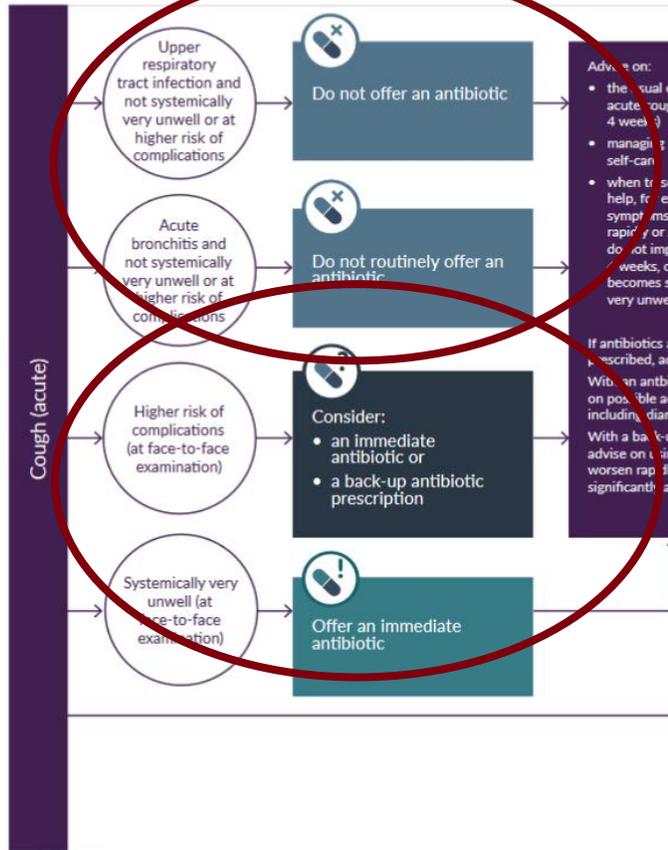
1. Prescribe 5 days of doxycycline, with self care and safety netting advice
2. No antibiotic with self care and safety netting advice
3. Delayed antibiotic with self care and safety netting advice
4. Prescribe 5 days of amoxicillin, with self care and safety netting advice



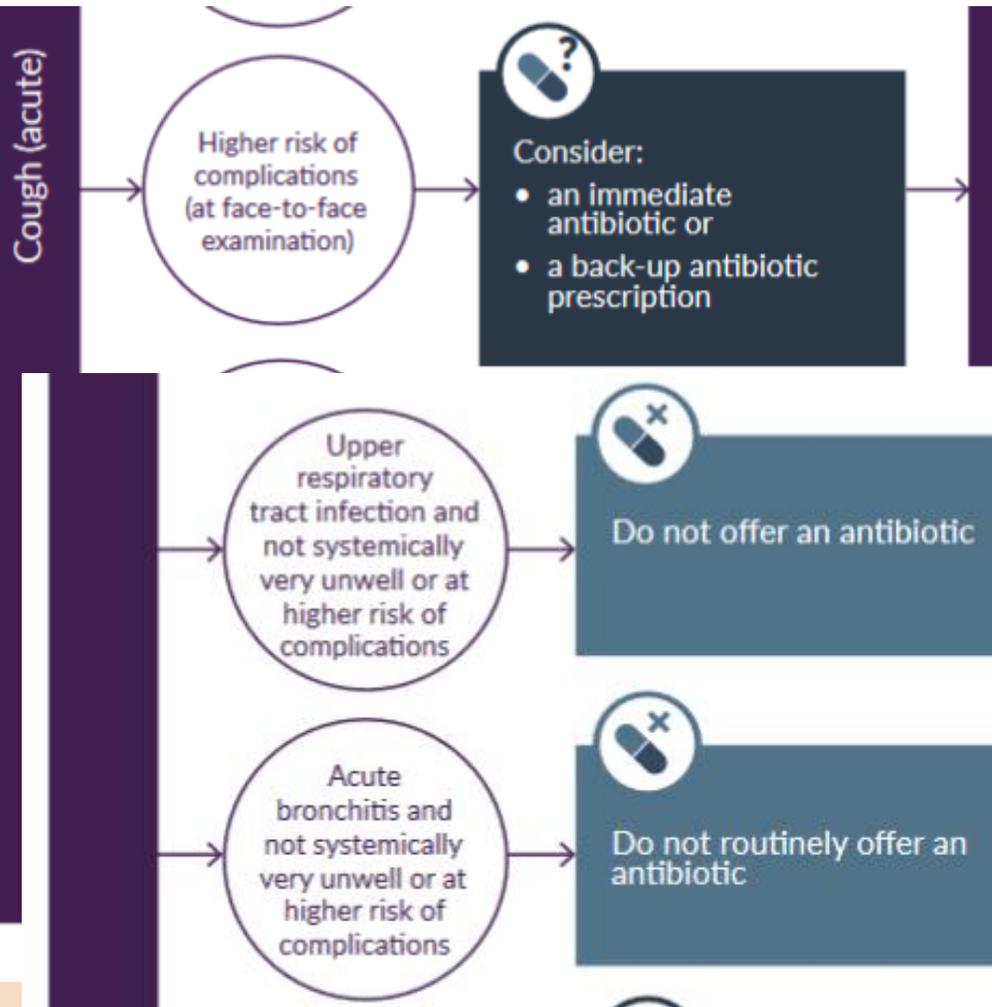
# Acute cough antibiotic prescribing

Clinical Scenario  
Acute Cough

## Cough (acute): antimicrobial prescribing



NICE uses 'offer' when there is more certainty of benefit and 'consider' when evidence is less certain



# Acute cough clinical scenario: Feedback

- 4-year-old with cough for past 4 days, yellowish sputum
  - Temp 37.8°C
  - Several previous episodes of lower RTI and insists antibiotics 'always help'
  - Respiratory rate within normal limits for age, no sign of significant work of breathing
  - Scattered course creps and wheeze, vesicular breath sounds, no focal crepitations
- 
- Antibiotic little benefit as no co-morbidity
  - Consider no antibiotics OR if high risk of complications, 5 days back-up antibiotic prescription with safety netting
  - Share a leaflet with the patient e.g. TARGET RTI leaflet
  - Advise patient symptom resolution can take 3 weeks

# Acute cough antibiotic prescribing for children

## NICE antimicrobial prescribing guidance:

Choice of antibiotic for children and young people under 18

### Choice of antibiotic: children and young people under 18 years

Antibiotic <sup>1</sup>	Dosage and course length <sup>2</sup>
First choice	
Amoxicillin	1 to 11 months: 125 mg three times a day for 5 days 1 to 4 years: 250 mg three times a day for 5 days 5 to 17 years: 500 mg three times a day for 5 days
Alternative first choices <sup>3</sup>	
Clarithromycin	1 month to 11 years: Under 8 kg, 7.5 mg/kg twice a day for 5 days 8 to 11 kg, 62.5 mg twice a day for 5 days 12 to 19 kg, 125 mg twice a day for 5 days 20 to 29 kg, 187.5 mg twice a day for 5 days 30 to 40 kg, 250 mg twice a day for 5 days 12 to 17 years: 250 mg to 500 mg twice a day for 5 days
Erythromycin	1 month to 1 year: 125 mg four times a day or 250 mg twice a day for 5 days 2 to 7 years: 250 mg four times a day or 500 mg twice a day for 5 days 8 to 17 years: 250 mg to 500 mg four times a day or 500 mg to 1000 mg twice a day for 5 days
Doxycycline <sup>4</sup>	12 to 17 years: 200 mg on first day, then 100 mg once a day for 4 days (5-day course in total)

<sup>1</sup> See [BNF for children](#) for appropriate use and dosing in specific populations, for example, hepatic impairment and renal impairment

<sup>2</sup> The age bands apply to children of average size and, in practice, the prescriber will use the age bands in conjunction with other factors such as the severity of the condition and the child's size in relation to the average size of children of the same age.

<sup>3</sup> Amoxicillin is the preferred antibiotic in pregnancy. Erythromycin is preferred if a macrolide is needed in pregnancy, for example, if there is true penicillin allergy and the benefits of antibiotic treatment outweigh the harms. See the [Medicines and Healthcare products Regulatory Agency \(MHRA\) Public Assessment Report on the safety of macrolide antibiotics in pregnancy](#)

<sup>4</sup> Doxycycline should not be used in pregnancy, and the possibility of pregnancy should be considered in women of childbearing age



# STARWAVE trial

- A tool to predict risk of hospitalisation within 30 days for children presenting with acute cough & RTI
- 7 characteristics were independently associated with hospital admission
- Distinguishes between three hospital admission risk strata –
  - very low,
  - normal or
  - high risk

Development and internal validation of a clinical rule to improve antibiotic use in children presenting to primary care with acute respiratory tract infection and cough: a prognostic cohort study

*Alastair D Hay, Niamh M Redmond, Sophie Turnbull, Hannah Christensen, Hannah Thornton, Paul Little, Matthew Thompson, Brendan Delaney, Andrew M Lovering, Peter Muir, John P Leeming, Barry Vipond, Beth Stuart, Tim J Peters, Peter S Blair*

“Clinical characteristics can distinguish children at very low risk, normal and high risk of future hospital admission for respiratory tract infection and *could be used to reduce antibiotic prescriptions in primary care* for children at very low risk”

# STARWAVE was developed to help predict future hospitalisation among children with cough

## The 7 symptoms and signs are:

- S** **Short** duration of illness ( $\leq 3$  days)
- T** Parent reported fever in the previous 24 hours or **temperature**  $\geq 37.8^{\circ}\text{C}$  at presentation
- A** **Age** is less than 2 years
- R** Clinician reported inter- or subcostal **recession**
- W** Clinician reported **wheeze** of auscultation
- A** Current diagnosis of **asthma**
- V** Parent reported moderate or severe **vomiting** in the previous 24 hours



# STARWAVE was developed to help predict future hospitalisation among children with cough

STARWAVE score		
0-1 (67% of all children)	At very low risk of future admission, 1:320	No antibiotic strategy
2-3 (30% of all children)	'Normal' risk of future admission, 1:70	No or back-up antibiotic strategy
≥4 (3% of all children)	Monitor closely for signs of deterioration	Same-day or next-day follow up, with immediate antibiotic

# Symptom benefit from antibiotics

	Total Duration untreated	Beneficial effect from antibiotics	NNT for one additional patient to benefit	NNT for one additional adverse effect
Otitis media	4 -12 days	8-12 hours	20	10
Sore throat	8 days	12-18 hours	6-18	-
Sinusitis	12-15 days	24 hours	18	8
Bronchitis	20-22 days	11-24 hours	10-22	24



# Antibiotic Harms

## Adverse drug event (side effect)

Every extra day of treatment increased odds of:

- side effects - 4%
- risk of resistance - 3%

## Development of resistance

Resistance after prescribing can persist for up to 12 months



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# Back up prescribing and resources

# Back-up antibiotic prescriptions - How?

1

Reason for giving it

2

Specific number of days to wait

3

Wording when explaining  
back up prescription

4

Code your treatment choice

READ codes (Emis, Vision)	SNOMED code (System One)	Definition
8OAN	967191000000104	<b>Provision of Treating Your Infection self-care patient leaflet with back-up antibiotic prescription issued (procedure)</b>
8CAk	248041000000103	<b>Patient advised to delay filling of prescription (situation)</b>
n/a	1065591000000109	<b>Delayed prescription given (situation)</b>



# TARGET: Treating Your Infection RTI Leaflet

Keep

## Treating your Respiratory tract infection (RTI)



### Your infection

- Middle-ear infection
- Sore throat
- Sinusitis
- Common cold
- Cough or bronchitis
- Other infection \_\_\_\_\_, \_\_\_\_\_ days

### Most are better by

- 3 days (can last 7 to 8 days)
- 7 to 8 days
- 14 to 21 days
- 14 days
- 3 to 4 weeks

### When to get help

If any of the below apply to you or your child, get an urgent assessment from a healthcare professional. If your child is under the age of 5, go to A&E immediately or call 999.

- Your skin is very cold or has a strange colour, or you develop an unusual rash.
- You have new feelings of confusion or drowsiness or have slurred speech.
- You have difficulty breathing. Signs that suggest breathing problems include:
  - breathing quickly
  - turning blue around the lips and the skin below the mouth, and
  - skin between or above the ribs getting sucked or pulled in with every breath.

If you (or your child) have any of the following symptoms, are getting worse or are sicker than you would expect (even if your temperature falls), trust your instincts and get medical advice urgently from NHS 111 or your GP.

- You develop a severe headache and are sick.
- You have a red, swollen tongue.
- You have redness, swelling and pain around the eyes or the ears.
- You develop chest pain.
- You have difficulty swallowing or are drooling.
- You cough up blood.
- You are peeing very little, or not at all.
- You are feeling a lot worse.
- Your child has a middle-ear infection and fluid is coming out of their ears or they have new deafness.

‘Most are better by’ section to help patients know when to (re) consult

### How to look after yourself and your family

- Have plenty of rest.
- Drink enough fluids to avoid feeling thirsty.
- Ask your local pharmacist to recommend medicines to help reduce your symptoms or pain (or both).
- Fever is a sign your body is fighting the infection. It usually gets better by itself in most cases. You can use paracetamol if you (or your child) are uncomfortable because of a fever.
- Use a tissue to cover coughs and sneezes and wash your hands with soap to help prevent spreading infection to your family, friends and other people.
- **Never share antibiotics and always return any unused antibiotics to a pharmacy for them to dispose of safely.**

Safety netting

### Less serious signs that can usually wait until you visit a pharmacist or your next available GP appointment

- You are not starting to improve a little by the time given in the ‘Most are better by’ column in the table above
- You have mild side effects such as diarrhoea. Get advice from a healthcare professional if you are concerned.

Back-up prescription

### Back-up antibiotic collection

Back-up antibiotic prescription to be collected after \_\_\_\_\_ days from \_\_\_\_\_ / / only if you are not starting to feel a little better or you feel worse.

- Colds, most coughs, sinusitis, ear infections, sore throats and other infections often get better without antibiotics, as your body can usually fight these infections on its own.

If you need antibiotics, take them exactly as prescribed. Never save them for later and do not share them with others. For more information, visit [www.antibiotiguardian.com](http://www.antibiotiguardian.com).

### Why it is important to take antibiotics as prescribed

Taking any antibiotics makes bacteria that live inside your body more resistant. This means that antibiotics may not work when you really need them.

Antibiotics can cause side effects such as rashes, thrush, stomach pains, diarrhoea, reactions to sunlight, other symptoms, or being sick if you drink alcohol with the antibiotic metronidazole.

Information about antibiotics & AMR



Keep Antibiotics Working

TARGET is operated by the UK Health Security Agency. This leaflet has been developed with healthcare professionals, patients and professional medical bodies. Version 10.0. Published: November 2024, Review: November 2027. KAW10-07 © Crown copyright 2024.

# TARGET pictorial TYI leaflet

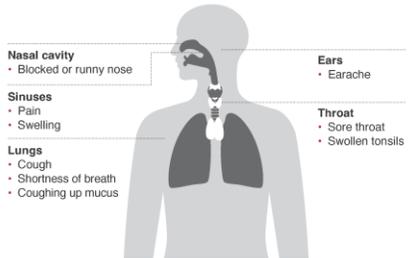
## Respiratory tract infections (RTIs)

A step-by-step guide on how to manage your infection

### What is an RTI?

A respiratory tract infection (RTI) occurs in the upper or lower respiratory tract, causing symptoms. A RTI is usually caused by a virus, but can sometimes be bacterial.

### What are some common symptoms of an RTI?



Version 4.0. Published: November 2024. Revision date: November 2027. This leaflet has been developed with healthcare professionals, patients and professional medical bodies. TARGET is operated by the UK Health Security Agency.

### 1 Help yourself to feel better

Whatever your infection, you can do the following to help.

 Take paracetamol to reduce pain. Always follow the instructions on the packet.	 Ask your pharmacist for advice on reducing your symptoms.
 Get plenty of rest until you feel better.	 Drink enough fluids to avoid feeling thirsty.
 Use tissues when you sneeze to help stop infections spreading.	 Wash your hands regularly and after using tissues.

For more information, visit the NHS website at [www.nhs.uk](http://www.nhs.uk). Most common infections get better without antibiotics. Find out how you can make better use of antibiotics at [www.antibioticguardian.com](http://www.antibioticguardian.com).

### 2 Check how long your symptoms last

 <b>Earache</b> Most get better by 3 days (can last 7 to 8 days)	
 <b>Sore throat</b> Most get better by 7 to 8 days	
 <b>Cold</b> Most get better by 14 days	
 <b>Cough</b> Most get better by 3 to 4 weeks	

If you are not starting to improve a little by the times given above, visit a pharmacist or contact your GP practice. If you are feeling a lot worse, phone NHS 111 or NHS 24 (see step 4).

### 3 Look out for serious symptoms

If you have an infection and develop any of the symptoms below, you should see a doctor urgently. Ring your GP practice or call NHS 111 or NHS 24.

 <b>Severe headache</b>	 <b>Very cold skin</b>	 <b>Trouble breathing</b>	 <b>Feeling confused</b>
 <b>Chest pain</b>	 <b>Problems swallowing</b>	 <b>Coughing blood</b>	 <b>Feeling a lot worse</b>

### 4 Where to get help

			
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If you have an **emergency**, call 999 immediately





# Healthier Together

NHS OUTSIDE THE UK | v

SEARCH SHARE FEEDBACK LANGUAGE



PREGNANCY AND BIRTH



NEW PARENT AND BABY



CHILD 1 - 4 YEARS



CHILD 5 - 11 YEARS



YOUNG PERSON



PROFESSIONAL

Child 1 - 4 Years > Recent Illness or Concern

## Cough and Cold

Coughs and colds are extremely common in young children. Over the first few years of life, your child might have these every month.

- Coughing is the body's natural way of clearing infection
- Most of these are likely to be caused by a virus, which means that antibiotics don't help. Antibiotics might cause side effects such as rash and diarrhoea, or increase the risk of developing antibiotic resistance.
- Having green snot or a noisy chest does not mean that your child has an infection needing



### On this page

[Introduction](#)

[When should you worry](#)



# Children with coughs (Polar bear) leaflet

## Caring for children with COUGHS



This leaflet contains information about how to look after a child who has a cough (not due to asthma).  
For more detail see [www.bristol.ac.uk/child-cough](http://www.bristol.ac.uk/child-cough)



### COUGH

Coughs can last for 3-4 weeks and make your child feel quite unwell but will still get better by themselves.

'Noisy chests' or 'chesty coughs' are quite common when young children catch a cold and are not necessarily a sign of a 'chest infection'.

Healthy children typically get a cough 7-10 times a year and this is not a sign that there is anything wrong with their immune system.

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### DISTURBED SLEEP

Coughs will often wake your child in the night. When the child lies down, more of the mucus from the nose and throat runs downwards and your child coughs more to clear it.

Coughing is part of the body's defence system which helps keep the lungs clear and fight the illness. Unfortunately this can wake the child in the night but does not mean the illness is more severe.

**For children over 1 year**, a spoon of honey (perhaps in a warm drink) half an hour before bed may help them to wake less often.

**For children over 2 years**, vapour rubs (containing camphor, menthol and/or eucalyptus) may help children sleep better.



### FEVER/HIGH TEMPERATURE

**In children, a temperature of over 37.5°C is considered a fever.**

Fever is a normal response to illness and does not harm children. It may even help to fight illness.

Children with a high temperature may be more likely to have a more severe illness, although most do not. Occasionally a child may have a fit. This shouldn't cause harm and treating the fever doesn't prevent it.

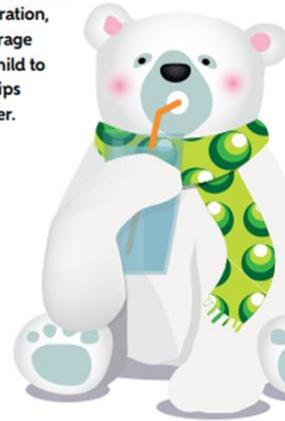
It is safe to use child paracetamol and ibuprofen to manage children's fever (and pain) for as long as needed. Follow the dosage on the bottle.

### DRINKING/EATING LESS

Children often eat and drink less when they have normal childhood illnesses. Most children can go a few days without eating much and this will not affect their longer term growth and development.

**All children need to drink regularly to avoid becoming dehydrated, especially if they are vomiting.**

**To help prevent dehydration, encourage your child to have sips of water.**



# Sending TARGET Information Leaflets via AccuRx

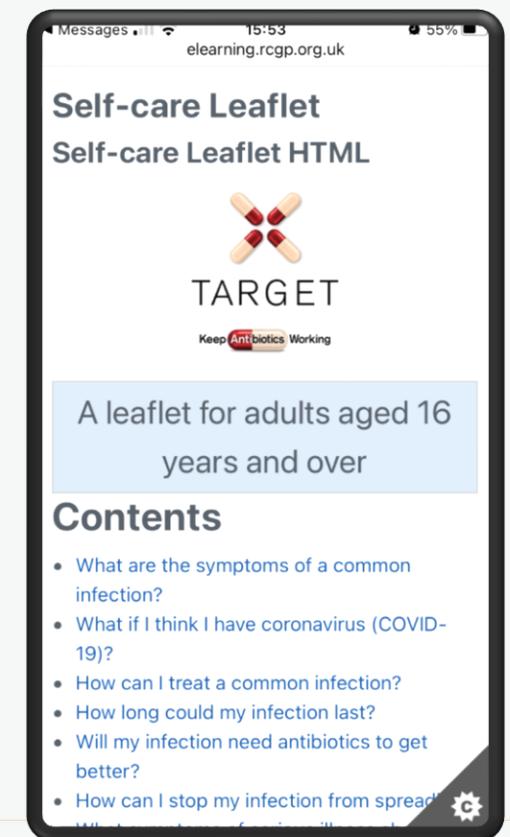
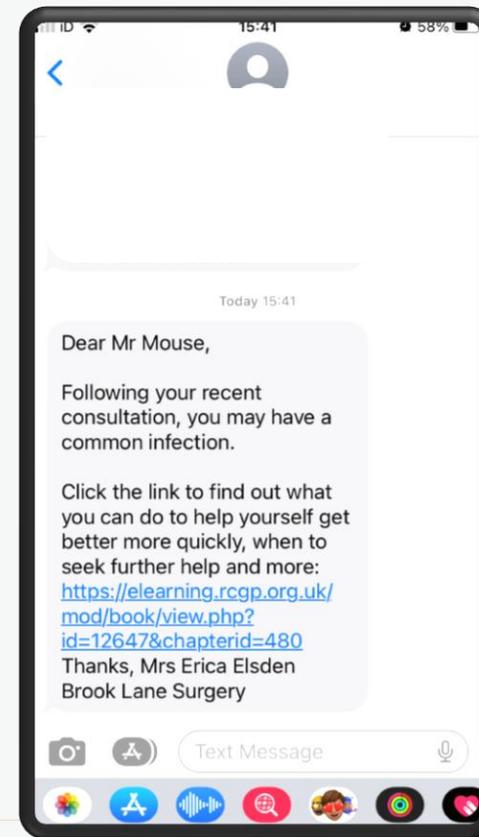
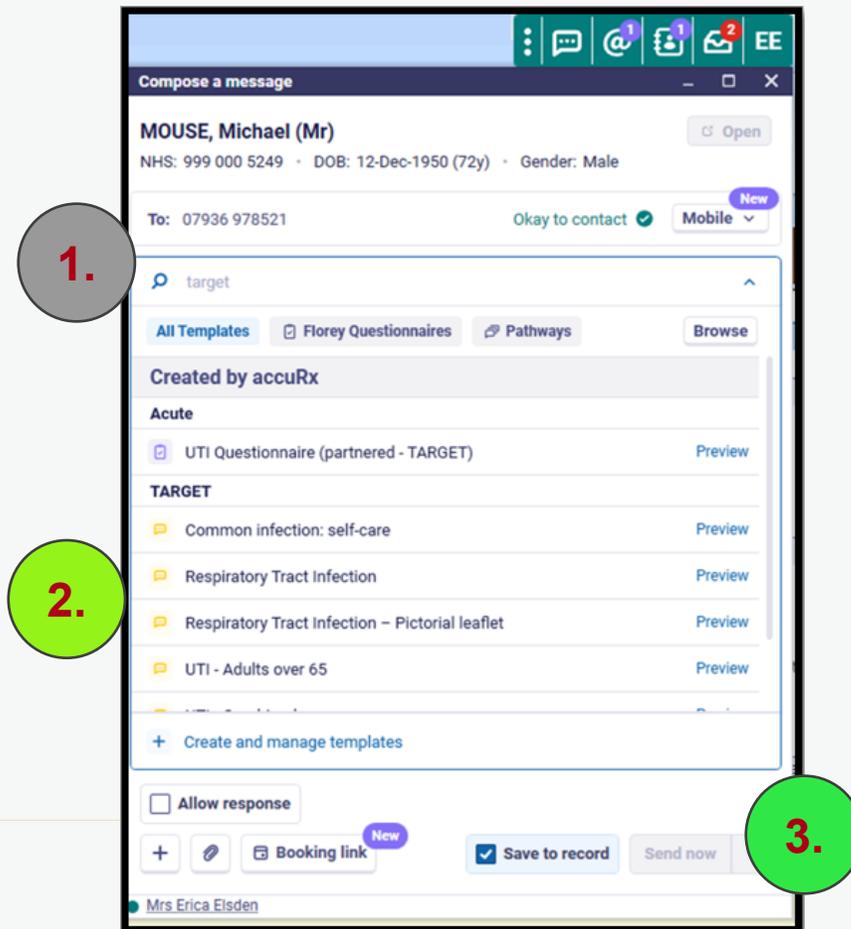
1. In the AccuRx message template search bar, type "target"

2. Click on the desired TARGET patient leaflet

3. Press 'Send Now'

4. The patient will receive a link to the chosen patient leaflet

5. The link will bring the patient to the leaflet on the TARGET website





# Take home messages

The demand for antibiotics for RTIs seems unrelenting – we need to get better at managing that

## Key actions:

- Effective/successful consultations that address parent/carer concerns and expectations
- Communicate and be explicit about the expected duration of symptoms (how long it will take 90% of children to feel better)
- Provide verbal and written safety netting advice
- Signpost to Healthier Together website for additional support
- Make sure the whole team is taking the same approach



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