We have developed a General Paediatric model of care where one consultant is identified as the lead for hospital based care for each such patient. During admissions, day to day care is delegated to the attending general paediatric team, but the lead liaises with them and the family as needed, ensuring smooth communication and consistency between all specialties involved, maintaining a holistic overview.

The lead continues to work with the family and community paediatrician post discharge and is involved in the development of advanced care planning focusing on management of symptoms and life threatening or life ending situations.

Once a month the General Paediatric Consultant Meeting is devoted to chronic care inviting neonatology, community paediatrics and other specialists to identify patients who may require a lead and anticipating children who may be admitted to hospital in the near future. The lead ensures updated reports are in the patient notes and on the clinical portal. We use this meeting for peer support, sharing dilemma's and expertise. Since formalising this approach in 2013 forty two children have been allocated a Lead Paediatrician and discussed one or more times at the meetings.

Providing trainees with experience in managing children with complex needs particularly, continuity of care, remains a challenge; this model provides a structured opportunity to experience this. Encouraging a trainee to identify such a patient and maintain contact with that patient and their lead is an excellent training opportunity.

Standards of care for acute General Paediatrics are becoming well established but they do not exist for acute management of the complex care required by these patients. It is the aim of our group to develop an educational model as well as to contribute to the development of standards to ensure that this care is delivered well and is a properly resourced role for a General Paediatrician in a tertiary centre.

G317(P) PAEDIATRIC STANDARDS IN A 'CONSULTANT-DELIVERED SERVICE'

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Aims RCPCH has recommended a move towards 'consultant-delivered service', stating that consultants "make better decisions more quickly" and that "availability of consultants can decrease the rate of unnecessary admissions". In our unit a twilight consultant shift is in place 3 days per week from 12:30 to 21:30.

Methods A retrospective case note review was undertaken on 93 attendances to Children's Assessment Unit (CAU) over a 6 month period.

We used the RCPCH 'Facing the Future: Standards for Paediatric Services' which recommends a senior review within 4 h and consultant review within 24 h of admission. We also looked at decision making regarding admission including a comparison between consultants and middlegrade doctors.

Results The main source of referrals to CAU is GPs. Overall, 63% of attendances lead to admission. Admissions are short with 46% of patients admitted staying for only 1 day. Admission rates are similar between Consultants (67%) and Middlegrades (71%). 82% of patients attending CAU have a decision regarding admission within 4 h.

76% of children attending CAU are reviewed by a senior, 54% are within 4 hrs. 59% see a consultant within 24 hrs.

Peak hours of attendances are 16:00 to 20:00. During twilight shifts consultants undertake 53% of senior reviews, compared to 9% at other times.

Conclusions Decisions regarding admission are mostly made in a timely manner. Rates of senior review could be improved. We suggest changing expectations in medical and nursing staff and improving documentation of cases discussed with seniors. Consultants may use the morning ward round as an opportunity to review new patients within 24 h of admission. Understanding peak hours of activity helps us plan rotas. We plan to reaudit this soon.

G318(P) DOC –I DON'T WANT TO TAKE MY MEDICINE!

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Aims Duration, schedule, formulation, palatability, cost, and adverse effects of medication are all factors contributing to poor compliance. Taste and palatability are significant barriers in non-compliance with paediatric medicines. We felt these concerns were not routinely explored whilst prescribing medications for children.

Methods We surveyed foundation, general practice, paediatric trainees, general practitioners and paediatric pharmacists in Wales. Our questionnaire addressed various issues concerning palatability, commonly associated antibiotics and possible reasons for non-compliance. Measures to improve compliance and awareness were also surveyed.

Results A total of 189 responses were received. 80% of prescribers encountered issues with palatability. 78% recognise that it is an important aspect of compliance. The age-group most commonly affected by palatability was 2 – 4 years [75%]. Penicillin V and flucloxacillin were the most common antibiotics to have a perceived palatability issue. Parental anxiety [47%] and incomplete course [40%] were significant concerns amongst non-compliant children. 71% of prescribers felt diagnosis was the key determining factor for antibiotic choice irrespective of palatability

Conclusions This is a unique survey involving prescription experiences of first line doctors. There is a discrepancy in awareness of palatability and its importance in prescription choices. Taste-masking and flavouring enhance paediatric medication compliance, thereby contributing to improved clinical outcomes. We strongly advocate all doctors to consider these important aspects in conjunction with appropriate microbial cover. Newer excipients and research are called for.

G319(P) ECHOCARDIOGRAMS IN CHILDREN – A PARENTAL PERSPECTIVE

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Introduction and aim Cardiac murmurs are reported in 50–90% of children at some time in their life, but only 1% are pathological. It is widely questioned whether performing echocardiograms on these children with asymptomatic murmurs is cost-effective or not. We designed this study to survey parents of children who

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