

intravenously or 6% nasogastrically). When we asked what would make parents confident about going home, the most common response was 'after reassurance that the child is not dehydrated'. Other responses referred to advice or physical symptoms.

Conclusion Knowledge of parental expectations provided by this study, particularly with regard to expectations of investigations and treatment could enable physicians to provide more comprehensive care, with particular emphasis on explanation. This may improve parental satisfaction and reduce re-attendance.

G238 MAKE LOVE NOT WAR: BRIDGING THE GAP BETWEEN PRIMARY AND SECONDARY PAEDIATRIC CARE

doi:10.1136/archdischild-2013-304107.250

²S Fosker, ²H Millar, ¹O Rahman, ¹C Bevan. ¹Childrens Emergency Department, Royal Alexandra Children's Hospital, Brighton, UK; ²Brighton and Sussex Medical School, University of Sussex, Brighton, UK

Aim To determine the number of presentations to a new Children's Emergency Department (CED) that could have been managed in primary care.

Methods All Patients were assessed to determine the appropriateness of attendance. Appropriateness was defined as any patient referred from primary care, or requiring any period of observation, a procedure or an investigation, or that were admitted. Patients appropriate for primary care management were defined as children that did not meet the above criteria, had a simple illness with no significant underlying pathology and were green in accordance to the NICE traffic light system. The outcome of all GP referrals was also reviewed.

Results 898 attendances (viral type illness 47%, injuries 32%) were reviewed. 27.4% were deemed more appropriate for primary care with 60% being < 5 years (23% < 1year). The majority (68.6%) were self-referral, 62% from within a 5miles radius and 30% from just 10 of the 111 GP practises.

16% were referred from primary care, 24.3% were admitted. The estimated minimum cost of these additional referrals was £286 520 per year, with 64.2% of these costs being children under the age of 5.

Discussion A large number of attendances to the CED could be managed in primary care. The health system needs to adapt in order to meet users' needs and continue the ethos of right patient right place right time. Using this audit data the local primary care Clinical Commissioning Group (CCG) and the hospital trust have worked together to implement many changes. The out of hours (OOH) service has been reinstated allowing specific patients to be triaged straight back to the primary care centre, who are prioritising seeing and calling back the under 5 year olds. CED has developed formal care pathways for common illness for use in primary care; CED is in direct liaison with the local GP forums to address concerns. Ultimately, CED services need to adapt to be able to care for an increasing volume of attendances, and primary and secondary care need to "make love not war".

G239 REDUCING NEONATAL READMISSIONS AND RE-ATTENDANCES WITH JAUNDICE: ROLE OF TRANSCUTANEOUS BILIRUBINOMETERS

doi:10.1136/archdischild-2013-304107.251

V Ponnusamy, A D'Amore. Neonatal Intensive Care Unit, Addenbrookes Hospital, Cambridge, UK

Aims Up to 60% of newborns have jaundice within the first week of life. Significant jaundice necessitates readmission to hospital. NICE guidance on neonatal jaundice in 2010 recommending checking bilirubin levels and not relying on visual inspection alone led to increased numbers of babies attending our Emergency Department

(ED). We aimed to address the raising re-attendances and readmissions to paediatrics.

Methods A n Audit identified increasing readmissions within the first week of life. We collected data for readmissions to wards and re-attendances to ED due to physiological jaundice. We compared readmissions prior to use of transcutaneous bilirubinometers (TCBRs) and for one month post introduction. A monthly average was used for comparison.

Results Over the years, the proportion of infants readmitted increased (Table 1). Most were term breastfed babies. Length of stay increased when discharged early. TCBRs can be used as a screening tool. We identified that screening by Community Midwives at home could decrease hospital referrals. TCBRs were obtained in May 2012 through charity funding.

Abstract G239 Table 1 Readmissions within first week of life 2009-2011

	June – Sep 2009	Sep – Dec 2010	Aug – Nov 2011
Number of readmissions for babies <1 week of discharge	26	42/72 (58%)	73/82 (89%)
Proportion readmitted for 'jaundice, poor feeding or weight loss with jaundice'	13/26 (50%)	28/42 (66%)	62/73 (84%)

Post TCBR use, average monthly re-attendances to ED fell from 40 to 16 (Table 2). Average monthly readmissions and financial costs to the Primary Care Trust (PCT) were calculated.

Abstract G239 Table 2 Re-attendances and readmissions: pre and post TCBR use

	Pre TCBRs 01/12–03/12	Monthly average	PCT billing	Post TCBRs introduction 06/2012	PCT billing
Time in months	3 months			1	
No of Re-attendances to ED	122	40.6	£16,916	16	£1,744
No of Readmissions	28	9.3		8	
Days of admission	78	26	£14,495	22	£7,931

Conclusions Introduction of TCBR's reduced attendance rates to ED, but did not significantly affect readmissions. PCT billing reduced significantly. Families could be monitored at home. We are pursuing other strategies like producing a DVD to promote awareness of jaundice and improve breast feeding support and plan to reanalyse following this.

G240 THE ROMLA MATRICES AS A TOOL IN INVESTIGATING GUIDELINE ADHERENCE AND CLINICAL OUTCOME: ARE THEY USEFUL IN CHILDREN WITH HEAD INJURIES?

doi:10.1136/archdischild-2013-304107.252

¹S Winearls, ²D Matheson, ³D Roland. ¹Emergency Department, Wanganui Hospital, Wellington, New Zealand; ²Medical Education, Nottingham University, Nottingham, UK; ³Paediatric Emergency Medicine Leicester Academic (PEMLA) Group, Leicester University, Leicester, UK

Background Paediatric head Injuries (HI) are a common presentation to emergency departments. National guidance is available to facilitate neuroimaging decision making in this cohort. However it is unclear how guidelines and their evidence base influence practise and patient outcomes. The ROMLA matrices are 2X2 classification algorithms relating evidence base adherence to either diagnostic accuracy (Rolma 1) or clinical outcome (Rolma 2).