British Association of General Paediatrics and the Paediatricians in Medical Management Group

G280 CLINICAL MANAGEMENT FOR SENIOR PAEDIATRIC TRAINEES – PUTTING THEORY INTO PRACTICE

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Background Paediatric trainees have variable training experience in clinical management before they become consultants. While there has been increased awareness in recent years of the need to incorporate this into training, there is no agreed way across all deaneries.

Aims 1. To pilot a clinical management course for level 3 trainees (ST6–8) in our deanery with the help of Keele University for 2 years (2012–14).

2. To survey other deaneries on clinical management training for level 3 paediatric trainees.

Methods We drew up a 4 day paediatric bespoke clinical management course with Keele University in 2012. The main course topics were history and structure of the NHS, financing healthcare, personality types, leading and motivating teams, leadership style and handling conflict, writing a successful business case and the basics of service improvement projects (SIPS). All attendees were expected to complete a SIP and present it to their group on the last day. We reviewed feedback after 2 cohorts of trainees (total 42) completed the course.

An email questionnaire was sent to all paediatric Head of Schools (HOSs) in October 2014.

Results Feedback for our course was consistently positive and all trainees felt they gained insight into topics that are not usually covered during their training. They appreciated the main course topics.

We received 7 replies to our email questionnaire. 6/7 deaneries allocated an annual £400–£600 study leave budget per senior trainee including life support courses. 4 deaneries provided management courses combined with other specialties but the trainees were not expected to complete SIPs. 3 deaneries did not offer formal course on management.

SIPs developed and presented by trainees

- Developing a new patient information leaflet on anaphylaxis
- Improving hand-over in the evening by liaising with IT
- Decreasing discharge delays due to pharmacy waits
- Reducing 4 h wait in children referred by GP
- Developing a checklist for admissions in PICU
- Improving oncology day theatre patient pathway

Conclusions After review of feedback, we made a few modifications and have decided to run this course yearly for the next 5 years.

A structured clinical management programme by deaneries would improve knowledge and confidence amongst trainees to help lead changes in the future.

G281 MAKING A CASE FOR 'CONSULTANT DELIVERED CARE' IN PAEDIATRICS

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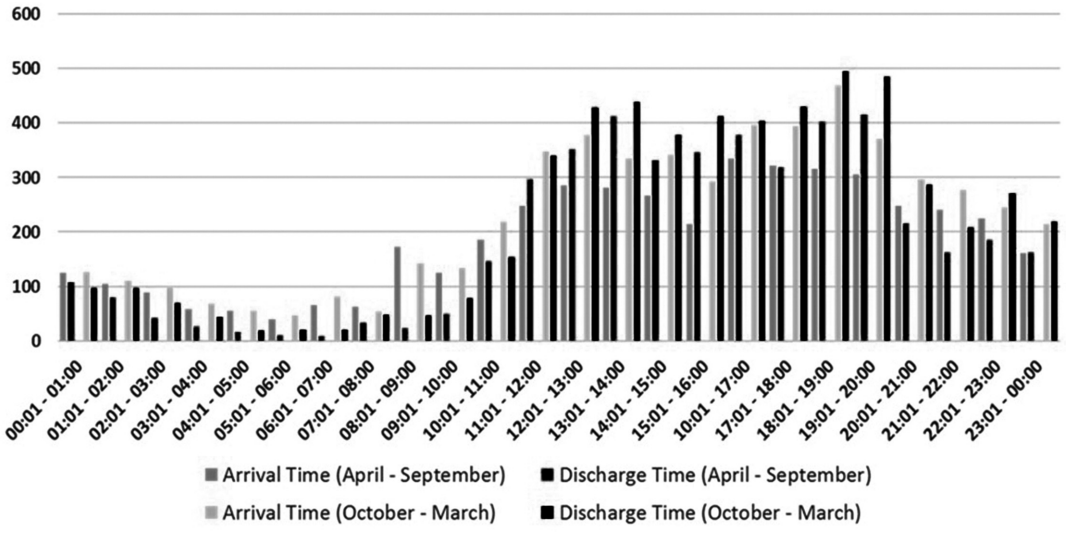
Aims The RCPCH standards, *Facing the Future standards* highlighted need for changing the paediatric services.

An important area of concern is that only 25% of units across the UK in 2013 had a consultant present at times of peak activity. There is evidence that a consultant led service is more efficient, ensures rapid decision making and improves outcomes.

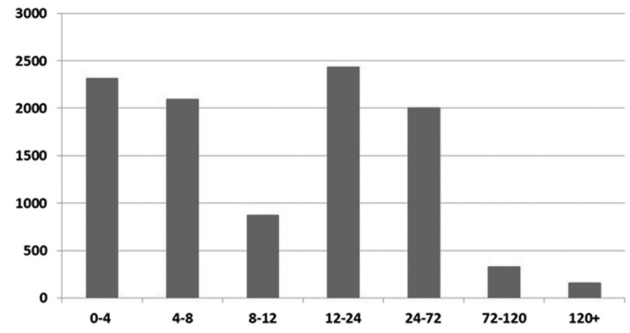
We recognised the need to change, but had to reconsider the options for delivering care in more innovative and efficient ways.

Methods We used hospital informatics data to make a clear case for consultant presence for extended hours and studied its impact on outcomes. Data was obtained for all 10015 admissions over 24 months on time of admission, time of discharge and length of stay. Average admissions were 418 per month over 24 months.

We used this information (Figures 1 and 2) to define peak activity hours (1200 to 2300 h), demonstrate the need for consultant presence and to implement service changes creating a 'short stay unit'.



Abstract G281 Figure 1 Hourly activity on the paediatric ward over 2 years



Abstract G281 Figure 2 Duration of all admissions (in hours) over 2 years

This data enabled us to make 2 significant changes to the way we ran our services:

1. Changes to job plans for all consultants: To remain available for extended hours working until 2200 and provide rapid clinical decision within an hour.

2. Changes to the Paediatric ward: Rreducing in-patient beds and utilising resources to create a 'Short Stay Unit' functioning between 0800 to 2200 h.

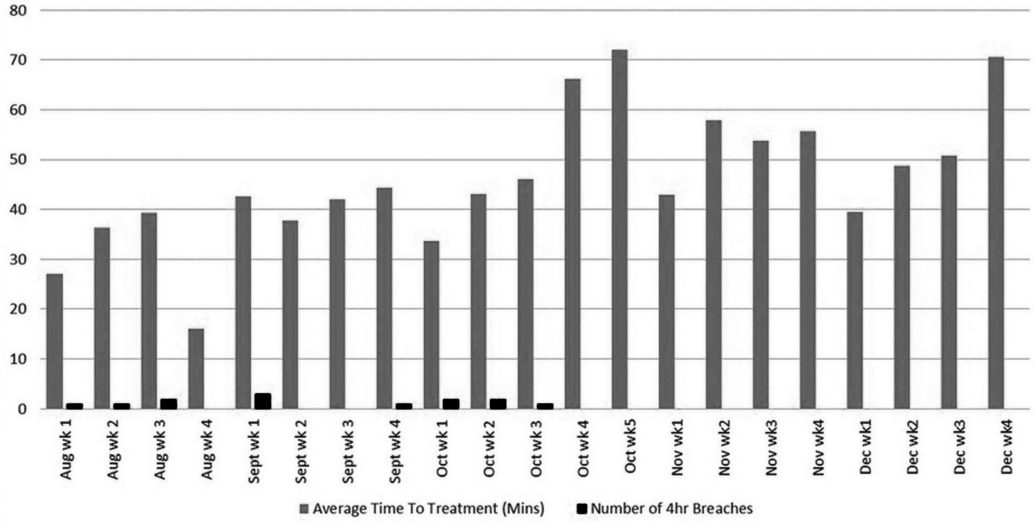
Results Most patients referred to the unit from A&E or GPs received an early senior opinion and commenced treatment within an hour (Figure 3).

We reduced the number of admissions by 34.6% over the next 5 months (Figure 4) compared to same months the previous years.

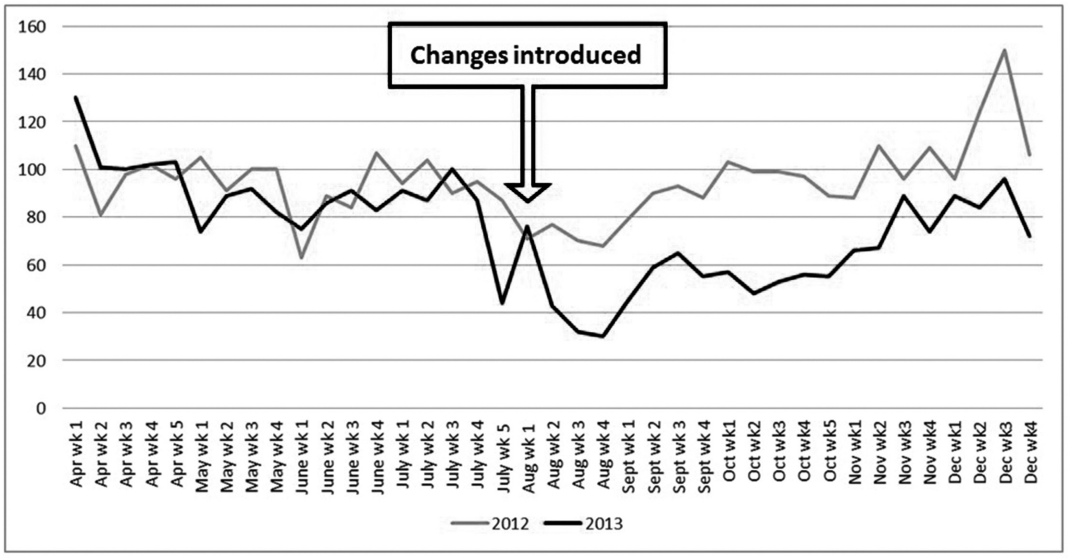
Conclusions Paediatric Consultants in our unit recognised the need for modifications to service and agreed to changes in job plans enabling senior presence and advice till late evenings.

We increased resources for assessment of unscheduled attendances to the hospital and provided Consultant delivered care in the extended evening hours. This improved our outcomes for quicker senior review and reduced hospital admissions. There was a percieved ncrease in patient satisfacted due to the reduced waiting time and time for starting treatment.

These outcomes clearly make a case for the RCPCH vision of Consultant Delivered Care.



Abstract G281 Figure 3 Average time for senior review



Abstract G281 Figure 4 Reduced admissions to the ward

G282 THE EFFICACY OF A MULTIDISCIPLINARY INTERVENTION STRATEGY FOR THE TREATMENT OF BENIGN JOINT HYPERMOBILITY SYNDROME (BJHS) IN CHILDHOOD. A RANDOMISED, SINGLE CENTRE PARALLEL GROUP TRIAL (THE BENDY STUDY)

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Introduction Joint hypermobility is common in childhood and can be associated with musculoskeletal pain and dysfunction. Current management is delivered by a multidisciplinary team but evidence of efficacy is limited. This clinical trial aimed to determine whether a structured multidisciplinary intervention resulted in improved clinical outcomes compared with standard care.

Method A prospective randomised, single centre parallel group trial comparing an 8-week individualised multidisciplinary intervention programme with current standard management (advice and a physiotherapy appointment). Children and young people (CYP) were assessed for pain, function, coordination and strength at baseline, 3 and 12 months.

Results 119 children, aged 5 to 16 years, with symptomatic hypermobility were randomised to receive targeted multidisciplinary intervention (I) (n = 59) or standard management (S) (n = 60). Of these, 105 were followed to 12-months. There was a significant improvement in child and parent reported pain, coordination and strength. However, no added benefit could be shown from the intervention (Table 1). The number of CYP showing significant pain reduction (>=40%) was 27 (50.0%) (I) vs 21 (41.1%) (S). Those pain free at 12 months were 29 (56.9%) (I) vs 20 (45.5%) (S). The response was independent of the degree of hypermobility.

Conclusions This is the first RCT to compare a structured multidisciplinary intervention with standard care in symptomatic childhood hypermobility. The study demonstrates significant improvement among subjects but no additional benefit from targeted intervention. The findings emphasise the benefit of informed diagnosis and management according to clinical need, but highlight the difficulty in demonstrating subtle benefit from specific interventions without better tools for case definition and outcomes assessment.

G283 EPILEPSY12 – UNITED KINGDOM COLLABORATIVE CLINICAL AUDIT OF HEALTH CARE FOR CHILDREN AND YOUNG PEOPLE WITH SUSPECTED EPILEPTIC SEIZURES

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Objective To assess changes between 2012 and 2014 in the quality of paediatric clinical and nursing care for UK children and young people affected with seizures and epilepsies.

Methods Epilepsy12, a UK wide audit, commenced in 2009 with the aim of evaluating epilepsy care against NICE and SIGN guidelines. All NHS hospital and community paediatric services managing children with epilepsy were invited to participate. National key recommendations and local action plans were made after Round 1. Round 2 was undertaken between 2013 and 2014 to assess changes since Round 1 and results are reported here.

Children referred for first EEG were used to find a new cohort of eligible children aged 1 month to 16 years receiving a first paediatric assessment between January and April 2013 for afebrile paroxysmal episodes. Retrospective case-note analysis was undertaken using a specifically designed web-based platform and audit pack. Service descriptor data were collected from secondary services on census day, 1 January 2014. Patient reported experience measure (PREM) questionnaires were collected from sequential children with epilepsy and their carers/parents attending clinics between February and March 2014.

Abstract G282 Table 1 The rate of change in primary and secondary outcomes over 12 month follow-up period, this data includes analysis from multilevel modelling

		Rate of change over 12 months (95% CI)			
Outcome variable	Baseline score	Intervention group		Control group	
Child pain assessment (Wong-Baker Faces pain scale, 0-5, zero is the best) n=103. Median (IQR)	2 (1-3)	-1.42	(-1.78 to -1.06)	-1.31	(-1.75 to -0.85)
Parent observed pain assessment (0-100 VAS, zero is the best) n=105, mean (SD)	35.90 (26.46)	-6.09	(12.90 to 0.73)	-6.22	(-13.62 to 1.18)
Child health assessment questionnaire (CHAQ) (0-3, zero is the best) n=104, mean (SD)	0.82 (0.63)	+0.02	(-0.12 to 0.16)	-0.03	(-0.13 to 0.64)
Child health 9 dimensional utility (CHU9D) (0-1, zero is the worst) n=104, mean (SD)	0.85 (0.11)	+0.02	(-0.01 to 0.04)	+0.002	(-0.02 to 0.03)
Movement assessment battery for children (M-ABC) (0-100, zero is the worst) n =104, mean (SD)	34.56 (28.61)	+2.60	(-2.92 to 8.11)	+8.51	(3.17 to 13.86)
Grip Strength (Dynamometer) n= 104, mean (SD)	57.29 (28.30)	+4.55	(0.16 to 8.94)	+6.75	(2.85 to 10.66)