

Results 192/196 paediatric services enrolled. 186 units provided service descriptor data, 174 clinical audit data and 145 PREM data. The clinical cohort consisted of 3449 patients; median age 5.2 years; male: female 55:45%. Anonymised PREM data were received from 2335 parents, carers, children and young people. 45% of first assessments occurred within an acute presentation. 35% of children had epilepsy diagnosed by 12 months. 22.6% of children had a documented neurodisability.

68% of paediatric services now have at least one Epilepsy Specialist Nurse (ESN). There has been a significant increase in percentage of children having ESN input; access to a paediatrician with expertise in epilepsies; appropriate assessment, classification and investigations in 2014 compared to 2012. PREM data showed 88% (1897/2148) overall satisfaction with services; 20% thought that staff are not good at working together.

Conclusion There is evidence of significant improvements in the provision of medical and nursing epilepsy care. However, many children still do not receive recommended practice and access fully resourced paediatric epilepsy services.

G284

KAWASAKI DISEASE BPSU SURVEY IN GREAT BRITAIN AND IRELAND

¹RMR Tulloh, ²R Mayon-White, ¹PM Craggs, ³D Shingadia, ⁴C Michie, ²A Hamden, ⁵O Franklin, ⁶A Ramanan, ⁷EJ Tizard, ¹GM Connolly, ⁸K Gargh, ⁹S Davidson, ¹⁰RM Lynn, ¹¹M Levin, ¹²P Brogan. ¹Cardiology, Bristol Royal Hospital for Children, Bristol, UK; ²Primary Care, University of Oxford, Oxford, UK; ³Infectious Disease, Great Ormond Street Hospital, London, UK; ⁴Paediatrics, Ealing Hospital, London, UK; ⁵Cardiology, Our Lady's, Crumlin, Dublin, Ireland; ⁶Rheumatology, Bristol Royal Hospital for Children, Bristol, UK; ⁷Nephrology, Bristol Royal Hospital for Children, Bristol, UK; ⁸Paediatrics, Wexham Hospital, Wexham, UK; ⁹Kawasaki Disease Parent Support Group, Coventry, UK; ¹⁰British Paediatric Surveillance Unit, London, UK; ¹¹Paediatrics, Imperial College London, London, UK; ¹²Vasculitis, Great Ormond Street Hospital, London, UK

10.1136/archdischild-2015-308599.261

Introduction Kawasaki disease (KD) is the commonest cause of acquired heart disease in the western world. We report here on the preliminary data for the first year of a 2-year national survey in Great Britain and Northern Ireland.

Methods Using standard BPSU methodology, children with complete KD (for the first year) presenting from January 1st to December 31st 2013 were studied with their treatments and complications. The steering committee reviewed cases that were unclear or incomplete.

Results Excluding incomplete KD and incomplete data sets, there were 180 with complete KD (15/month). Peak presentation was in March, boy:girl ratio was 1.8 and 69% were 1 to 4 years old. The highest incidence was in children under 5 years especially in London and East Anglia (5.6 / 100,000) and lowest in the Midlands (2.8/100,000). Highest incidence was in Chinese (21.9/100,000), Black African and Caribbean (14.5/100,000) and Mixed ethnicity (15.3/100,000). 81% saw a GP at median 2 days after fever commencement and admission was median (range) of 2 (0–27) days later. Fever duration was 6 (1–28) days. 97% had rash, usually at the start of fever, which was on the trunk or widespread in 89% and was macular in 75%. Bilateral non-purulent conjunctivitis (91%) occurred at 4 (0–27) days and mucositis (97%) at 5 (0–27) days. Periphery involvement was up to 32 days in 156 (86%). Lymphadenopathy was least common (65%) often after 5 days. The BCG scar was inflamed in 11.

CRP ranged from 1–501 mg/l, albumin from 17–45g/l, lowest platelet counts were below $150 \times 10^9/l$ in 14.

31 (22%) had dilated coronary arteries, 9 had pericardial effusion and 12 had ECG abnormalities.

Intravenous immunoglobulin (2g/kg) given within 7 days to 95%, but not to 9 complete cases (delayed diagnosis). Second dose was given to 13 children. High dose aspirin (30–50mg/kg) followed by low dose aspirin was given to 92%.

19 had sequelae, 15 with persistence of coronary artery dilation, with no deaths.

Conclusions These preliminary results show a high incidence of coronary artery disease with the old guideline for KD and give new data on seasonality, ethnicity and correlation with clinical symptoms.

G285

PAEDIATRIC PREPARATION DAY: SMOOTHING THE TRANSITION FOR YORKSHIRE AND THE HUMBER FOUNDATION AND GP TRAINEES

¹T Stephenson, ¹D Singh, ²N Medd, ³V Davies, ³L Blakemore, ²S Sandhu, ²S Clark, ³H Shore. ¹Hull Institute of Learning and Simulation, Hull & East Yorkshire Hospitals NHS Trust, Hull, UK; ²Sheffield Children's Hospital, Sheffield Children's NHS Foundation Trust, Sheffield, UK; ³Leeds Children's Hospital, Leeds Teaching Hospitals NHS Trust, Leeds, UK

10.1136/archdischild-2015-308599.262

Background Delivery of safe, high quality healthcare relies upon adequate training and education.¹ Concern exists regarding the preparedness of junior doctors for their expected clinical roles despite Tomorrow's Doctors and the implementation of the Foundation Programme.^{2,3} Foundation and General Practice (GP) trainees rotate through secondary care paediatric rotations expected to perform clinical skills. Yet, the vast majority will have very limited practical paediatric experience. As traditional teaching methods including 'see one, do one, teach one' become increasingly unacceptable, simulation-based medical education (SBME) is being advocated to provide opportunities for deliberate practice and avoidance of patient harm.⁴ Internationally, paediatric bootcamps are starting to emerge. However, both regionally and nationally, bespoke opportunities for Foundation and GP trainees to develop practical paediatric skills prior to paediatric rotations are lacking.

Methods A one-day regional paediatric and neonatal skills course was developed and piloted for Foundation and GP trainees rotating into secondary care paediatrics. This provided trainees with the opportunity to observe and practice fundamental procedural and resuscitation skills on part-task trainers and low-fidelity manikins under the supervision of senior paediatric trainees. Course evaluation was achieved through a comparative pre and post-test design using confidence levels and a bespoke MCQ to assess knowledge acquisition for qualitative and quantitative data respectively.

Observation/Evaluation

58 doctors attended four pilot courses. Complete pre and post-course comparison data was achieved from 57 trainees. The mean MCQ score rose from 60.7% (95% confidence interval, 58.5% to 62.9%) to 83.9% (82.4% to 85.3%), $p < 0.0001$. Although statistically significant increments in mean confidence levels were demonstrated for every skill, the largest increases were associated with performing lumbar punctures, paediatric and neonatal life support, cannulation and venesection.

Conclusion This simple intervention is a feasible way to support Foundation and GP trainees ahead of paediatric rotations. This should facilitate a smoother transition into their clinical roles, when complemented with departmental induction programmes. The opportunity to practice skills in a safe

environment without the risk of patient harm is highly desirable in modern healthcare. We hope that our bespoke Paediatric Preparation Day course will be adopted to enhance future trainee and patient safety.

REFERENCES

- 1 Department of Health. Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values. A mandate from the Government to Health Education England: April 2014 to March 2015
- 2 Brennan N, Corrigan O, Allard J, *et al.* The transition from medical student to junior doctor: today's experiences of Tomorrow's Doctors. *Med Educ.* 2010; **44**:449–458
- 3 Matheson C, Matheson D. How well prepared are medical students for their first year as doctors? The views of consultants and specialist registrars in two teaching hospitals. *Postgrad Med J.* 2009; **85**:582–589
- 4 Aggarwal R, Mytton OT, Derbrew M, *et al.* Training and simulation for patient safety. *Qual Saf Health Care* 2010; **19**(Suppl 2):i34–i43

G286 EARLY EXPERIENCE WITH ELECTRONIC GROWTH CHART USE THROUGHOUT A LOCAL HEALTH BOARD

¹THC Williams, ²S Mistry. ¹Child Health, Aneurin Bevan University Health Board, Abergavenny, UK; ²CCube Solutions, Milton Keynes, UK

10.1136/archdischild-2015-308599.263

Aims Electronic patient records are the future. We are proceeding toward full digitisation of the past, and, until direct electronic entry is fully established, contemporaneously for written notes and other documents. However a scanning solution cannot be applied to the growth chart. Developing our own electronic version was for control of development, and ensuring integration with the established portal to all electronic records (CWS) in the Health Board. CWS is available to all 9000 clinical users in primary, secondary and community care.

Methods Development was clinically led, working with the company conducting digitisation of medical records. A graphing product plots measurements onto a chart image. Images were created from growth data available from the Medical Research Council. Charts are for 0–2, 0–4, 0–18 years, boys and girls, with ability to display gestation correction, bone age and target height. Charts can be optionally displayed in any age range, either as a single measurement or in combination of height and weight, and in the 0–2 age, also with head circumference. Table information shows calculations of BMI, and height velocity. Location of data entry is mandated, and user identity recorded according to the CWS login. Different levels of access, determined by clinical role, and training allow measurements to be entered from any site.

Results A pilot phase began June 2014. By October the use of paper was supplanted for most patients. Presently 3199 children have active growth charts with data entry largely from secondary care, but use is rapidly increasing, and becoming more established from community and primary care. Feedback overall has been very positive, with many examples where clinical practice has been enhanced, primarily related to the fact that all clinicians in all settings can see and use the same chart on-line. Refinements are steadily being added, influenced by user opinion. A Down syndrome chart will shortly be available.

Conclusions The electronic growth chart is proving a successful substitute to paper, and working well across our Health Board. Future development and design will be directly influenced by user feedback. There is enormous potential in future enhancements, including use on mobile devices.

G287 IMPACT OF TELEPHONE REMINDERS ON ATTENDANCE RATE AT PAEDIATRIC CLINICS

¹S Chinnappan, ¹E Gole, ²B Martin, ¹M Ahmed. ¹Paediatrics, Queen's Hospital, Burton-Upon-Trent, UK; ²University of Leicester, Leicester, UK

10.1136/archdischild-2015-308599.264

Background Non-attendance in clinics has a major economic impact in the National Health Service. Literature review indicates that the major reason for non-attendance is patients or parents forgetting their appointment and reminders before clinic appointment reduces the “did not attend” (DNA) rate. Telephone call reminders were introduced for all paediatric outpatient appointments from February 2014 in our District General Hospital setting.

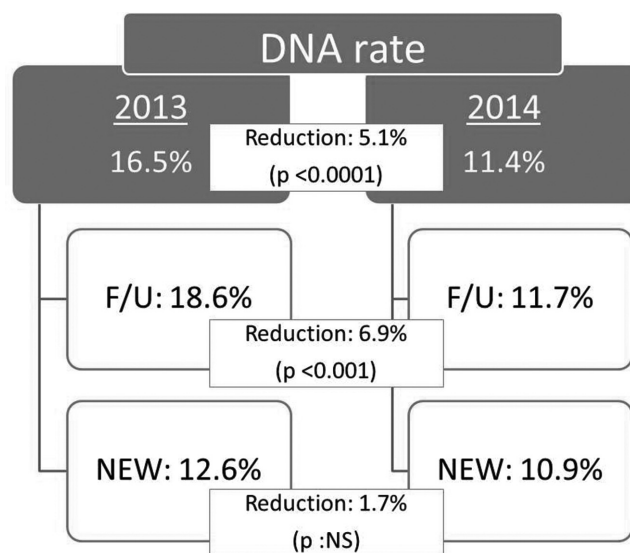
Aim We aimed to evaluate the DNA rate at the paediatric outpatients after implementation of telephone reminders.

Methods Using our hospital outpatient database, DNA rates were reviewed for 6 months (Feb–July 2013) and compared with the DNA rates for similar duration in 2014 (before and after the introduction of reminders). For Feb–July 2014 period, comparison was also made for patients who confirmed attendance during reminders versus those left a voice message and those who didn't receive a call or did not answer.

Results Total number of patients in 6 months (2013) were 4156 [2674 follow-up (F/U), 1482 New] and 4732 (3100 F/U, 1632 New) in 2014 (Figure 1). Overall DNA rate for both F/U and New appointments in 2014 was 11.4% (post intervention), which was 5.1% (p value < 0.0001) lower than the total DNA rate in 2013 (16.5%). Although reduction was noticed in both F/U and New appointments but it was only statistically significant in follow up (6.9%, p value < 0.0001) compared to new appointment (1.7%, p value 0.1470).

DNA rate was lowest at 3.4% in the patients who answered and confirmed the appointment. Patients confirming attendance were less likely to DNA compared to those patients who had voice messages (10.98% DNA, p value 0.0041) or not answering phone/not called (13.65% DNA, p value 0.0001).

Conclusion Our results endorse the usefulness of telephone reminders and validates that confirmation of clinic appointment



Abstract G287 Figure 1 DNA rate results