adiposity in the neonate [SS + TR $p = 0.003$, $p = 0.008$ respectively; Sum of skinfolds $p = 0.011$, $p = 0.002$ respectively] [Table 1]. Maternal early and late pregnancy TNF α was also associated with 6-month-old central adiposity [SS/TR ratio $p = 0.002$, $p = 0.030$, respectively]. Fetal TNF α did not exert a significant influence on neonatal anthropometry but was associated with infant triceps skinfold at 6 months.

While fetal IL-6 was associated with birth length and waist:height ratio, maternal IL-6 was not significantly associated with adiposity.

On multiple linear regression analysis, TNF α contributed significantly to the majority of the final models for both neonatal and infant anthropometry, however, the models themselves were not significant. Any associations between maternal or fetal IL-6 with neonatal and infant anthropometry were no longer significant in the multiple regression models.

Conclusion Maternal TNF α significantly correlates with greater offspring adiposity at birth and 6 months and therefore may act as a potential antenatal indicator of a predisposition towards early childhood obesity.

G314(P) CAN MULTIDISCIPLINARY SIMULATION IN A PAEDIATRIC DEPARTMENT IMPROVE CLINICAL GOVERNANCE?

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Background Simulation is increasingly becoming an integral part in paediatric teaching. It offers an excellent opportunity to practice medical emergencies in a safe environment and allows addressing human factors that are pivotal in safely managing the critically ill child. However, multidisciplinary simulation in our paediatric unit has also facilitated discussion about clinical governance issues within the wider institution.

Aims Does multidisciplinary simulation program in paediatrics address clinical governance issues?

Methods Over a four month period ad hoc in house multidisciplinary simulation sessions involving medical and nursing staff of all levels from the paediatric, anaesthetic, radiology and emergency medicine department were conducted. The simulation sessions were held on paediatric wards and in the emergency department. Faculty members were resuscitation officers, paediatricians, anaesthetists and nurses with experience in conducting simulation. The sessions lasted 20–25 min; followed by debrief for another 20 min. Immediate feedback on the simulation sessions and learning points was obtained. The quality, the usefulness and the conduct of the simulation were evaluated in a feedback form.

Results In total, thirteen simulation sessions were held over a four month period and there were an average of 11 attendees per session. During immediate discussions areas of concern were identified. These included clinicians' performance, human factors and clinical governance issues. Governance risks included inadequate resuscitation equipment and emergency protocol folder, access to emergency lifts, and the quality of emergency activation system.

Conclusions Multidisciplinary simulation sessions are an important tool in addressing human factors that are crucial to successfully managing the critically ill patient. Multidisciplinary paediatric simulation has been vital in identifying and addressing

clinical governance issues such as above. Subsequently, these areas of improvement were escalated to the divisional management team and appropriate steps were taken to address them and minimise the risk to sick children.

G315(P) DOCTORS, DEATH AND DIVERSITY: ARE WE AWARE OF THE CULTURAL NEEDS OF PARENTS DURING BEREAVEMENT CARE?

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Background When a child dies, the interactions between medical professionals and parents are remembered clearly and impact significantly both positively and negatively on the family's grieving process and eventual recovery. In our richly multi-cultural society it is an increasing challenge to provide sensitive, appropriate bereavement care.

Aims To determine whether paediatric doctors have basic knowledge of the cultural practices during end of life care associated with the five main religious affiliations present in our community (Muslim, Christian, Jewish, Hindu and No Religion).

Methods An electronic questionnaire was sent to all paediatric trainees and consultants working in hospitals in one training sector of the UK. A combination of case based multiple choice questions and single answer questions were used. Results were collated anonymously.

Results 111 (28%) of questionnaires were returned. Most doctors were able to identify Faith Leaders of Islam and Judaism (83% and 81% respectively), and identify support for those of no specific religious affiliation, however only 5% of respondents could name a Faith Leader for Hinduism. Regarding actions at the time of death; Christian rituals were best understood (66%) followed by Islamic (54%), Hindu (44%) and Jewish (30%) traditions. Only 28% of respondents were aware that organ donation is not strictly forbidden in any of these religions. Overall, there was no relationship between training grade and cultural knowledge.

Conclusions As doctors we are not well informed about the predominant religious needs of our community. This is likely to impact adversely on our ability to offer appropriate bereavement care to parents. Our false beliefs about barriers to organ donation may also prevent us from offering this opportunity to newly bereaved parents. We plan to produce a nationally available training package in order to equip paediatric doctors with the knowledge to provide high quality, culturally sensitive end of life care.

G316(P) CHRONIC AND COMPLEX CARE – A MODEL FOR GENERAL PAEDIATRIC LEADERSHIP IN A TERTIARY CENTRE

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Children with complex needs and their families coming into hospital with an acute admission may face a very unfamiliar environment despite perhaps having been under the care of community multidisciplinary teams for years.

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