There was no local Tier 2 or 3 weight management services available for this age group.

The school doctor action plan included education of teachers on obesity and introducing Tier 2 lifestyle weight management programme as pilot for secondary students. The special needs dietician negotiated a reduction of puddings. The dietetics service commissioners were informed of the need, resulting in plans to expand the service.

Conclusions There were many overweight students previously unidentified that required further management. Teachers did not accurately identify students that are overweight and therefore might not be best placed to initiate referrals. There are gaps in school health service including screening for obesity and services that should be in place for this age group according to NICE guidance. In today's obesogenic environment the school doctor role should include advocating for students to attain healthy weight, (Measuring Up 2013).

Acknowledgments School nurses, Teachers, Kitchen Staff, Dietician, Students and Parents, Tier 2 Team

G466(P) PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG) IN DISABLE CHILDREN – A BENCH MARKING EXERCISE

SS Saran, DW Wasala, NA Ayub. *Paediatrics, Royal Shrewsbury Hospital, Shrewsbury, UK*

10.1136/archdischild-2015-308599.420

Background The Paediatric Gastroenterology Unit based at the Royal Shrewsbury Hospital provides a service for two hospitals. Its subsequent management is supported by the Community Paediatric Nurses.

A benchmarking exercise of the PEG Service was undertaken and audited against the European Society for Parenteral and Enteral Nutrition (ESPEN) Guidelines.

Methods All children with a PEG in-situ were identified from the Community Nurses PEG database. The electronic records of these patients were accessed for relevant data and input into a Microsoft Excel 2010 database by a single researcher. The ESPEN standards were used to audit the service in the relevant domains.

Results 53 children with a PEG were identified. There was a clearly documented indication for a PEG in 96%, with neurologically disabled children at risk of aspiration comprising the largest group (47%). Feeding difficulties and Failure to thrive (FTT) made up 30% while other indications were Sensory Feeding Disorder in combination with other primary disorders (13%) dysmotility (4%) and metabolic causes (2%). The primary diagnosis was neurological in 55%, gastrointestinal 11%, renal 4% and cardiovascular, respiratory and endocrine 2% each. There were multiple diagnoses in 11%

Nasogastric feeds were instituted and documented prior to the PEG in 94% and may have been used in a further 2% but not documented.

More than half the children had their PEG sited at the age of 13–36 months (52%), a further 15% under 13 months while 20% were after the age of 36 months. Almost one third of the children (29%) had no complications from the PEG. Localised infection was the commonest complication (28%) with granulation tissue (13%), mechanical problems (dislodgement 8%, blockage 4%), skin ulceration (10%) and leakage (8%) as other complications.

PEG feeds were successful in improving the weight centiles of these patients.

Parental satisfaction with the service could not be evaluated retrospectively.

Conclusions The PEG Service at the Shrewsbury and Telford Hospitals NHS Trust adheres to ESPEN standards in the majority of patients and is associated with a low complication rate. Parental Satisfaction with the service should be sought prospectively.

G467(P) AUDIT OF THE QUALITY OF MEDICAL REPORTS FOR CHILDREN WITH SPECIAL EDUCATIONAL NEEDS

¹A Goodson, ²T Juniper, ²C Lloyd, ²H Miller, ²P Reid, ¹M Rose. ¹Department of Community Paediatrics, Oxford University Hospitals Trust, Oxford, UK; ²Medical School, Oxford University, Oxford, UK

10.1136/archdischild-2015-308599.421

Introduction The purpose of the statutory assessment of a child's Special Educational Needs (SEN) is to gain clear picture of the whole child. Medical advice must be included and should describe any health provision reasonably required by the child's learning difficulties or disabilities. Families are now involved in the co-production of their child's Education Health and Care plan. For medical advice to be effective, it needs to be clear, accessible and specific, and ideally written in layman's terms.

Aim To assess the quality of the medical reports submitted to education for Statements of Special Educational Needs.

Method We audited all the medical reports submitted to education between January and June 2014 for a Statement of Special Educational Needs (SSEN). This work was part of pilot exploring data collection on child disability for planning purposes. A limited number of quality indicators were selected from medical advice guidelines. Data on coexisting health needs and actions arising were also recorded.

Results A total of 125 reports were analysed for children, median age 8.8 years, 74% boys. 48% of the reports were derived from existing medical records. 52% of reports were generated after a new medical consultation. Results from this latter group are presented.

85% reports recorded growth, 85% vision, 72% hearing and 65% all three. Many medicals made reference to a lack of background information, especially for children with SEMH, ASD/ADHD.

Advice related to the child's SEN and to associated medical problems (such as asthma) was not written consistently.

Many associated health problems were identified: 11% of children were overweight, 18% obese. 17% had visual problems, 14% nutritional, 15% continence, 11% general medical problems. In many instances these problems were severe enough to prompt referral to therapy services for 9%, to CAMHS 8%, continence 5%, general medical 9%.

Conclusions The quality and detail of the medical reports was very variable and the medical examination identified many unmet health needs that might otherwise not have been recognised. These findings will be used to inform the crafting of medical advice and the development of new tools and guidelines for EHC plans.