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 dietician and teachers 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

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**

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**Introduction** The purpose of the statutory assessment of a child’s Special Educational Needs (SEN) is to gain a 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 (SEN). 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.
THE MAJORITY OF REFERRALS FROM GP TO GENERAL PAEDIATRIC OUTPATIENT CLINIC COULD BE MANAGED BY ALTERNATIVE METHODS

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Aims
1. Audit 100 referrals made to a hospital general paediatric outpatient clinic from General Practice to assess (i) Appropriateness (ii) Possible alternative methods of management
2. Implement alternative and innovative methods of management using a multi-professional approach
3. Improve quality of care for patients

Methods
Using a proforma, each referral was assessed by 3 people: A Paediatrician (taken from a pool of 3 Consultants), A GP physician (taken from a pool of 2) and A Paediatric nurse specialist

Results
76–97% of patients seen in paediatric general outpatients could have been managed with at least one alternative method. The range reflects variation in assessor’s opinions (Figure 1 and Table 1).

Conclusions
The majority of cases seen in general paediatric outpatients in this sample did not require secondary care. Importantly, this study suggests that, with the support and partnership of secondary care, General Practice has the potential to be able to provide a safe, more rapidly accessible and cost-effective paediatric service than that currently being offered at the level of a general paediatric outpatient clinic.

In terms of our progress: (i) Telephone hotline will be rolled out shortly (ii) Rapid access clinic opens in April 2015 (iii) Roll out of Community nurses (multi-professional approach) (iii) Development of email service and virtual clinic (iv) Increased support for GPs

EFFECTIVENESS OF A NOVEL PATHWAY TO REDUCE VITAMIN D DEFICIENCY IN A HIGH RISK POPULATION

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Aim To evaluate whether we have been successful in reducing Vitamin D deficiency in non-ambulant children in a Special School

Background Vitamin D is derived from exposure to UVB light, and from dietary sources, it plays a vital role in calcium homeostasis. Consequences of vitamin D deficiency include; osteopenia, rickets, poor growth and muscle weakness. There is also the risk of not achieving maximal bone mineral density, with subsequent long-term consequences for adult bone health.

We investigated a group of children attending a special educational needs school; with a diagnosis of cerebral palsy or neuromuscular disorder.

These children are categorised as high risk for vitamin D deficiency. The aim was to assess vitamin D status and determine whether levels improved with supplementation.

Method 25–Hydroxyvitamin D levels were analysed from blood tests for 52 children collected from 2010 – 2014.

Standards
Optimal >75nmol/L
Normal >50nmol/L
Insufficient 25 >50 nmol/L
Deficient <25 nmol/L

Results
44 children had >1 vitamin D blood test result available. 20—35% of children had insufficient or deficient levels detected during screening.

Deficient vitamin D levels None remained deficient on final blood test.
50% improved to normal/optimal levels with supplementation.

Insufficient vitamin D levels 77% remained insufficient on final blood testing
50% improved to normal/optimal levels with supplementation.

Conclusion In a cohort of 44 children undergoing surveillance for vitamin D levels, 55% had insufficient or deficient levels during the screening process.

All of the children diagnosed with Vitamin D Deficiency had increased levels on subsequent screening, 50% improved to normal or optimal levels.

However 77% of children with insufficient Vitamin D levels on screening remained insufficient.

From our experience lack of compliance in supplementation was evident in the ‘Insufficient’ group. This subgroup of at risk children and their caregivers require further information regarding the benefits of normal/optimal vitamin D levels and subsequent bone health. We are offering alternative supplementation regimes to try and improve compliance.