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

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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

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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.

G468(P) 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

Could the patient have been managed by alternative methods?

Abstract G468(P) Figure 1 Alternative methods of management

Abstract G468(P) Table 1

	Average time lapsed to secondary care (days)
Symptoms not resolved	58.8
Symptoms resolved	72

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) (iv) Development of email service and virtual clinic (v) Increased support for GPs

G469(P) 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 testing

50% improved to normal/optimal levels with supplementation.

Insufficient vitamin D levels 77% remained insufficient on final blood test.

23% improved to normal or optimal.

Of the 44 children: 45% had optimal/normal vitamin D levels throughout.

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.