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George Still Forum

G507 RELATIONSHIP DEVELOPMENT INTERVENTION; A DEVELOPMENTAL PERSPECTIVE TO AUTISM MANAGEMENT

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Introduction/Aim The aim of this paper is to present the experiences of two families of children with autism spectrum disorder (ASD) using a particular intervention.

The deficits of individuals with ASDs can be divided into homogeneous "primary" deficits, which define the disorder, and heterogeneous "secondary" deficits, which may or may not be present. Primary deficits reflect poor development of dynamic neural functioning and the failure to develop dynamic intelligence.

NICE Guidelines The management and support of children and young people on the ASD (August 2013) recommends that interventions for core ASD features include training of parents, caregivers, and teachers to increase joint attention and reciprocal communication using video-feedback methods appropriate to the child's developmental level.

One such intervention, Relationship Development Intervention (RDI), uses the principle of typical development of Dynamic Intelligence via Guided Participation relationship, which either never gets to develop or gets disrupted early in the development of a ASD child. (development psychology research)

RDI is implemented through intensive parent education to reconstruct their natural "guide" relationship from a developmental perspective, modelling and role-playing, regular videotape review of parent-child performance, and school staff training.

Methods This intervention has been used on my own son for 3½ years and another child with an ASD for 1 year. They were followed through regular videos and Relationship Development Assessment (RDA) of the child and parents every 6 months.

RDA consists of a semi-structured observational assessment (RDA-RV) focusing on three interpersonal parent-child processes: shared attentional focus, ability to co-regulate an interaction, and ability to share emotional experiences.

Results Both families showed improvement in their child's ability to interact and engage, accept and adjust actions with parent modelling and pace adjustment, understand changes and

variations with continuity, and co-ordinate their actions with others.

After RDI for 3½ years One child was able to 1) understand and use nonverbal cues, gestures, and facial expressions; 2) explore new situations and activities, participating with other adults to learn; and 3) handle group activities/peer games like almost any normal child.

Conclusions The results show overall improvements in functioning related to ASDs. An examination of the literature reveals a growing body of empirical evidence and best practice recommendations supporting the practices embedded in RDI.

G508 ARE PAEDIATRIC SERVICES BETTER GEARED UP THAN CAMHS TO MONITOR PATIENTS ON STIMULANT MEDICATION?

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Stimulant medications are widely used to control symptoms of Attention Deficit Hyperactivity Disorder in children and NICE has issued comprehensive guidelines in 2008 about diagnostic criteria based on DSMIV and monitoring of patients on medication

RCPSYCH under QIP through PRESCRIBING OBSERVATORY FOR MENTAL HEALTH -UK (POMH) undertook a national audit – topic 13a "prescribing for ADHD medication" 2013.

Audit tool, sampling options poster and participation were sent to POMH lead contact. Data was collected over a period of one month and entered on line. data was analysed over 6 month period and results were published. It measured 6 standards Heart rate, BP, Height, Weight, Cardiovascular risk assessment and substance misuse risk before starting treatment, 3 months after and over a year

There were 5479 patients in 48 Trusts under 370 clinical teams. There were 429 Paediatric patients in the sample treated by paediatricians. 3737 by CAMHS teams and 1313 adult patients. Children aged 13–8 were the largest group, 83% were male, 80% were caucasian. commonest co morbidities: 25% had sleep disorder, 23% pervasive developmental disorder. Adults had 25% had mood, personality and stress disorder. 30% had no co morbid disorder.

Our Trust compliance was highest in the sample with 100% in all the 6 standards before and 3 months after starting treatment and 88% over the year.

We provide ADHD service in DGH setting and treat ~ 200 patients per year. We run 4 dedicated clinics a month and have designed specific templates for initial and follow up clinics to capture the data and paediatrics is more familiar in plotting growth charts, measuring BP and performing physical examination than CAMHS colleagues which has helped us to do well in this audit. A well focussed team with limited resources can provide high quality care and this has been reinforced by a recent service user survey.

It is unclear from this audit what percentage of services are provided in UK by paediatricians and CAMHS. As the project was initiated by RCPSYCH Paediatricians providing a service were probably not aware hence less data input.

G509(P) MANAGING PARENTAL EXPECTATIONS IN PAEDIATRIC ADHD CLINICS – A NEW MODEL OF CARE

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Method A Prospective, questionnaire based study of parental expectations of children and adolescents attending a Paediatric ADHD follow up clinic from July 2013–august 2014. Case selection through the hospital appointment system, by parental choice.(clinician blinded).

80 completed forms were evaluated. Clinical details were verified from electronic records at data entry.

Results The age of children and adolescents who attended the clinic ranged from 6–17 years with a mean of 10.90yrs. The M:F ratio was 74:6. The primary diagnoses were ADHD(43.7%), ODD(20%), ASD (5%), CD (5%), LD (5%), Tourette's, anxiety and behaviour problems. Secondary diagnoses were ADHD (25%), ODD (15%), Social Interaction difficulties, insomnia, anxiety and significant mental health problems

56% were satisfied with the ADHD management, 5% had a mixed reaction and 5% not.18.7% did not comment. The rest did not have ADHD.

The reasons for satisfaction were as follows 25% happy about overall Mx, 12.5% about the medication response, 5% about symptom improvement.no comment from the rest.

Reasons for non-satisfaction were lack of CAMHS support, lack of educational support, no improvement of symptoms.

Conclusion The model of care based on parental expectations should provide a quick and easy approach to manage the next consultations effectively by focusing on reasons for satisfactions and not during the previous. A larger study awaits.

Parental Expectations at review

Primary management	Secondary management
Aggression	Sensory issues
Behaviour	Sibling rivalry
Medication review	Non compliance
Symptom review	Memory improvement
Anxiety	Dependency on Rx
exclusion	housing
transition	DLA
Good Exams results	Educational support
Self esteem diagnosis	Hygiene counselling
Therapy to Stop lying	Impact of puberty
Therapy to Stop stealing	Relationship advice
Improve sleep	
Improve social interaction	
Better handwriting	

RCPCH Quality Improvement Trainee Session

G510 IMPROVING CHILD HEALTH OUTCOMES THROUGH INTEGRATED CHILD HEALTH TRAINING CLINICS

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Context Set in local GP Surgeries, integrated child health training clinics, for infants, children and young people under 18 years and parent/carers. The work involved secondary, community and primary care health care professionals: GP and Paediatric Registrars, GPs, Consultant Paediatricians, Practice Nurses and Health Visitors.

Problem Child health outcomes in the UK are amongst the worst in Europe. Care is often fragmented, especially at the primary/secondary interface. The curricula across professional groups is varied and locally professionals in these pathways are unknown to each other with little shared understanding of one another's practices.

Assessment of problem and analysis of its causes Nationally it is reported that not all GPs have dedicated child health training. Paediatric trainees report suboptimal experience of outpatient clinics and management of long term conditions, and this was evidenced in a local survey. Integrated training was identified as a potential solution via an early pilot that suggested it could improve knowledge, skills, and working across professions. An aim was to understand the nature of this learning, if a change in outcomes was possible, and the feasibility (including economic viability) of a refined model.

Intervention A GP ST3–4 is paired with a Paediatric ST5–8 to see children together in the GP Surgery for a set of 4–6 sessions over six months. Seeing booked and “walk in” patients they are supervised locally and remotely by trainers/consultants who facilitate reflective learning. Cascading of learning happens at MDT meetings after clinics and at workshops.

Study design A pragmatic, mixed method evaluation of the pilot.

Strategy for change A representative project team led by a Registrar was set up (including a lay advocate). Workshops addressed problems and shared best practice e.g. how to get the most out of the clinics. Learning teams disseminated results locally to their peers. An aim was to develop a ‘how to’ guide to support roll out after the six month pilot.

Measurement of improvement Qualitative information was gathered through workshops, analysis of learning logs and interviews. Reported learning was analysed thematically. Families' feedback was achieved via questionnaires and follow up telephone interviews. A retrospective notes audit using NICE Quality Standards in four common childhood conditions was undertaken before, during and after the clinics avoiding the Hawthorne effect. A health economics model was developed to inform conclusions.

Effects of changes 44 Learning pairs and their teams were involved in learning that was rich and spanned clinical knowledge, skills and how to work well across professional boundaries. Ongoing relationship have been established with verbal handovers taking place where they did not exist before. From 848 consultations, 351 patient surveys were completed. 99% had a good experience of care with 87% more confident to manage their child. Adherence to NICE guidance moved from 57% before, to 72% during and 76% after [$p < 0.01$] and suggests learning can be significant and immediate during the clinics. The economic modelling showed that only a small change in outcomes was required to make the model viable and we concluded this change was practical and achievable. This is a dynamic tool that can support integrated child health.

Lessons learnt The main barriers were clinical release for Paediatric registrars from hospital posts and embedding the MDTs. The most successful solution was getting buy-in and support from the supervisors and consultants. Once engaged, and clinics