

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

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|----------------------------|----------------------|
| 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