We review the literature on the incidence of such events and conclude that these are likely to be under-recognised and under-reported. We subsequently make a case of why these cases should be reclassified as 'never events'. Finally we make recommendations on, what procedures can be followed to minimise the incidence of such events.

G411(P) CAPTURING CHILDREN AND YOUNG PEOPLE'S VOICES: IMPROVING PATIENT-CENTRED PAEDIATRIC CARE

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Aims The intention of the survey was to provide actionable insight into the experiences of children, young people and their families when receiving care as an inpatient or day case admission at NHS trusts.

Methods The Children and Young People's Inpatient Survey was developed and piloted by Picker Institute Europe alongside specialist children's hospitals in 2010. Focusing on aspects of care that children reported as important, this survey has been extended to cover day case admission and licensed to the Care Quality Commission since 2014. Running for the second time in 2017, the Children and Young People's Inpatient and Day Case Survey is now a biannual part of the National Patient Survey Programme.

This survey was specifically designed to be engaging and child-friendly, containing three versions of the questionnaire: one for parents of children aged 0–7 years; one for children aged 8–11; and the other for 12–15 year olds. Whilst targeted at children/young people, the last two versions contained sections for parents/guardians to also provide feedback.

Results presented are from 71 acute NHS trusts in England. Each provided a systematic stratified sample (three age brackets, date of birth and gender), totalling 73 344 patients who received care between October and December 2016. Feedback was invited via postal questionnaire sent to patients' home addresses, followed by two reminders to non-responders.

Results An overall response rate of 26% (n=18,687) for eligible patients was achieved, of which 92% of children reported that overall they were (very) well looked after. Similarly 84% of parents felt that members of staff definitely provided information about their care and treatment that they could understand. However, 55% of children did not feel fully involved in decisions about their care and treatment, with 30% reporting that they did not always understand what hospital staff said and 22% not being able to fully discuss their worries.

Conclusions The survey provided a high level of actionable feedback, highlighting some areas of good performance, for example most children felt able to ask staff questions, as well as areas for improvement such as greater provision of emotional support.

G412(P) SHARING 'BEST PRACTICE' AMONGST TRAINEES AND TRAINERS TO OPTIMISE THE QUALITY OF PAEDIATRIC TRAINING

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Aims The Paediatric Trainee Survey is performed annually in a continuing effort to improve paediatric training across the deanery by anonymously obtaining feedback from all Paediatric trainees about their experiences in training. Every year, this survey highlights a wide variation in quality and practice in training across the deanery. Therefore, this project aims to identify the local practice which makes certain trusts excel in their training feedback and distribute this information across the deanery with the goal of ensuring equal standards and experiences.

Method Using the 2016 Paediatric Trainee Survey, we analysed the quantitative results and identified the top three performing trusts for each of the selected five survey indicators. These indicators covered the following aspects of training; Induction, Internal and external teaching opportunities, management experience and training, clinical leadership training opportunities and teamwork and morale in the department. The College Tutors and Trainee Representatives for the identified trusts were contacted with specific questions related to their indicator to obtain information about their local practice. This information was collated and distributed on the Deanery bulletin and website and at Deanery training days with feedback obtained through discussions with trainees and trainers.

Results Feedback was obtained and analysed from the top performing trusts and common themes in local practices were identified for each of the five survey indicators. These themes were named 'Best Practice' and shared amongst the trainees and trainers in the deanery.

Conclusion This project has highlighted main themes in practices in five key aspects of Paediatric training which have been shared across the deanery to improve the overall standard and experience of Paediatric Training. Subsequent work is required to obtain the same information amongst the remaining survey indicators highlighted in the annual Paediatric Trainee Survey and in distributing these practices to other deaneries in the United Kingdom.

G413(P) NICU QUALITY IMPROVEMENT: MESSAGE OF THE WEEK!

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Aims Critical or High Level Incidents are unfortunately a part and parcel of clinical care, which we all strive to eliminate or at very least minimise. In most units, when they occur, an incident form is submitted online by the clinical staff involved. An investigation may be carried out, and the individuals involved receive feedback. Often, incidents recur due to poor awareness of past events, as disseminating information to different clinical teams is challenging.

To enhance awareness of NICU High Level Incidents, this large neonatal intensive care unit has sought out novel ways to disseminate feedback on incidents occurring, to improve clinical practice and maximise learning from adverse events or near misses. As part of improving knowledge of HLIs and the investigation outcomes, a middle-grade Risk Management role was created in May of this year, alongside the corresponding senior nursing roles.

Methods Since commencement of this QI initiative, the named Risk registrar acts as a liaison doctor, disseminating feedback

on a weekly basis to the medical team, through (P) production, email and discussion at communication meetings. Information given highlights recurrent themes, near misses and the learning points from recent HLIs. In tandem, nursing teams receive similar feedback about incidents relevant to the care that they provide.

Results In this 60-cot unit, 40 to 60 critical incidents are reported each month, demonstrating our culture of openness and education. Since May 2017, Messages of the Week have focused around medication errors (prescribing and administration), inter-specialty communication, discharge planning, documentation and WBITS (wrong blood in tubes.) There is a significant improvement in reported awareness of HLIs at all grades.

Conclusion As we strive to improve the quality of care that we provide for our NICU babies and their families, we must continue to explore novel methods of enhancing education and communication within our teams. With challenges in shift working and high turnover of staff in large neonatal units, disseminating a clinical risk Message of the Week to front-line medical and nursing staff is an effective way to ensure lessons are learnt from adverse events.

G414(P) ALWAYS EVENTS: LESSONS IN PAEDIATRIC CARE

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Aims 'Always Events' is a framework of practice that aims to improve patient experience through positive goal-setting in a person- and family-centred approach. Through partnering with patients and their families, the aim is to identify fundamental behaviours that should be performed by the healthcare system for every patient, every time¹.

The aim of this study was to explore families' experience of their inpatient journey to inform the development of Always Events guidelines with the ultimate goal of enhancing families' experience of care.

Methods We conducted one to one structured parent interviews exploring aspects the parents or their child had experienced while on either the general paediatric or neonatal ward. The interviews and questions were designed to encourage open discussion focusing on the patients' journey in the department from admission to discharge, aimed at identifying practices that could be integrated as Always Events. Responses were transcribed, collated and coded.

Results 23 interviews were conducted: 9 from the general paediatric population and 14 from the neonatal unit. The responses were positive, with all parents reporting a high level of care and appreciating being asked what mattered to them. Themes considered to be key in improving their experience included honest and informed communication (both staff to staff and staff to parent), collaborative and practical understanding of care (parental education, familiarisation of the unit before and during admission, and comprehensive discharge decision making), and the creation of a safe and comfortable environment. Parents on the neonatal unit also cited peer support as highly valuable.

Conclusion This pilot study highlighted the value of engaging families in establishing potential Always Events within the

paediatric department. Two benefits emerged: firstly, parents enjoyed providing feedback and found the process rewarding; secondly, it identified valuable experiences relating to everyday care which could be explored further and used to develop fundamental principles. Our next stage is to explore these themes through multi-professional and parental focus groups with the aim of co-designing and implementing Always Events.

REFERENCE

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G415(P) OBSERVATIONS IN A PAEDIATRIC EMERGENCY DEPARTMENT: IMPACT OF SKILLMIX ON TIME SPENT DURING PATIENT ASSESSMENT

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From the coal face to strategic planning many assumptions are made about what staff do when working and the cost of training to trusts. It is assumed that less experienced staff earlier in their careers take longer to manage clinical problems than senior doctors. This assumption has been investigated in adult acute care settings.¹The present study was stage1 of a quality improvement approach looking at factors that might detract from patient throughput.

One medical student (AF) observed individual patient assessments by medical staff over 4 weeks. Time spent undertaking different activities from point of first contact up to discharge were recorded. Post-discharge activity was recorded separately, plus qualitative data relating to outcomes.

43 consultations were observed. All assessments were completed within 4 hours. Systematic delays varied between patients but contributed to 19% of total time. Documentation made up 12% of patient contact time. A number of simple issues were identified as contributing to time delays – eg difficulties in communication between hospitals, incorrect labelling. Seniors were significantly quicker in assessing patients than junior trainees, and also spent the least time with the patients. Total time spent on patient care was not significantly different across all grades of juniors and consultants. Time spent on senior reviews was significantly greater for junior trainees compared to middle grades.

These findings are similar to observations in adult medicine about assessment activity.¹ They provide some insights into the relative costs and utility of different grades of staff. Understanding how work occurs gives an opportunity to develop new working practices. Senior medical staff are more efficient in clinical assessment, but no more efficient in documentation than juniors. The next phase of this study is to work within the department to highlight opportunities for greater efficiency in relation to systematic delays and documentation.

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G416(P) A HOSPITAL-BASED SURVEY OF ORAL HEALTH KNOWLEDGE AND PRACTICES OF PARENTS AND CARERS IN DERBYSHIRE

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Background Tooth decay is largely a preventable disease. It affects almost a quarter of 5-year-olds and was the most common reason for hospital admission for children aged 5–9 years in 2014–2015 in England. There is a huge financial burden of tooth decay on the NHS.

The aim of our survey was to ascertain the oral health knowledge and practices of parents and carers of children attending the Derbyshire Children's Hospital.

Method Parents or carers of children attending our hospital were surveyed between August and October 2017 using an anonymised paper-based questionnaire. It was developed using the 'Delivering Better Oral Health' document, which is an evidence-based toolkit published by Public Health England. The questions assessed knowledge, oral hygiene regime and dietary habits. Oral health information leaflet was provided after completion of the questionnaire.

Results Derbyshire Children's hospital is a busy District General hospital with ~87 000 visits in 2016. A total of 800 surveys were completed representing about 1% of our expected attendance per year.

Most, 414 (52%) were ≥7 years old, whilst 217 (27%) were 0–3 years and 166 (21%) were 4–6 years old. Only 187/800 (23%) of children were reported to be brushing their teeth correctly. Additionally, 114/383 (30%) of children ≤6 years of age do not regularly receive appropriate help with brushing. This was significantly worse amongst 4–6 year olds, $p=0.006$. Although 711 (89%) of parents/carers were aware of free NHS dental care for children, only 246 (31%) visited or planned to visit a dentist at the earliest opportunity i.e. as soon as teeth erupt. Parents/carers reported that 172 (22%) of children had unhealthy snacking habits.

Conclusion To our knowledge, this is the first hospital based survey in England. There appears to be gaps in the knowledge of parents/carers regarding good oral health. Our survey also highlighted unhealthy dietary habits with potential implications on oral health and wider impact on health. Oral health should remain in everyone's agenda to enable every child grow up free from tooth decay and have the best start in life. We propose oral health promotion and education for parents, carers and children. Hospital visits provide an excellent opportunity.

G417(P) THE IMPACT OF NON-24 HOUR BLOOD CULTURE INCUBATION AND REPORTING ON THE NEONATAL UNIT

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Introduction A plan to centralise microbiology services in the region has led to a proposal to instal a local incubator near NICU or Paediatric ward. This due to the general consensus that 24 hour blood culture incubation and reporting will

improve our clinical care and shorten the duration of antibiotic therapy and hospital stay of patients. Currently, laboratory staff will incubate blood culture samples only during working hours of 8–12 hours. Negative blood culture at 36 hours, with normal infection markers will allow us to stop antibiotic therapy where a baby is not septic.

Aim To assess the implication of non-24 hour blood culture incubation and reporting on clinical management of babies on the neonatal unit.

Method This was a retrospective audit carried out over 3 weeks. Information was sourced from Laboratory reports, prescription charts and medical notes. Babies admitted from other hospitals, whose blood cultures had already been taken were excluded.

Results 28 babies were audited from NICU, HDU and SCBU. 22 were screened for early onset sepsis, and 6 babies screened for late onset sepsis. 1 positive blood culture result found. 22 babies had normal CRP at the time of screening and 12–24 hours after the start of antibiotics.

- Time of blood culture taken to start of incubation-

Range: 1 hour 16 min – 13 hours 10 mins

Average: 7 hours 13 mins

- Time of blood culture taken to 36 hours incubation-

Range: 36 hours 50 mins – 49 hours 18 mins

Average: 43 hours

- Duration of antibiotics therapy:

- 5 or more days for 7 babies

- 60 hours for 4 babies

- 36 hours for 2 babies

- 48 hours for 14 babies

Conclusion Non-24 hour incubation and reporting of blood cultures affect the duration of antibiotic therapy. It has no significant impact on the hospital stay on the neonatal unit. However, a similar audit on the postnatal and paediatric ward will show a significant effect of antibiotic duration on hospital stay and its cost to the trust. A local incubator will be essential to the neonatal and paediatric unit.

British Academy of Childhood Disability and British Association for Child and Adolescent Public Health

G418 THE CLINICAL SPECTRUM OF DORSAL STREAM DYSFUNCTION IN AUTISM – A RETROSPECTIVE COHORT STUDY OF 13 CHILDREN

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Aims Bilateral dysfunction of the parieto-occipital cortex, linked to the visual cortex by the dorsal stream, variably produces simultanagnosia (SIM), optic ataxia (OA), and gaze apraxia. This triad, rarely reported in childhood, comprises 'Balint syndrome'. 'Dorsal stream dysfunction' (DSD) describes milder degrees of this disorder.