to the clinical setting; with senior clinicians and nursing staff being less accepting of balanced electrolyte solutions in general ward areas. Significant lack of knowledge of intravenous fluid physiology was demonstrated by some prescribers.

Conclusion Our findings demonstrate an increase in the administration of balanced electrolyte solutions, such as Plasma-Lyte 148, as fluid boluses; this is in keeping with other international surveys of fluid administration (1,2). Similarly, we have also found significant differences in fluid bolus administration practice across different clinical areas as demonstrated by Jonsson and Perner in 2017.

We have demonstrated the importance of on-going multi-disciplinary educational efforts in continuing the evolution of intravenous fluid bolus administration practice to reflect current best practice.

G79(P) PHYSICIAN AND PARENTAL DECISION-MAKING PRIOR TO ACUTE MEDICAL ADMISSION

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Background There is a rising number of acute medical paediatric emergency hospital admissions in England and Scotland, and the rise is explained by increased short-stay admissions. Our objective was to undertake qualitative interviews with parents and clinicians to better understand what factors, other than the health status of the child, may influence decision-making leading to an admission.

Methods Semi-structured interviews were conducted with parents, clinicians working in general practice, out-of-hours or accident and emergency (referring clinicians) and doctors working in acute medical paediatrics (receiving clinicians) within 24 hours of a child being admitted to hospital

Results Ten parents (including one caregiver), seven referring clinicians and ten receiving clinicians were interviewed. Parents described erring on the side of caution when seeking medical opinion and one mentioned anxiety. Among themes seen among referring clinicians, 'erring on the side of caution' was also identified as was managing 'parental anxiety' and acting on 'gut instinct'. Among receiving clinicians, themes included managing parental anxiety and increasing parental expectations of the health service.

Conclusions The study of parent and referring clinician decision-making prior to a hospital admission can identify 'teachable moments' where interventions might be delivered to slow or even arrest the rise in short-stay acute medical admissions. Interventions might, for example, assure parents or referring clinicians that hospital referral is not required and help clinicians understand what they interpret as 'parental anxiety'.

G80(P) HARMONISING ANTIBIOTIC USE WITHIN THE OXFORD ACADEMIC HEALTH SCIENCES NETWORK

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Antibiotic resistance is a very pressing concern to the future of paediatric infections and antibiotic use. We have a duty to

our patients to try and stop further antimicrobial resistance from occurring.

One way we thought we could try and tackle this very pressing concern is to establish a common guideline for antibiotic use for the common paediatric infections in the Oxford Academic Health Sciences Network (AHSN).

A total of 5 hospitals are included in the Oxford AHSN, four district general hospitals and one tertiary level hospital. This project involved a multidisciplinary team of professionals from within each hospital. The multiprofessional team included microbiology consultants, pharmacists, general paediatric consultants as well as infectious disease consultants.

Initially, in this multidisciplinary forum, the group looked at the positive microbiology culture and sensitivity results of all the sterile fluid samples sent to the laboratories, in all 5 hospitals, in the 2 years prior to the start of this project. That is looking at the years 2013–2015, within the region. The sterile fluid samples included were urine samples, blood culture samples and cerebrospinal fluid samples. This was an important initial step as we needed to know if a common guideline was plausible depending on the positive microbiology culture results. This work showed us that the organisms cultured in these samples were very similar, with similar resistance patterns within the whole region. Therefore allowing us proceed to harmonise practice of antibiotic prescribing throughout the network.

The group then looked at all the guidelines for antibiotic prescribing that were present within each hospital at the time. Looking at the similarities and differences at that time. With the results from the microbiology as stated previously and looking at the guidelines presented a consensus was reached within the group.

This project from start to finish took about 18 months to complete.

This guideline has the first line empiric antibiotic therapy recommended for the common paediatric infections including sepsis, meningitis and pneumonia. Also included in the guideline is urinary tract infections, joint infections, soft tissue infections, Ear nose and throat infections and abdominal infections.

This guideline is now embedded in practice in all of the four district general hospitals within the region as well as the tertiary level hospital.

G81(P) BRIDGING THE GAP: GP HUB CLINICS AND MDT TEACHING SESSIONS

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Aims Despite the fact that children account for 20%–25% of the caseload of GPs, training in Paediatrics is not compulsory. Public expectation is that parents should have access to specialist care immediately. Several studies have concluded that substantial numbers of children referred to secondary care can be successfully managed in primary care. These were the main drivers for setting up a GP hub clinic and Multi-disciplinary team (MDT) teaching sessions in our area.

Methods GP hub clinics were set up and evaluated over a period of 7 months between February and October 2017. Each clinic had capacity to see 5 new patients and took place

every 2 weeks. An MDT session on some of these cases was undertaken every 6 weeks.

Results 10 consultant delivered clinics were held. There were 41 new appointments with 3 DNAs and 7 follow ups with 2 DNAs. The DNA rate was 7.3% for new patient slots (hospital DNA rate 14.7%) The follow up to new patient ratio was 1:1.03 (The ratio was 1: 1.56 ratio for the hospital based clinic). 2 patients were cancelled (4%) as opposed to 18% cancellation rate in hospital clinics.

Overall, there was a reduction of 21% of all GP referrals (hub and non-hub clinics) in comparison to the same period in 2016. There was a reduction in referrals of 24% from the practice hosting the hub clinics.

In the opinion of the consultant doing the clinic, the majority of children could have been managed in primary care with GP education (53%); GP advice and guidance (71%) or by an alternative practitioner (53%).

96% of patients were positive about the booking process, the clinic and follow up arrangements. 100% of the MDT session evaluations were positive. The GPs fed back formally and informally that the resource was highly valued.

Conclusion The DNA rate and follow up to new ratio was favourable probably due to the short wait to see the consultant. Parents valued the service as it was close to home and in a familiar environment. GPs valued the MDT teaching sessions. Primary care services need to be supported by secondary care services to bring care closer to home.

G82(P) HOW CONFIDENT ARE PAEDIATRICIANS AT MANAGING ADOLESCENTS WITH ACUTE MENTAL HEALTH PROBLEMS?

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Background Mental health problems are increasing in prevalence within the paediatric population. Paediatricians are expected to work alongside CAMHS teams to assess and support these children, often with little training. In rare cases a child may require sectioning under the Mental Health Act.

This issue was previously raised in RCPCH consultation 'Looked after children: knowledge, skills and competences of health care staff'.

Aims We wanted to examine the experience and training of paediatricians in managing children with mental health problems, particularly with sectioning children.

Methods An online questionnaire was sent to paediatricians across one training deanery. Information was gathered on frequency and experience of sectioning children. We also looked at knowledge regarding available support and training.

Results 27 paediatricians responded: 13 (48%) consultants, 12 (44.5%) registrars, and 2 (7.5%) other doctors.

With regard to managing children with acute mental health issues, 79% of registrars were involved at least weekly, with 85% of consultants involved monthly.

Only 3 doctors (11%) had sectioned a child. Reasons for sectioning were suicidal ideation, food refusal, and acute mental health issues.

All staff surveyed had received support from CAMHS or the hospital crisis team. All of the doctors involved in sectioning children had found the situation difficult and stressful.

78% of doctors surveyed felt that further training on sectioning patients should be available. Those respondents who said disagreed or were unsure about this gave the suggestion that this should be the responsibility of the CAMHS team. There were, however, concerns raised about the availability of urgent expert CAMHS assessment and advice.

Conclusions Children with mental health issues are increasingly presenting acutely to paediatric units. Paediatric registrars appear to be more frequently involved than consultants in their acute treatment. The experience of sectioning a child is rare and usually directed by CAMHS. This is recognised to be a difficult process for paediatricians, who have limited knowledge and confidence in this process.

This survey demonstrates that the vast majority of paediatricians would welcome further training and support in this area.

G83(P) 'LEARNING FROM EXCELLENCE': EXPERIENCE IN A DISTRICT GENERAL HOSPITAL PAEDIATRIC DEPARTMENT

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Aims Dr A.Plunkett pioneered the philosophy of 'learning from excellence'. The method was initiated to highlight that observing and reporting excellence within healthcare can provide new opportunities for learning and improve staff morale.

Our aim was to initiate excellence reporting within our Paediatric Department, assess the uptake amongst staff and evaluate how staff members have found the process.

Methods In July 2017, excellence reporting was initiated. Reporting boxes were distributed within Paediatrics and Neonates. Paper forms are available in these clinical areas which include the report date, name of sender and receiver, reason for the report and details about how we can learn from this. Once a report has been submitted it's collected by a named Consultant who emails the sender and receiver with certificates. The receiver is also sent the written comments.

After initiation of the scheme, questionnaires were distributed to both senders and receivers of the reports to obtain feedback on the process.

Results In the first three months, 78 excellence reports were submitted. Nurses received reports most frequently (32%), followed by trainees (28%). Consultants, clerical staff, student nurses and play specialists have also been reported.

The most commonly reported themes included good team work (38%), good clinical skills (16.7%) and excellent communication skills (11.5%).

Feedback from recipients revealed that 87.5% felt more appreciated at work after their report. 93.7% were very happy to have received their report and 100% felt receiving a certificate as well as the written report worked well. 87.5% of recipients said that they were more inclined to report a colleague following their nomination and this has improved uptake within the department.

100% of senders found the process of completing and submitting an excellence report easy.