Aims Following divisive contract negotiations, with significant pressure on the NHS, and an inflexible postgraduate training system, there is growing concern for junior doctor (JD) morale and engagement. The new JD contract introduces a powerful tool for positive change – the Exception Report (ER). Initial rates of ER have been low, with concerns of JD disillusionment and potential for dis-engagement if responses to ER are perceived as insensitive. We aimed to identify current JD thoughts, ideas and feelings on ER at a specialist paediatric hospital.

Methods A focus group was held to characterise current JD opinion on ER. The group was advertised primarily to Junior Doctor Forum (JDF) members, with JDF members asked to invite their JD colleagues. Eight JDs attended a structured focus group. Opinions and ideas were sought on ER triggers and root-causes, and on potential solutions, as well as current feelings on ER and supervisor approaches to ER that were anticipated to be conciliatory or inflammatory. Findings were presented as mind-maps to the JDF to review completeness and validity.

Results Pervasive themes of clinical workload, doctor-specific admin, staff mix and resultant pressure on educational opportunities arose, along with a recognition that these issues transcend staffing groups. ER was strongly felt to be part of constructive departmental system/structural review, rather than a reflection on the reporter. Themes from the focus group are supported by currently submitted ERs.

Conclusion ER should be considered a symptom of a just departmental culture. They should be used positively to identify system issues, with the baseline assumption that the trainee is not at fault. Financial compensation and time-off-in-lieu (TOIL) are recognised as important, fair, and necessary for safe and sustainable practice, however, recognition of effort, work and personal sacrifice are considered indispensable.

G125(P) 'PAEDIATRIC FAMILIES'- A BUDDYING SCHEME TO SUPPORT NEW TRAINEES

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Aims To improve morale amongst trainees and ensure that they feel supported. The Paediatric Families project was developed in order to provide peer support for new ST1 (the 'child') Paediatric trainees. It was modelled on university budding systems and designed to support new trainees during a recognised challenging period of training.

Methods ST2-ST8 trainees (the 'parents') were recruited through the local paediatric website. Each paediatric training family consisted of two 'children' who were matched with two 'parents'. Matching was geographical sector based and occurred in 2016, prior to commencement of ST1 training. A Typeform survey was sent to all family members nine months later to review experiences of the project.

Results The survey was sent to 179 family members with a response rate of 29% (39% of 'parents' and 19% of 'children').

Only 33% of respondents had met their family. Reasons for not meeting included lack of interest from other family

members (41%) and rota incompatibility (19%). Most family members communicated through email and WhatsApp.

'Parents' stated the advantage of the project was being able to assume a mentoring role (37%) and support junior trainees (33%). 'Children' felt that advantages included mentoring (30%), career guidance (25%) and support (25%).

59% of family members felt that having a paediatric family was useful and 57% agreed that having social events would be helpful.

Conclusion The paediatric family project is a novel practical approach to supporting junior trainees. Although initial interest was high, only a third of families met with the result that over a third of respondents questioned the usefulness of the scheme. Based on the feedback received the following changes have been implemented for the current cohort:

Improved support for parents – including e-mail advice and a 'top ten tips' guide before starting.

Regular organised social events.

Matching within trusts so that family members can have 'on the job' support. In the current cohort currently over 95% of trainees are matched within the same trust.

G126(P) DEVELOPING LEVEL 1 TEACHING IN PAEDIATRICS AS A QUALITY IMPROVEMENT PROGRAMME (QIP)

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STEP 1 teaching is a monthly programme for Level 1 (ST1–3) Paediatric trainees. There has been a great deal of change in education within the Deanery and STEP 1 was noted to be suffering.

Aims Our primary aim was to create a teaching programme for trainees which complied with RCPCH curriculum, was educational and well-received by trainees.

Methods We identified the issues with STEP 1 teaching in September 2016. At this time, we undertook an audit to identify how compliant with the RCPCH curriculum the teaching had been prior to our interception of the project (October 2014 – November 2016). Following this, we produced a STEP teaching programme to roll over 12 months, mapped to the RCPCH Level 1 curriculum.

We contacted Consultants within the Deanery and higher level trainees outlining the programme and asking for teaching support. Once we received interest, we then produced a teaching timetable for the next year which is now complete until July 2018. We outlined the aims for each teaching session ensuring the curriculum was met.

Throughout this QIP, we have undertaken trainee feedback surveys to help develop the programme.

Results The initial audit undertaken showed that of the 12 subspecialties outlined in the curriculum, only 67% were taught. Within these, there was <50% compliance with listed curriculum items.

We undertook trainee feedback surveys which highlighted issues with teaching and suggestions for improvement. Since creating the new teaching timetable, we have sent out a further survey to the same trainees. Results awaited.

Conclusion Having undertaken STEP 1 teaching, we understood the importance of having a well-structured and organised programme and wanted to develop this idea.

The feedback initially identified problems with the quality of teaching, and through organisation and communication with Consultants from the Deanery, we have been able to create a well-structured teaching timetable for the next year involving Tertiary Centre Consultants and District General Hospitals, which complies with the RCPCH curriculum.

We hope to extend this programme to become an 18 month rolling programme. We will continue to undertake regular feedback surveys and forum discussions to continually develop the programme and make it a success.

G127(P) IMPROVING VITAMIN D SUPPLEMENTATION IN CHILDREN AGED 0–5 YEARS BY IMPROVING HEALTH PROFESSIONALS' KNOWLEDGE OF UPDATED VITAMIN D GUIDANCE

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Guidance from the RCPCH and Public Health agency (PHA) recommends all children 0–5 years should receive vitamin D supplementation (excluding those receiving more than 500 ml of formula milk/day).

Aim Our aim was to assess current level of vitamin D supplementation in children aged 0–5 years within our trust and assess awareness of RCPCH/PHA guidance among parents and health professionals.

Methods A survey was completed with parents/carers of children aged 0–5 years attending outpatient clinics. We surveyed if children were in receipt of vitamin D supplementation and parental awareness of vitamin D guidance. Education via vitamin D information leaflets was provided to all surveyed.

An online survey was circulated to medical and health visiting staff. 99 responses were received.

Results 40 children were surveyed. 34 of these children should have been receiving supplements. Our survey identified 15% of these children were receiving supplementation. 75% of parents/carers had no awareness of vitamin D guidelines. There was no uptake of healthy start vouchers for vitamins. Healthy Start is a government scheme aiming to improve the health of low income families including the provision of vitamin coupons.

72% of health professional respondents were aware of vitamin D guidance yet only 14% correctly identified children who should receive vitamin D supplementation. 63% were not aware of how parents/carers apply for healthy start vouchers. 74% stated they had not received training in vitamin D supplementation. Respondents suggested that they would benefit from face to face teaching sessions and e-learning modules.

A teaching programme was created to improve health professionals' awareness of vitamin D guidance. Following attendance at the session 100% of attendee's reported that they felt more informed about vitamin D guidance. 89% suggested that the teaching will change their practice with 93% stating that they will now recommend vitamin D supplementation to children aged 0–5 years in their care.

Conclusion Our project identified the lack of awareness around vitamin D supplementation and emphasises the importance of education amongst professionals to improve vitamin d supplementation within the paediatric population. Ongoing

engagement with the PHA is necessary to improve public awareness and uptake of supplementation.

G128(P) SAFER PRESCRIBING IN ADHD – ALIGNING DOCUMENTATION WITH NICE GUIDELINES

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Aim NICE provide evidence-based guidance for the prescription of medication used to treat school-aged children diagnosed with severe ADHD. A local audit undertaken in 2014 evidenced that prescribing standards were not recorded fully or clearly in the patient's notes. As part of the changes to practice, a new ADHD prescribing proforma was introduced throughout the department to improve patient safety in line with NICE guidelines. As part of a PDSA cycle, a further audit was then undertaken to assess the effectiveness of the changes to practice implemented.

Method Hospital Coding was used to identify children commencing ADHD medication in 2016 in a local hospital. Retrospective analysis of medical notes was carried out to review documentation of the medication prescriptions. NICE CG72 was used as the gold standard.

Results 48 cases were identified with 10 excluded (unable to obtain notes). Male 87%; Female 13%. Following an in-depth analysis of medical notes and clinic letters, the results were not dissimilar to the 2014 findings. Whilst highlighting several positives in prescribing practice, other standards of documentation remained poor (table 1). The proposed prescribing proforma was also not in regular use with only 8% of notes containing a copy.

Abstract G128(P) Table 1

Nice CG72 gold standard	Percentage of cases
First line medication	100%
School-Aged	100%
Professional with ADHD Expertise	97%
Baseline Observations	74%
Part of Comprehensive Treatment Plan	71%
ADHD Severity	8%
Consideration of Comorbidities	34%
Assessment of Cardiac PMH	5%
Cardiac Fhx	32%
ECG	39%
ECG if Positive Fhx	100%
Mental/Social Assessment	13%
Substance Misuse/Drug Diversion	8%

Conclusions Similar to 2014 audit data, documentation in ADHD prescribing remained substandard and did not meet the gold standards of NICE CG72. Through presenting the data and talking to clinicians, it became apparent that some were not aware of the prescribing proforma or did not have access to it. Others were resistant to using something that was felt to be time-consuming or dictatorial to their practice after years of experience.

Subsequently, an abbreviated 'prescribing checklist' has been created in conjunction with prescribers, focussing on the weaker areas of documentation. It aims to being more user