

- when there was concern that a child's problems might be related to prenatal alcohol exposure.

**Results** 20 children were assessed in the first year.

8 children were diagnosed as having FASD. Other problems related to conditions such as attachment difficulties, ADHD and learning disability.

There were a small number of children where prenatal alcohol exposure was suspected but unknown, particularly following adoption.

Some children are still awaiting psychological assessment (due to maternity leave) before a diagnosis can be ascribed.

**Conclusion** It was possible to build in a specialist clinic without significant extra resources.

Additional resources required were a) software required for the facial analysis, and b) training in the use of the 4-digit code (available as an on-line module)

As the clinic developed, an increasing part of the clinic time was taken up with multidisciplinary discussion in 2 areas: what information was available at the time of referral, and what further information/assessments would be required which would be helpful in reaching a diagnosis, and in reaching consensus regarding the final diagnosis.

Informal feedback from teachers, social workers and carers has shown that they have found the clinic helpful and valuable. (formal feedback in progress).

The presence of a specific clinic dedicated to FASD helped provide a focus for referral concerns, develop and concentrate expertise among professionals, and allow ongoing collection of appropriate data.

#### G161 MULTI PROFESSIONAL WORKING TO DEVELOP A HEALTH OUTCOMES FRAMEWORK FOR CHILDREN IN CARE

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**Aim** The aim of our working group was to ensure the health outcome measures for Children in Care (CIC) reported by Providers were consistent, relevant and achievable. An objective of the framework was to be an accountable system, where the partners hold themselves to account through the framework, linked by a shared ambition.

#### Methods

- A service improvement forum was already in place following a long process of service mapping across social care, CIC health teams and CAMHS
- A workshop was held to establish what each service deemed important health outcomes. This was analysed and themes and specifics produced
- Members of the team met with the CIC Council to obtain their views about health outcomes and reporting
- Commissioners, Providers and Designated CIC professionals met to refine a document 'CIC health outcomes framework'

**Results** Themes from CIC Council meeting

- CIC like how personalised the health assessments are, and felt strongly that the information collected and used to inform planning of health services should be personalised and at an individual level
- CIC feel that health services seem more interested in physical health than mental health, but were clear that emotional health and wellbeing is an important issue; this can be difficult to uncover, so indepth assessment, time and creative approaches are needed
- Access to health information when CIC reach adulthood is important

CIC health outcomes framework comprises of

- A 17 page document with 15 performance indicators – measured against standards, evidence, assurance, responsible agency

#### Conclusions

- National measures/indicators are focused on the timeliness of assessments. Local ambitions and outcomes aim to measure the extent to which we are benefiting the health of the children in our care
- There are multiple interdependencies in the CIC health system, with agencies reliant on others fulfilling their responsibilities. Local partnership of agencies could hold itself to account for its effectiveness in working together if the right outcomes were identified, and subscribed to by all parties
- There are challenges associated with having multiple organisations, including several NHS providers, in the CIC health system, particularly with regard to data collection and information sharing. Logistical and transactional challenges can be mitigated by strong and trusting relationships between partners, and a commitment to solution focused approaches

#### G162 EVIDENCE THAT AN IMMERSIVE VIRTUAL REALITY SCENARIO CAN BE USED TO TRAIN SAFEGUARDING TO DOCTORS IN PRIMARY CARE

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**Introduction** Most child protection will be seen in primary care but is often subtle.

**Methods** We invited GPs to undertake a medical consultation in a virtual reality 'cave'. We obtained ethical approval from UCL for this being a covert child safeguarding scenario: participants were informed that they were testing the use of Virtual Reality in GP consultation. We produced a simulated consultation using two avatars: Chris, who came for a medically challenging consultation, and his accompanying 6 year old son Tom. Safeguarding cues presented were either subtle or obvious. Chris was angry towards his son, refused to allow Tom to go to the toilet and appeared to swipe at him.

**Results** We recruited 63 GPs (26 male; 33 female) who ranged in age from 25 to 59 years and had worked between 1 and 36 years. Fourteen GPs failed to detect the safeguarding cues (3 in the obvious cue scenario and 13 in the subtle cue scenario). Analysis of the post scenario questionnaire provides useful information about the use of virtual reality in medical

training. One important question posed after the scenario was 'Were you concerned about Tom's relationship with Chris?' This clearly cued those who hadn't picked up on this previously. All participants including these 14 GPs made comments that they had some concerns about what was going on (see Table). One participant's comments sum it up well. 'He swiped at him at the beginning of the consultation, made a disparaging comment and did not let him go to the toilet'.

**Discussion** The GPs responses to this virtual reality scenario were very interesting. Most of their comments can be applied to real life scenarios but this has to take advantages over using role play often considered as the 'gold-standard'. Young children cannot be used as actors as they are unable to divorce play from reality. This becomes even more pertinent if the subject matter is child protection where there is something unpalatable about using young children who are being abused. By directly filling the questionnaires after undertaking the scenario those who had missed that this was a safeguarding scenario could be cued in a way to reconsider what had happened in a private and constructive way.

G163

### INVESTIGATION OF THE PROCESS AND EXPERIENCE OF GAINING MENTAL HEALTH TRAINING AS A COMMUNITY PAEDIATRIC TRAINEE

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**Introduction** The RCPCH General and Community Child Health (CCH) curricula list nearly 50 competencies related to child mental health. It has long been recognised that these competencies are difficult to achieve without dedicated CAMHS training. As CAMHS is not an *Allied Specialty* according to the RCPCH, an *Out of Programme Experience* or *Training* (OOPE/T) must be undertaken.

**Aims** To explore the process and benefits of a CAMHS training post for CCH trainees.

**Methods** A focus-group discussion at a regional training meeting, followed by collaboration with a colleague undertaking a survey of CCH trainees nationally, explored the attainment of mental health competencies. The steps followed to undertake formal CAMHS training were: identification of a suitable OOPT post, approval from the local department, the NHS trust, the Deanery, the RCPCH and the GMC.

**Results** Local and national surveys highlighted the difficulties in achieving mental health competencies within standard CCH training as well as lack of provision of CAMHS training. The process of applying for an OOPT took 12 months and was fundamentally facilitated by supportive, professional links between the local CCH and CAMHS Consultants. The CCH CSAC was supportive, and recognised the opportunity for competencies to be met.

**Conclusions** Benefits for the trainee, the CAMHS team, the CCH team and patient care were identified. Weekly consultant supervision and regular joint assessments provided ample opportunity to complete workplace-based assessments. There were opportunities to work within all CAMHS subspecialties. Attendance at CAMHS regional weekly registrar training meetings provided further learning and networking opportunities.

A formal training post in CAMHS led to valuable clinical experience for a future consultant career in CCH, but would

also be valuable for trainees in General Paediatrics or other sub-specialties. The post in itself naturally led to a liaison role, facilitating communication between CCH and CAMHS teams and benefiting patient care.

Future work to streamline the process of accessing this type of post by the RCPCH and RCPsych will be of great benefit for the specialities as a whole, to the local departments and ultimately for the patients being treated in those settings.

G164

### INTRODUCTION OF CPIPS WITH COLLECTION OF CLINICAL AND PATIENT JOURNEY DATA; EARLY OUTCOMES FROM 'ONE-STOP' MDT CLINIC ARE REDUCTION IN OUTPATIENT TIME, SHARED TEAM DECISION MAKING AND PROBABLE REDUCTION IN TIME TO INTERVENTIONS

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**Background** Children with cerebral palsy (CP) are recognised to have long-term morbidity. CPIPS (CP Integrated Pathway Scotland) standardises management and has been shown to reduce hip dislocation and surgical intervention. Benefits of this approach are 1) appropriate and evidence-based surveillance and 2) early referral to appropriate specialists. There are improved patient outcomes following CPIPS introduction, however limited studies reporting patient journey or financial healthcare outcome measures.

**Aims** To report outcomes of the graded introduction of CPIPS, initially the 'one stop' MDT clinic.

**Methods** Retrospective review of healthcare records of all children seen in CPIPS clinic (March-October 2017); reporting clinical and patient journey outcomes.

**Results** 23 children have been seen in the CPIPS 'one stop' clinics; which include a community paediatrician, paediatric orthopaedic surgeon and physiotherapist. 17% (4/23) children had significant medication changes; such as starting muscle relaxants. 65% (15/23) children had subsequent list for specific specialist management, with 13% (2/15) receiving botulinum toxin injections and 87% (13/15) being listed for orthopaedic surgery.

These children were previously seen separately by specialists therefore we estimate that 23 extra outpatient appointments are available. Single clinic attendance is beneficial for children (reduce time away from school) and families (reduced travel/missed work, parking expenses, inconvenience).

Clinicians reported that shared decision making during the clinic facilitated 1) team learning 2) patient-centred holistic decision making taking into account family circumstances 3) facilitated subsequent treatments as relevant teams were present with the family to plan optimum interventions and timings.

**Conclusion** We present initial outcome data from the CPIPS 'one stop' MDT clinics, which have demonstrated shared decision making, positive initial comments from both professionals and families; and a theoretical financial benefit with reduced clinic usage and probable shorter time to interventions. 65% of children were subsequently booked for specialist intervention, supporting the need for 'red' alerts prior to review, ensuring appropriate children are assessed.

Further studies are needed to explore the clinical and patient journey outcomes in children with CP; alongside the outcomes