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

¹C Coleman, ¹S Haden, ²E Fergusson, ³E Payne. ¹Community Paediatrics, Oxford University Hospitals Foundation Trust, Oxford, UK; ²CAMHS, Oxford Health Foundation Trust, Abingdon, UK; ³Community Paediatrics, UK

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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

¹S Pal, ¹J Taylor, ²K Stohr, ¹A Sansome. ¹Community Paediatrics, Cambridgeshire Community Services, Cambridge, UK; ²Trauma and Orthopaedic Surgery, Cambridge University Hospitals NHS Foundation Trust, UK

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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