achieve essential national and international standards for CHD service provision on the Island. The basic concepts of such a network are of partnership, service integration and formal arrangements.

Results To date, all NI Cardiac Catheterisations are carried out in ROI. In addition, all NI emergency and urgent surgical cases have been transferred to ROI, thereby eliminating the need for children and families to travel to GB. During 2018, the Network commenced the transfer of elective surgical patients to ROI. The Network model of care includes the development of services in regional centres, the introduction of 5 Paediatrician with Expertise in Cardiology (PEC) posts across the island, implementation of an all – island CHD research strategy and the development of a joint training and education programme for health care professionals. This is the first cross-jurisdictional Clinical Network internationally and the initiatives above, complicated & often complex in a single jurisdiction, are even more so when operating cross-jurisdictionally, particularly in the midst of Brexit uncertainty.

Conclusions The all-island CHD Network is a linked groups of health professionals and organisations, working in a co-ordinated manner, to ensure equitable provision of high quality, clinically effective services to this complex cohort of patients. There have been many learnings, many of which are transferable to other multi-agency Networks and Systems.

OC24

THE VISION AND POTENTIAL FOR A NATIONAL CHILD HEALTH E-HEALTH FRAMEWORK IN EUROPE

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Good records are vital to joined-up healthcare, ensuring delivery of preventive health, and monitoring public health. In all health spheres, digitisation and e-health are the appropriate new technologies. However, hitherto children have been badly served, and the literature shows minimal recent research in Europe.

All European countries are encouraged to lodge with WHO their current e-health plan. In 2016 the Models of Child Health Appraised (MOCHA) project examined these for 30 countries, and found only 11 (36.6%) had specific mention of children and adolescents' issues. However, some countries had innovations in hand, including a cloud-based immunisation system in Hungary, and a parent and child portal in Latvia.

Record linkage is vital, yet only 25 (83.3%) of countries have a unique health record identifier, with only 9 (30%) issuing from birth. All countries but four have general use of electronic health records in child primary care. Only Croatia has a child-specific primary care EHR; most others are all age systems.

Fourteen countries have a separate child public health record system; in half of these are appointments issued. Countries vary in data exchange policies between primary and secondary care; with community and preventive health providers, and with the school health service. There is also variation between countries on children's record access, and on confidentiality from parents.

Standards bodies are involved in a European Patient Summary, which only marginally impacts on children's needs. ECDC promotes all-age Immunisation Information Systems.

WHO promotes Home Based Records, but there are no standards, or established best practice.

Web sites and mobile phone apps are modern health support tools, but they can be unreliable and can breach privacy. Only six countries have accreditation processes for apps, and eight have them for web sites. A few countries have instigated specific web sites for health advice for children.

E-health is an ideal way to facilitate child health clinicians and give children relevant easy access to services. Several good initiatives exist, and ECDC and standards bodies are contributing, but overall the situation is poor. But with evaluation and collaboration involving professional and standards bodies, WHO and the EU, existing best practice could be drawn on to identify an optimal model on which all countries could draw. This would include:

Record linkage from birth

Standards for data items and functionality including condition-specific algorithms.

Access, sharing, and consent protocols

Approved anonymised use for research

Web site and app approval criteria.

OC25

GROWTH AND NUTRITION SUPPORT IN INFANTS WITH UNIVENTRICULAR PHYSIOLOGY

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Background Growth impairment in infants with univentricular congenital heart disease is well documented. Meeting nutritional requirements in the early phase of infancy can be particularly challenging as these infants undergo complex surgical palliation within the first few days of life. This audit is a retrospective study aiming to evaluate the nutritional status of these infants.

Method Eighty-nine infants with single ventricle physiology underwent a surgical Norwood or a hybrid/interventional procedure (stage 1) as a neonate in OLCHC during the time period January 2014 - December 2018. Subject data collected included demographics, procedure type, anthropometry, mode and type of feeding, nutritional intake and nutrition related complications. Weight for Age Z scores (WAZ) were calculated using the World Health Organisation Standards.

Results WAZ <-2 is a screening criterion for undernutrition. Mean WAZ at birth was -0.1 on discharge was -1.44 and prior to stage 2 surgery Bidirectional Glenn was -1.26. On discharge (median length of stay 25 days) post stage 1 procedure, 29% of infants had a mean WAZ < -2. A paired sample T test demonstrated that the drop in mean WAZ from birth to discharge is statistically significant p value <0.001 (significance <0.05).

Median number of days to any form of nutrition support was 3 and to first enteral feed was 6. Median number of days to achieve basic energy requirements from EN was 16. Preoperative trophic feeds and parenteral nutrition were provided to 18% and 38% of infants respectively. Vocal chord palsy and chylothorax arose frequently amongst the Norwood group with one in five infants experiencing such difficulties. On discharge post stage 1 intervention, 48% of infants were