

- there is no indication of connective tissue disorder, specific rheumatologic disorder, unexplained and/or significant comorbid medical symptoms, nor of complex neuro-disability history.

**Results** There are 421 and 437 children in total on the 'routine' and 'soon' waiting lists respectively. These children are waiting on average 631 and 592 days, and the longest wait is 1550 and 1516 days on the 'routine' and 'soon' waiting lists respectively. Review of the diagnosis provided on the referral indicates that 89% on the 'routine' waiting list and 65% on the 'soon' list are appropriate for APP triage.

**Conclusion** An APP triage clinic is feasible to help manage the waiting list for paediatric rheumatology. The implementation of an APP triage clinic can ensure that only those referrals that require a consultant review are seen at consultant clinic. All others may be successfully managed by an APP.

### GP292 PROFESSIONALS' CONSULTATION SERVICE IN THE CHILD SEXUAL ABUSE (CSA) UNIT

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**Introduction/Background** St Louise's Unit provides assessment and therapy services for children/young people where CSA is a concern. The multidisciplinary, multiagency professionals' consultation model was introduced in 2016, and adapted in 2018. Some children/young people referred to the unit for assessment and/or therapy regarding CSA, have other complexities in their lives such as concerns of other types of abuse, living in care and other health concerns (including mental health concerns). Therefore introducing additional specialist CSA services to the child's life, may in fact add to these complexities.

**Aims and objectives** When a referral is received in St Louise's Unit, the Consultation service aims to bring together the professionals already involved in the child/young person's life by offering additional support for those professionals.

**Methodology** The interdisciplinary team came together as part of the Children's Health Ireland Quality Improvement and Patient Safety Programme in 2018. A retrospective review of the referrals to St Louise's Unit was carried out and data from referrals from June 2018 to March 2019 was collected.

**Results** For that 9 month timeframe, there were 89 referrals to St Louise's Unit, with 20 directly to the Consultation Service. Consultation appointments were offered on Wednesday afternoons. Interdisciplinary representation from St Louise's Unit, Laurels Clinic, Tusla, An Garda Síochána other agencies involved in the child/young person's life all met in St Louise's Unit for a 2 hour meeting. The outcomes were 50% of referrals were discharged, 43% were forwarded for assessment and 7% were referred to therapy services in St Louise's Unit.

**Discussion** The consultation service is a collaborative and reflective process that allows for shared thinking in complex cases and supports case progression or resolution. Some of the outcomes included working through assessment versus therapy dilemmas with the system around the child; successfully resolving CSA concerns in custody and access cases in a way that was least intrusive for a child; identifying mental health

concerns; and preserving foster placement and stability for a child.

**Conclusions** This structured consultation service in St Louise's Unit has led to collaborative working within the unit and with other professionals involved in the child/young person's life where CSA is a concern. In the 20 cases reviewed, this service supported the professionals already involved in the complexities of the child's life with least intrusion for the child.

### GP293 DEVELOPING MARSIPAN INTEGRATED CARE PATHWAYS FOR CHILDREN AND ADOLESCENTS WITH EATING DISORDERS- REAL WORLD CHALLENGES AND RECOMMENDATIONS

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**Background** Anorexia Nervosa has the highest rate of mortality and morbidity of the mental health conditions. Much of this is related to the physical consequences of starvation and can lead to medical admissions. Integrated care pathways have the potential to decrease admission rates, reduce duration of stay, and prevent patients slipping through gaps between services. The Junior MARSIPAN risk assessment guideline is a best practice framework that has potential to enhance integrated decision making between mental health, paediatric and primary care for children and adolescents with eating disorders.

**Objective** To explore the use of Junior MARSIPAN risk guidelines in collaborative decision making in a Regional Tertiary Referral Hospital, and to understand any associated barriers and enabling factors in their implementation.

**Methods** Patients discharged from Cork University Hospital with a diagnosis of Anorexia Nervosa/Eating Disorder were identified using HIPE data, over a 2-year time period. Variables collected included: admission and subsequent number of bloods performed, assessment of cardiovascular stability, contact with Child and Adolescent Mental Health Service (CAMHS), MDT meetings, the presence of psychiatric comorbidities and evidence of discharge planning.

**Results** Of the 38 patients who presented to hospital, 20 were identified as having been admitted overnight over the time period, involving 16 patients. The mean number of admissions per patient was 4(2–11), mean age 15.1years (9.6–17.8 y) and 14 were female. The majority of admissions (68%) were unplanned and most were self-referrals. A total of 11 physicians were involved in the care in addition to 6 CAMHS teams and 2 GPs. There was inadequate evidence of documentation of physical risk parameters (BMI%, Orthostatic BP), biochemistry for monitoring of refeeding syndrome, and of multidisciplinary approach to care and discharge planning.

**Conclusions** Complexity and delayed communication was a significant barrier to the implementation of junior MARSIPAN across the 17 different teams involved. There is a need to develop MARSIPAN Lead clinician 'champions' and to standardised approaches across services, adult, Paediatric and child psychiatry, in order to minimise variability in patient clinical care experience. An integrated care pathway, based on the

Junior MARSIPAN Guidelines, is proposed to improve initial assessment, inpatient management of refeeding risks and to plan discharge. It is hoped this will lead to safer, more supportive and seamless care for young people with eating disorders when they become medically unstable.

**GP294 JUNIOR CLINICIANS' EXPERIENCES IN LEADING IMPLEMENTATION OF NEW MODELS OF CARE: DESIGNING AND DEVELOPING A PAEDIATRIC HOSPITAL AT HOME SERVICE**

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Promoting care closer to home for children has been a policy objective for some time and has been reiterated in NHS England's 10 year plan. Models delivering acute care outside the hospital across Europe have shown to deliver equivalent clinical outcomes whilst reducing ED re-attendance and length of stay. Junior clinical staff often rotate through multiple hospitals and as such can share best practice across organisations. However, too often leadership structures are not set-up to nurture, support or empower junior clinicians to enact change. In the context of worsening morale of the junior medical workforce as well as inner city difficulties in retention of junior nurses, providing opportunities to lead and participate in service development can increase engagement.

We report experiences of designing and developing a paediatric hospital at home service with a focus on recruitment and retention. The service was pitched to executive level by a junior doctor, with planning and design co-led with a junior charge nurse, supported by a team of consultants, senior matrons and operational leads. The junior clinicians led design workshops, wrote a funding bid and drafted the service specification.

Design workshops engaged doctors, nurses from both ED and ward backgrounds as well as parents and a wide range of professionals. Each was asked to bring a junior colleague and subsequently interviewed on their experiences of engaging in service design. For the majority of participants this was their first experience of service design, all felt more likely to engage in future discussions about the service and more invested in working in the service. Senior colleagues reported contributions of junior colleagues as valuable by providing a different perspective, including adding a health promotion aspect.

Junior clinicians can be well placed to lead new service development, particularly in a multi-professional partnership. As well as delivering improvement in quality of care, there are retention benefits to the workforce in enabling leadership roles and opportunities to engage in service development. Adequate support from senior leaders and engagement of wider team are critical enablers.

**GP295 HAEMOPHILUS INFLUENZA (HI)EARLY ONSET SEPSIS CASE CLUSTER: A CASE REPORT**

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**Background** To describe two cases of neonatal (HI) early onset septicaemia.

**Case 1** Female infant born at term to a 25 years old primigravida. Mother had pyrexia one hour post-delivery. Septic screen performed and IV antibiotics started. Afterwards, mother remained clinically well and no organisms were isolated in her blood culture. At 12 hrs of age the newborn developed pyrexia, poor feeding and hypertonia. Full septic screen was obtained and antibiotics were started. Bloods showed leucopenia, neutropenia and high CRP, and her blood culture grew *H. influenzae* (HI) at 48 hours of age for which antibiotics were adjustment according to sensitivity. PCR test confirmed non-type able *H. influenzae* (NTHi). Antibiotic course completed and follow up at 2 months showed normal growth development.

**Case 2** 26 years old presented with reduced fetal movement and light vaginal bleeding. Bloods showed leucocytosis & neutrophilia. Chorioamnionitis suspected and antibiotics commenced. Her blood culture grew (HI) at 31 hours post incubation with no growth reported on her HVS or MSU. Six hours later, a baby boy was delivered at term. He was admitted to NICU for intermittent grunting. Septic screen performed and antibiotics started and further adjusted according to sensitivity. Only blood PCR test detected (HI) type B (Hib) with no growth on blood culture. He was discharged home in a good condition after antibiotics course completed. Placental swabs showed (HI) on the placental fetal surface.

**Discussion** (HI) should be considered as a potential maternal, fetal and neonatal pathogen. However, HI infection became much less since the introduction of Hib vaccine. (HI) growth in maternal vaginal swabs should always be reported by the laboratory to the requesting clinician. Specimens collected from the placenta or vagina of pregnant mothers showing signs of premature rupture of the membranes, chorioamnionitis and antepartum or post-partum sepsis should be inoculated onto agar selective for (HI), in order to ensure recovery of this pathogen. (NTHi) have been recognized as obstetrics and gynecology pathogens. Since its significant morbidity and mortality, incorporating a screening protocol to detect colonization may have beneficial effects.

**GP296 EPILEPSY &US – GIVING A REAL VOICE TO CHILDREN, YOUNG PEOPLE AND FAMILIES AS PART OF A NATIONAL AUDIT PROGRAMME**

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Epilepsy12 was established in 2009 with the aim of helping epilepsy services to measure and improve care for children and young people with seizures and epilepsies across England and Wales. Epilepsy12 is delivered by the Royal College of Paediatrics and Child Health.

For Round 2 of the audit, children and young people with epilepsy, and their parents/carers, were invited to complete a Patient Reported Experience Measure (PREM) questionnaire on their experiences of care from their epilepsy service over the previous year.

2,335 questionnaires were returned. Some findings were:

- 88% were satisfied with overall care from their epilepsy service