Abstract G100(P) Table 1 How regularly are you taking your breaks?

	Pre-Conference	Post Conference	July 2019	October 2019
Always/Mostly Taking a Break	44%	87%	59%	TBC
Sometimes/Occasionally/Never Taking a Break	56%	13%	41%	TBC

pressure was also an issue 'the squeeze'. 'Unexpected work' and 'lack of wiggle room' alongside 'staffing shortages' made planning difficult. 'Peer pressure' to keep working and 'not being seen as a human being' with a sense of 'personal guilt' need to be addressed.

Environment: 'nice staff room' and 'ability to hand bleep over' with 'scheduling breaks as a team'. Leaders also need to role model alongside 'giving yourself permission'. We all need to find 'courage to have break uninterrupted'.

Discussion Our workshop shows there are barriers and enablers to taking a break. Changes are needed as individuals but more importantly as teams and organisations to enable all colleagues to feel empowered to take their breaks. Our workshop has shown an improvement in number of colleagues taking a break. We are now planning the next stage to roll out wider.

G101(P) TEAM EQUIP (EDUCATION IN QUALITY IMPROVEMENT IN PAEDIATRICS)

SJ Gray.

10.1136/archdischild-2020-rcpch.80

Background

- No previous team-based multi-disciplinary Quality Improvement (QI) training package in child health in region
- Huge appetite for change across city/trust – bid made to Health Education England

Aim

- To deliver a 1-year QI programme to groups of multi-disciplinary professionals working across child health in city and facilitate group project work-streams (minimum of 8) utilising these QI skills to deliver specific, measurable, achievable, realistic improvements within the year.

Process

- All groups working with children invited across hospital trust & primary care
- 15 Team EQUIP sessions organised with standardised structure
- First part: Introduction to QI and methodology
- Second part: Interactive project planning (brainstorming areas for improvement, dot voting & Pareto charting to decide on project(s) followed by driver diagram, process mapping, generating SMART aim & initial stage planning)

Outcome Measures

- Pre- and post-course questionnaire relating to knowledge, interest and involvement in QI
- Variable measures for different work-streams

Results

- 64 attended sessions with improvement in knowledge, interest and likelihood to get involved

- 19 work-streams in progress spanning a wide array of improvement areas relating to child health

Learning Points

- Running a programme like this single-handedly is massively time consuming but good for quality control
- NHS work pressures are over-whelming (2 sessions cancelled last minute by day surgery and one of the GP teams)
- Incentives (free lunch, prizes, conference funding) work
- Facilitating self-directed projects works wonders for engagement & motivation for the vast majority (but not all!)

Next Steps

- Supporting ongoing projects & dissemination via poster production, conference presentations & publication
- Spread learning & experience to other specialties through trust-wide QI steering group & for child health regionally via regional QI network, Q network & nationally through RCPCH conference & RCPCH QI Central

G103(P) QUALITY IMPROVEMENT PROJECT ON HANDOVER SESSIONS IN THE PAEDIATRIC DEPARTMENT OF A DISTRICT GENERAL HOSPITAL

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10.1136/archdischild-2020-rcpch.81

Aims The aims of this project were to improve the quality of morning handover, making them succinct but effective and ensuring they provided learning opportunities for trainees.

Methods We handed out questionnaires to staff in the paediatric department, at random, to conduct a survey. The questionnaire comprised of 11 positive statements about the handover, which they had to qualify as either 'strongly disagree', 'disagree', 'neither agree or disagree', 'agree', 'strongly agree' or 'don't know'. In the first phase (pre-intervention) we gathered their initial responses to these statements. We then introduced our 7-step handover guide (adapted from the RCPCH handover assessment tool), which was used at every morning handover for 1 month. The staff's opinions on these statements were then re-evaluated using the same questionnaire (post-intervention phase).

Results The percentage of staff who answered 'agree' or 'strongly agree' increased after the intervention for 9 out of the 11 positive statements about handover. It was only 'clarity about the most unwell patients at the end of handover' and 'handovers are enjoyable and non-intimidating' that yielded worse results after the intervention.

Questionnaire statements:

1. The handovers are well structured
2. I feel well-informed about the patients at the end of the handover
3. It is clear who the most unwell patients are at the end of handover
4. I am aware of all the patients with safe-guarding or child protection issues by the end of handover
5. Patients with similar names are clearly identified
6. Important safety issues are highlighted during handover e.g. patients with severe allergies, equipment issues etc.
7. Infection control issues are identified e.g. patients with RSV
8. It is clear which staff are rostered on for the day and whether there are rota gaps

Abstract 103(P) Table 1 Percentage of staff that gave an agree/strongly agree response to each survey statement

	1	2	3	4	5	6	7	8	9	10	11
Pre	66.67%	86.67%	93.33%	80%	60%	40%	80%	66.67%	60%	73.33%	86.67%
Post	80%	90%	60%	100%	80%	50%	90%	100%	90%	80%	80%

9. Teaching opportunities for the day are highlighted
10. When I am the one giving handover, I feel comfortable doing so
11. Paediatric handovers at Peterborough are enjoyable and non-intimidating.

Percentage of staff that gave an agree/strongly agree response to each survey statement (table 1).

Conclusion The intervention improved the quality of our morning handover sessions. A follow up survey is being put in place to assess whether these improvements have been sustained.

G104(P) CRIT: CHILDREN RECEIVING IMMUNOSUPPRESSIVE THERAPY: A CROSS-SPECIALITY REVIEW OF PRACTICE AT A TERTIARY CHILDREN'S HOSPITAL

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10.1136/archdischild-2020-rcpch.82

Aims Immunosuppression has become integral to the management of a wide range of childhood illness. Although total numbers of children and young people (CYP) on immunosuppression is unknown, they are thought to be increasing. Multiple paediatric sub-specialities initiate and monitor different immunosuppressive therapies with anecdotal variation in prescribing and monitoring practices. To understand existing variations in care, we undertook a retrospective review, focussing on:

- Number of CYP on immunosuppression;
- Drug monitoring and antimicrobial prophylaxis;
- Numbers of serious infections.

Methods CYP attending our hospital on immunosuppressive medication were identified from speciality teams (excluding immunology/oncology patients). Immunosuppressive agents were defined as:

- Long-term/high-dose steroids
- Cytotoxic drugs
- Biologic agents/monoclonal antibodies

Data were collected on a representative sample of patients under each speciality:

- Diagnosis;
- Current/past immunosuppression;
- Current/past antimicrobial prophylaxis;
- Consideration of risk for specific infections;
- Serious infective episodes.

Existing speciality/departmental guidance on prescribing, monitoring and surveillance was collected.

Results 416 CYP on immunosuppression identified; data were collected on 77 (18.5%), with cross-speciality representation.

47/77 children are currently prescribed ≥ 2 agents with 8/77 presently off immunosuppression. 46/77 were not prescribed prophylaxis at any point. In those who were, cotrimoxazole (n=28) was commonest.

54/77 patients had past VZV exposure documented or tested. 7/77 patients attended after chickenpox exposure; 2 required admission for treatment. 10/77 patients were hospitalised for possible bacterial infection; none had proven bacteraemia but 2 developed cryptosporidiosis.

All patients had FBC checked with varying frequency (weekly–once only). 14/77 developed lymphopaenia; of these, 8 had subsets checked. There was no clear relationship between speciality and monitoring frequency.

Two specialities were able to provide departmental guidance for the management of intercurrent infection.

Conclusions There is a large population of CYP on a wide range of immunosuppression. There is inter-speciality variation in the agents prescribed, monitoring schedules, infection risk stratification and antimicrobial prophylaxis. Departmental protocols are uncommon and not readily accessible outside of speciality or hospital, making out-of-hours decisions unnecessarily challenging.

This wide variation in practice and lack of evidence-based guidance is unacceptable.

Regional immunosuppression guidance may improve the quality of care offered to immunosuppressed children in our region.

G105(P) INITIATIVE TO IMPROVE CLINICAL CODING FOR PATIENT ADMISSION EPISODE (INPATIENT) BY RECORDING PATIENT CO-MORBIDITIES

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10.1136/archdischild-2020-rcpch.83

Background We reviewed benchmarking data about comorbidities in paediatric medicine provided by Civil Eye Research compared to other tertiary hospital. The data showed that our hospital (paediatric medicine) was on the lowest spectrum compared to other hospitals of similar size. This prompted us to look it in depth with an aim to improve our recording of co-morbidities and clinical coding.

Aim To record patient co-morbidities during each admission episode.

Methods We applied Quality Improvement (QI) methodology (PDSA cycle- Plan, Do, Study, Act) in this project.

Coding champion's role helped to bridge the gap between clinical coding and the medical teams. We identified relevant co-morbidities and designed a paediatric co-morbidity sheet. These sheets were formally launched on all the paediatric