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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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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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