on their children’s health. The widespread presence of ‘fake news’ was adding to the confusion. Our Paediatric Integrated Care team based in a tertiary centre in London approached local parents and community centres to organise online child health workshops.

**Objectives**

- To support parents and carers in gaining knowledge and confidence to care for children and young people during the pandemic
- To re-educate and reduce anxiety related to child health concerns
- To be responsive to our community and their health needs
- To make innovative use of video-conference technology and group teaching methods
- To make best use of professionals’ time

**Methods**

We worked closely with Community and Maternity Champions, who organise groups of local volunteers to promote health and wellbeing in North West London. Two Community Champions showed interest in having a webinar for parents on COVID19 and its impact on children in May 2020. We agreed dates and times for the 2 webinars. The Community hosts promoted the sessions and asked participants to submit any questions in advance so that the webinars could be tailored around the audience’s needs. The session lead (paediatric senior registrar) and other paediatric junior doctors prepared a presentation and answers to the pre-submitted questions. The format for the webinars was flexible, co-designing the sessions with the champions. The first had a 15-minute presentation followed by Q&As, the second did not have a presentation to allow more conversation with the families who joined. After each webinar, we sent resources for the community hosts to share. After trialling two webinars in May, we were contacted by other community centres. We organised six more webinars from June to December 2020. We captured data during the webinars, such as teaching material used, duration, session breakdown, size and type of audience. We tested different approaches for feedback, sharing survey links at the event and follow-up with the hosts two weeks after the event.

**Results**

From May to December 2020, we organised 8 webinars with 5 Community Centres, two youth groups and one secondary school, with a total of 72 attendees. Initially they were focused on COVID19, then we introduced other topics, including mental health, asthma and common childhood illnesses, depending on what the community hosts and local families requested. On average we ran the webinars for 1 hour. Formal and informal feedback confirmed that the webinars addressed concerns and that the attendees and community hosts found the sessions useful and reassuring. Peer to peer learning during the sessions was encouraged and this was key to improving audience’s confidence in addressing health concerns.

**Conclusions**

The COVID19 pandemic has opened up innovative ways to collaborate with community centres and have conversations on health-related topics sharing expertise. This project has also provided an important learning opportunity for paediatricians in training. The success of this programme is likely to lead to implementation of similar and related programmes, even after the end of the pandemic.

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**British Society for Paediatric Dermatology**

**PAEDIATRIC STEVENS-JOHNSON SYNDROME AND TOXIC EPIDERMAL NECROLYSIS: A RETROSPECTIVE CASE SERIES & EVALUATION OF PRACTICE**

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**Background**

Stevens-Johnson syndrome and toxic epidermal necrolysis are rare but devastating skin reactions that carry a significant risk of mortality and serious morbidity in paediatric populations. The British Association of Dermatology (BAD) released new guidelines in 2018 for the management of Stevens-Johnson Syndrome (SJS) and toxic epidermal necrolysis (TEN) in children and young people, which included recommended audit points for evaluating patient care.

**Objectives**

The aim of this study was to evaluate presentations of paediatric SJS/TEN to an English NHS trust over the last 10 years and retrospectively assess the management of these cases against the 8 audit points recommended in the BAD guidelines.

**Methods**

Hospital electronic records were searched from January 2010 to January 2020 selecting for presentations attached with the ICD-10 codes for Stevens-Johnson Syndrome (L51.1) or Toxic Epidermal Necrolysis (L51.2). Inclusion criteria included a final diagnosis at discharge of SJS and/or TEN overlap and an age under 18 years at presentation. Where a patient had recurrent admissions, each admission was assessed separately against the guidelines.

**Results**

After screening, 14 presentations from 12 patients met inclusion criteria. Of these presentations, 8 had confirmed infectious aetiologies (including Mycoplasma species (n=3), Streptococcus pneumoniae (n=3), herpes simplex virus (n=1) and parainfluenza (n=1)), 3 had presumed infectious aetiologies with no definitive positive testing, 1 had a presumed drug aetiology, and 2 had uncertain aetiologies. Initial causality assessments, review of oral and urogenital involvement, ophthalmology assessment and evidence of MDT involvement were present in all cases. While there were no mortalities, half of patients (6 of 12) went on to develop at least one long-term sequelae, of which psychiatric (n=3), urological (n=2) and respiratory (n=2) complications were most common. In 8 of the 14 cases there was no written documentation that patients, parents or GPs were counselled on the recurrence risk at discharge, and where this was documented, this was frequently in outpatient letters (n=5) rather than in discharge letters (n=1). In 12 out of 14 cases, there was no clear documentation that patients and parents had been counselled on the potential for long-term sequelae.

**Conclusions**

This retrospective case series highlights a predominantly infectious aetiology in paediatric SJS/TEN with 78% confirmed or suspected infectious trigger. We have shown that the new BAD guidelines can be readily applied to assess the management of paediatric SJS/TEN. While most in-patient care met recommendations, there was limited documentation of parents and GPs being counselled on the risk of recurrence and long-term sequelae. The BAD guidelines include an
adaptable proforma letter which should be implemented to ensure clearer information on discharge. The frequency of long-term sequelae in this series highlights the need for continued research into this area and appropriate support following discharge.

Paediatric Clinical Leaders: Service Planning, Provision and Best Practice

![GIVING CLINICAL GOVERNANCE A MAKEOVER – A QUALITY IMPROVEMENT PROJECT (A WORK IN PROGRESS)](10.1136/archdischild-2021-rcpch.262)

**Background** Clinical Governance (CG) underpins the daily practice of doctors, nurses and allied health professionals (AHPs), affecting how we care for patients as well as ongoing education and aspiration to excellence.

The 7 pillars of Clinical Governance, namely: Risk Management, Clinical Audit, Education and Training, Clinical Effectiveness, Information, Patient Experience and Staff Management influence every aspect of working. However, involvement in clinical governance is frequently seen as the remit of consultants and senior managers, and can feel far removed from junior doctors, nurses and others on the ground day-to-day.

This project took place across the general paediatric and neonatal departments of a busy London District General Hospital. It was conducted during the Covid-19 pandemic, with its additional pressures.

**Objectives** The aim of this project was to:

- Gauge levels of knowledge, awareness and involvement in CG amongst the entire paediatric and neonatal teams.
- Raise the profile of CG.
- Investigate ways of disseminating information from CG activity, including meetings, rapid reviews, serious incident reports.
- Begin a monthly CG newsletter.
- Run other CG-based teaching and activities aimed at increasing awareness.

**Methods** Quality Improvement methodology was followed, using the Model for Improvement.

An initial questionnaire of junior and senior doctors, nurses and AHPs evaluated understanding of CG, most effective ways of communication, reading habits of existing departmental bulletins, and areas of CG participants wished to learn more about. This was used to generate change ideas.

**Measure** We surveyed the same group monthly on their perceived knowledge, involvement and awareness of CG. This generated a score out of 12.

7 Plan-Do-Study-Act cycles were carried out (to date):

- Choosing name of a new monthly newsletter by competition,
- A monthly Clinical Governance newsletter ‘The Chaterpillar’, communicating learning points from CG activity; ‘Greatix of the month’; CG Pillar of the month; and advertising upcoming learning events,
- Seminar on Quality Improvement,
- Simulation training based on a serious incident involving an adolescent in a mental health crisis,
- Teaching following a pharmacology rapid review,
- Interactive Clinical Governance teaching
- Reflections on ‘Journey of a Datix’

**Results** Multiple changes were adopted into the fabric of the department, including the monthly CG newsletter, regular mental health-based simulation training, and clinical governance in the teaching timetable.

Although the measure across the three months showed the median score of knowledge, involvement and awareness of CG remained unchanged, there was greater participation of junior doctors, nurses and AHPs in subsequent surveys. The consultant’s scores were generally high, so this consistency implied greater multidisciplinary involvement was occurring within the department.

**Conclusions** Clinical Governance remains the foundation of clinical activity, and quality improvement methodology has brought about change within our department. Further change ideas include a ‘Clinical Governance Week’ and greater involvement of nurses. The project (still in progress) has led to lasting impact and enrichment of the paediatric department.

There is new involvement, ideas and energy to be harnessed beyond the traditional senior management, enabling lasting improvement in clinical practice for our department and beyond, as more individuals are empowered with the knowledge and skills required to be tomorrow’s leaders.

British Association of General Paediatrics

![HOW TO BE BRILLIANT AT OUTPATIENTS – A CO-PRODUCED PROGRAMME TO IMPROVE TRAINEES’ CONFIDENCE AND SKILLS IN THE OUTPATIENT SETTING](10.1136/archdischild-2021-rcpch.263)

**Background** Less than half of paediatric trainees attend the recommended ‘20 clinics per year’; there are anecdotal reports of trainees attending twelve or fewer before becoming consultants. In order to be adept outpatient practitioners, trainees need exposure and independent practice, guidance and support around the outpatient learning experience. Junior doctors in our department felt under-confident in the outpatient paediatric setting and were missing learning opportunities as a result.

**Objectives** To co-produce and pilot an evidence-based programme of interactive sessions for foundation, GP and paediatric trainees, delivered within the departmental teaching rota, to address junior doctor lack of confidence in the outpatient setting.

**Methods** A series of sessions co-produced and co-delivered between paediatricians, trainees and primary care, to trainees at a teaching hospital. Sessions covered the practicality and art of outpatient practice, with case-based examples. Contents included: who is referred and how, the triage process and clinic formats, key goals for a consultation and its structure,