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

890 GIVING CLINICAL GOVERNANCE A MAKEOVER – A QUALITY IMPROVEMENT PROJECT (A WORK IN PROGRESS)

¹Hajera Sheikh, ¹Hannah Marshall, ¹Emma Devereux, ¹Katherine Taylor, ¹Anna Gerrard-Hughes, ²Belinda Ng. ¹North Middlesex Hospital; ²North Middlesex Hospital

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

891 'HOW TO BE BRILLIANT AT OUTPATIENTS' – A CO-PRODUCED PROGRAMME TO IMPROVE TRAINEES' CONFIDENCE AND SKILLS IN THE OUTPATIENT SETTING

¹Lucy Pickard, ²Ryan Jayesinghe, ¹Lizanne Noronha, ³Sonia Tsukagoshi. ¹King's College Hospital NHS Foundation Trust; ²King's College London; ³Royal College of General Practitioners International

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,

clinic outcomes, information capture and results follow-up, dictation and letter writing. This was followed by an interactive 'choose your own adventure' section covering the art of outpatient practice, including the hidden agenda, shared decision making, Maslow's hierarchy of needs, the gift exchange, and managing uncertainty. A separate session on case-based examples of common presentations such as abdominal pain and headache, including the evidence base around investigation and management and applying the aforementioned principles.

Participants scanned a QR code before and after each session to rate their knowledge and confidence pre and post, and give feedback on the sessions.

Results Half of participants (n=22) said they had not had adequate time to attend outpatients. Their mean confidence in dealing with common outpatient conditions prior to sessions was 6.4/10. Articulated concerns included '*not knowing how to proceed with a case if help isn't immediately available*', '*not knowing how to follow up*'.

Post session, participants' mean confidence was 8.9 (39.1% increase). The mean score for usefulness of sessions was 10/10. Participants stated an appetite to receive more outpatient training including '*more video demonstrations, how to start outpatient consultations, how to finish, to learn communication in outpatient settings*'.

Participants fed back that the sessions 'Helped me realise there is no set style and you have to find a way of your own', 'It has given me tips on how to get to the real reason for the patient coming to the doctor'.

Conclusions Trainees' confidence in the outpatient setting can be increased with the use of a training programme delivered within the departmental teaching rota dedicated to the art and practice of outpatients with case-based illustrative examples. This session will be run for each subsequent cohort of trainees.

Child Protection Special Interest Group

892

CHILD SEXUAL ASSAULT FORENSIC ASSESSMENTS – AN IMPROVEMENT PROJECT

Lydia Garside, Cheah Jamie, Bernadette Walsh. *Sydney Children's Hospital*

10.1136/archdischild-2021-rcpch.264

Background The forensic assessment of children with alleged child sexual assault (CSA) is largely carried out by the child protection units (CPUs) of tertiary hospitals in Australia on a 24/7 basis. The doctors on these rosters are a mix of community, general and child protection paediatricians. The case numbers are low and they are often referred out of hours and at the weekends. These assessments are time-critical, have huge medical, emotional and legal ramifications for the family and, as such, can be anxiety-provoking for the clinician. At Sydney Children's Hospital (SCH), we decided to address this problem by doing a Quality Improvement (QI) project.

Objectives To ensure 100% of doctors on the on call CSA roster were confident they could carry out CSA forensic assessments according to the New South Wales (NSW) forensic guidelines by February 2021.

Methods This project was registered and approved by the Clinical Governance Unit (CGU) of SCH network and followed standard QI methodology. Initially the problem was identified, a SMART aim agreed upon and the stakeholders consulted. There was a wide consultation process looking at

previous projects assessing a similar problem. A driver diagram was produced with primary drivers of patient and clinician factors, resources and equipment required and the NSW forensic guidelines for CSA. Various problems were identified such as incorrect labelling, wrong samples being taken, not acquiring the correct consent and what to do in certain common scenarios such as a child refusing examination.

One solution was to produce a CSA simulation programme for paediatricians which would address all the primary and secondary drivers. CSA was likened to paediatric resuscitation in that it often occurs after-hours, is rare, time-critical and there is only one opportunity to get it right. We therefore partnered with the simulation department at the hospital.

Results A one day simulation package was written and produced in conjunction with the simulation team at SCH. The pilot forensic CSA workshop was delivered to a group of paediatricians (n=6) currently on the on call roster. The simulation material comprised of a communication station, forensic swabs and toxicology, colposcopy and sexually transmitted diseases screening. Various educational modalities were used such as an instructional video, simulation of pelvic models with hand-made silicon hymens in different states of injury and role play. There was an evaluation before and after using the Likert scale. Pre course evaluation demonstrated 5/6 (80%) of paediatricians 'strongly disagreed' or 'disagreed' that they were confident in the CSA forensic examination process. Post course evaluation demonstrated 6/6 (100%) of paediatricians 'agreed' or 'strongly agreed' that they were confident with the examination.

Conclusions The infrequent yet critical nature of a CSA forensic examination requires the clinicians delivering the service to have the correct skills and training and be able to maintain them. The QI process identified a solution of a simulation package that was created and delivered by the clinicians from SCH. The pilot workshop has been well received and pre and post evaluation of the workshop demonstrated a 100% increase in the confidence of the doctors.

Paediatric Special Interest Group: British Society of Haematology

893

EFFICACY AND SAFETY OF DEFERIPRONE AND DEFERASIROX EITHER SINGLE OR COMBINATION IN BETA THALASSEMIA MAJOR PATIENTS ON REGULAR TRANSFUSIONS

¹Miteshkumar Ramwani, ²Dayaram Chaudhary. ¹United Lincolnshire Hospitals NHS Trust, ²Sparsh Children's Hospital, Jaipur

10.1136/archdischild-2021-rcpch.265

Background Iron chelation therapy has a very important role in the management of beta thalassemia major patients, who are on regular transfusion therapy. The objective of the study was to compare the efficacy and safety of deferiprone and deferasirox either single or in combination in reducing serum ferritin levels and effects on complete blood count, renal function tests & liver function tests in thalassemia major patients.

Methods This was a hospital based prospective observational study in India. The participants were thalassemia patients of age group 2–18 years with serum ferritin levels >1000 ng/ml,