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

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CHILD SEXUAL ASSAULT FORENSIC ASSESSMENTS – AN IMPROVEMENT PROJECT

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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

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

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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,