Conclusions There is a discrepancy between what the clinician documents about giving advice and what the family remembers. We clearly need to find a better way to give families information that they will remember and they can rely on. We hope that the impact of our change will not only be to educate and empower parents to manage their child's condition, but also open parents up to other available resources which they can access the next time their child is unwell, and therefore reduce the number of inappropriate A+E attendances. We have traditionally always given parents written information leaflets, but as technology changes and advances, we need to consider different ways of giving parents information that can also reduce our carbon footprint. We anticipate that this intervention will provide easier access for staff and patients to relevant patient centred information, thereby improving patient and parent education, reducing anxiety and as a consequence reducing the number of inappropriate re-attendances to hospital.

Quality Improvement and Patient Safety

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IMPLEMENTATION OF COMMUNICATION STRATEGY TO IMPROVE INFORMATION DISTRIBUTION AND PATIENT CARE DURING THE COVID-19 PANDEMIC

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Background This project was undertaken at a large tertiary teaching hospital involving members of the multi-professional team involved in patient care during the COVID-19 pandemic. Early on, we realised that much of our information distribution relied on emails and face-to-face meetings. With rapidly changing guidelines and recommendations, quantity of information to distribute became overwhelming. Staff were receiving multiple, daily trust-wide and department-specific emails. There was huge information overload, resulting in miscommunication.

Objectives 1. To provide up-to-date information that has been appraised for accuracy, relevance and importance

2. Increase effectiveness in information distribution - identify relevant recipients, timely distribution, minimising information overload, and creating a repository for reference

Methods Our QI methodology is based on the model for improvement framework and PDSA cycles.

PDSA cycle 1: Identifying stakeholders, and a preferred method of communication

- Stakeholders were identified and engaged.
- Baseline data was taken from the trust's internal communication survey data
- We agreed on a trial information distribution via an intranet page

PDSA cycle 2: Implementation of the Covid-19 intranet page

- Paediatric Consultant led the design of the webpage, including content, location and structure.
- The webpage was reviewed using Dalhousie university criteria.
- Informal feedback was regularly sought from stakeholders to upkeep the webpage. A formal survey was could not be completed at 3 months due to staff redeployment.

PDSA cycle 3: Improving awareness of the intranet page - in progress.

- The intranet page was advertised in induction for new staff and disseminated in the monthly staff bulletin.
- Survey was performed at 6 months to collect quantitative and qualitative data to assess staff use and satisfaction

Results PDSA cycle 1: We identified staff bulletins, emails, intranet and team meetings as staff's preferred methods of communication. 51% of respondents reporting using the intranet daily, and a further 29% using every few days. 90% rated the intranet as a useful resource.

PDSA cycle 3: Survey data showed that 75% reported accessed the website, with 61% of these using it on a weekly basis. It was mostly accessed for information for staff, PPE guidance and testing policies. The website was rated highly for accuracy, ease of access, useful and up-to-date information. All topics were rated useful and respondents were highly likely to recommend it to other colleagues. Qualitative responses were assessed with word clouds. The 3 main words were as follows: key successes - easy, organised, relevant; areas for improvement: awareness, reminders, layout. Of the 25% that did not use the webpage, all cited lack of awareness as the reason.

Conclusions These were unprecedented times with rapidly changing guidelines. Creation and distribution of easily accessible up-to-date information to colleagues was increasingly important. Creating a central point of reference worked well for a large hospital where the staff base changes regularly and already have saturated email inboxes. Ensuring that information was aimed at all members of the MDT provided streamlined and unified information.

British Society for the History of Paediatrics and Child Health (ePoster presentations only)

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LEGG-CALVE-PERTHES DISEASE: A TRANSATLANTIC EFFORT

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Background Legg-Calves-Perthes (LCP) disease, or Perthes' disease, has been present since prehistoric times, with paleopaethologists identifying what is believed to be the most ancient case in 6th to 3rd Century BC Italy. Nevertheless, it was over two millennia later in the early 20th Century that LCP was named and its aetiology investigated. The historical development of LCP represents only a part of the wider development in paediatric orthopaedics occurring at the time, a period revolutionised by Rontgen's discovery of X-rays in 1895.

Objectives A historical overview of Legg-Calves-Perthes disease.

Methods Literature review.

Results Early research of paediatric hip conditions centred on direct visualisation under anaesthesia, biopsy and clinical assessment. Rokitsky, an 18th century pathologist, is now believed to have incorrectly ascribed some early cases of LCP as hip infection and tuberculosis, both conditions predominant at the time. The lack of radiographic imaging provided a