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

1079 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)

1081 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

stumbling block to the identification of LCP and it is retrospectively believed that many cases of LCP were incorrectly diagnosed as hip infection, tuberculosis, slipped upper femoral epiphysis, and osteochondritis.

Röntgen's discovery of X-rays in 1895 revolutionised orthopaedics to what it has become today. From 1909 to 1910 the first formal descriptions of LCP dutifully followed from A. Legg in the USA, J. Calvé in France, and G. Perthes in Germany. While united in their radiographic descriptions, they differed greatly in the pathophysiology they postulated. Trauma, abnormal osteogenesis and inflammation were all proposed, but are now considered incorrect. Rather it was histological studies by Phemister in Chicago, in 1921, that first suggested an aseptic cause of necrosis of the femoral head. This concept was furthered by Konjetzny in 1926, who demonstrated a compromised vascular supply to the femoral head of patients with LCP.

In the next stage of radiographic assessment, Waldenström in 1922 was able to build on the work of Phemister and described four radiographic stages of LCP disease: initial, fragmentation, re-ossification and healed. These stages still hold true today, demonstrating remarkable insight, and have only recently been modified in 2003 by Joseph et al, giving rise to the *modified*-Waldenström classification system. Later work by Stulberg in 1981 resulted in the Stulberg classification, an important prognosticating classification used today.

The management of LCP has evolved from two early schools of opinion: unloading of the hip to allow neovascularisation and containment of the hip. Early approaches focused on the former and resulted in prolonged bedrest, long admissions and poor compliance. Later efforts focused on containment and were first applied by Harrison et al, who in 1969 introduced the Birmingham hip abduction splint. Further orthoses by Petrie in 1971 and Curtis et al in 1974 followed, however suffered high complication and failure rates. Simultaneously, operative containment was being established and Soeure and De Racker introduced the femoral varus osteotomy in 1952, soon followed by Salter's innominate osteotomy in 1962.

Conclusions The history of LCP demonstrates the importance of ongoing research and debate to obtain sound understanding and improved outcomes in child health. Future work continues to optimise and advance existing knowledge.

British Academy of Childhood Disability

1082

PATHWAYS: TRANSFERRING YOUNG PEOPLE WITH COMPLEX NEEDS FROM A CONSULTANT PAEDIATRICIAN TO A CONSULTANT ADULT PHYSICIAN

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Background The number of young adults with complex medical needs living into adulthood is increasing as a result of early detection, advances in medical treatments and improved health. Upon leaving children's services, they and those who

care for them, must learn to navigate new and unfamiliar adult healthcare systems. For those with complex multi-system disease, many with physical and cognitive disabilities, this can involve multiple sub-specialty appointments: care that has been well-coordinated by generalist and community paediatricians can become complicated and fragmented. As children, many of these young people will have had established routes to emergency hospital admission to well-known wards and healthcare teams. In adult services these admissions procedures can feel less bespoke with poor experiences being reported on busy admissions units involving unfamiliar wards and staff.

Objectives We describe steps taken to improve the experiences of young adults and their carers accessing adult secondary healthcare and achieve recommendations from NCEPOD *Each and Every Need*: a handover clinic, review of admissions procedures and provision of a single-point of contact at the hospital.

Methods Clinicians from Community Paediatrics, Palliative and General Medicine formed a working-group and applied quality-improvement methodology to create a transition clinic for young people with complex medical needs. Qualitative data for service development was collected through semi-structured interviews with carers, an online survey completed by the multi-professional team and via patient feedback forms.

Quantitative outcomes were used to characterise the complexity of the clinic attendees as well as demonstrate the diversity of the multidisciplinary team (MDT) involved. These included tracking clinical concerns using the health, functioning and wellbeing score, prospective data collection of involvement of other medical specialties, changes to medication, discussion of advance care plans and admission prevention. Finally, data on A&E attendances, hospital admissions and length-of-stay were collected for patients in the transition clinic and a comparison group.

Results 14 clinics took place for 30 young people over 39 appointments in 9.5 months. The average age was 18.83 years (range 17.45–20.12 years) and the average number of diagnoses/patient was 5.36 (range 3–10) with neurological diagnoses being most frequent. Clinics were attended by professionals and carers from >14 disciplines/agencies. Health, Functioning and Wellbeing scores showed the average number of carers reporting 'no concerns' increased at each time-point while the average numbers reporting 'some concerns' and 'serious concerns' decreased from the first appointment to the second but the changes were not statistically significant. Professionals reported participation in the clinic was an effective use of their time, that it promoted MDT working and that it improved patient care. Data on A&E attendances, hospital admissions and length of stay for patients in the pathways clinic and comparison group did not show any statistically significant differences.

Conclusions The steps taken to improve the experiences of young adults with complex medical needs, as well as those that care for them, accessing secondary healthcare services had a positive impact and were welcomed including by the multi-professionals involved. Well-coordinated and appropriate secondary healthcare is vital for the continued health and quality of life of this vulnerable group.