2. The advice from peers, EQIP team and RCPCH&Us was useful in reforming the feedback questions.

3. The tests of change broke down the steps in easily manageable steps and the driver diagram created a visual representation of task.

4. The improved teamwork and bonding within the team improved the ability to respond to the challenge posed by Covid19 and the epilepsy care was able to continue without any significant impact

5. The platform thus created helped other innovative ideas to flourish to improve care. For example the Team created a WhatsApp video service for families to send videos to, so that prompt review and advice can be given.

Some of the feedback results include.

Questions	Results		
Would you be willing to take part in a feedback project	100% agree		
Preferred Clinic times	Morning 72%	Afternoon 8%	Evening 16%
Current appointment duration	Too long 16%	Too short 34%	Just right 50%
What alternative consultations format would you like? (Before Covid19)	Video consultation 15%	Telephone 67%	Both 16%
Themes families wanted to discuss in clinic	Most common themes included Seizures, Medication, Education and Mental Health		

Qualitative feedback will be detailed in the poster

Conclusions Using formal QI tools and support mechanisms greatly improve the success of QI initiatives with improved outcomes for patients.

British Association of Child and Adolescent Public Health

1159

IMPROVING UPTAKE OF HEALTHY START VOUCHERS DURING THE COVID-19 PANDEMIC

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Background Healthy Start Vouchers are a UK government scheme to improve the nutritional health of pregnant women, mothers and children from families with low incomes. Healthy Start provides vouchers that can be exchanged for fruit, vegetables and milk. They are accepted in all major supermarkets but variably in smaller independent food shops. Local uptake of Healthy Start Vouchers is low, having decreased from 67% of eligible families in January 2017, to 56% in January 2020.

In our inner-city borough, there are widespread health inequalities. Children in the east of the borough are more likely to be affected by income deprivation, to be overweight and have lower levels of attainment. Children in the east are also less likely to have access to healthy food. Due to the

COVID-19 pandemic in March 2020, many more families were expected to see a drop in income and begin receiving universal credit.

Objectives This project began in March 2020, aiming to increase the uptake of Healthy Start Vouchers by eligible families, and to increase the number of retailers accepting the vouchers, by targeting areas of deprivation and independent retailers which target specific ethnic groups (as these represent a large proportion of the local community).

Methods To increase the number of eligible families in the borough applying for Healthy Start Vouchers, we:

- Created adverts promoting Healthy Start on the borough's Facebook and Twitter pages
- Created a page about Healthy Start Vouchers on the borough's website and an information leaflet for families
- Created promotional posters to display on digital advertising boards
- Organised a webinar for professionals who have contact with families (e.g. health visitors, social workers, the local connected communities programme, etc) about local health inequalities and provided information on how to promote Healthy Start Vouchers to families they have contact with.

To increase the number of retailers accepting Healthy Start Vouchers, we targeted local retailers who were eligible to accept Healthy Start Vouchers but not yet registered with the scheme, providing information on the benefits of joining the scheme.

Results 53 delegates registered for the webinar. Feedback showed 88% of attendees felt the session increased their understanding of local health inequalities and 84% felt it increased their knowledge about Healthy Start Vouchers.

Data from the Healthy Start website shows that, from January 2020 to January 2021, the number of families receiving Healthy Start Vouchers increased from 1244 to 1521 (22%), and the families eligible for vouchers increased from 2234 to 3109 (39%). Therefore the uptake of Healthy Start Vouchers decreased from 56% to 49%.

32 local retailers were contacted, 13 responded, 3 expressed an interest in registering to accept Healthy Start Vouchers.

Conclusions It is encouraging that more local families have registered to receive Healthy Start Vouchers, but unfortunately during the COVID-19 pandemic, the number of families eligible to receive vouchers has risen at a faster rate. Further work is required both to better publicise the Healthy Start scheme to eligible local families, and to determine the extent which this project's interventions contributed to additional families registering to receive the vouchers.

Quality Improvement and Patient Safety

1160

USING QUALITY IMPROVEMENT (QI) TO IMPROVE VIDEO CONSULTATIONS IN COMMUNITY PAEDIATRICS DURING THE COVID-19 PANDEMIC

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Background Our community paediatrics service serves a diverse inner-city population of approximately 70,000 children and young people, with high rates of deprivation. During the COVID-19 pandemic, we shifted rapidly from face-to-face assessments to video assessments, with unknown implications on quality of care. Lack of guidelines and preventable technical problems led to incomplete assessments and precious time wasted. This could lead to adverse health, developmental, educational and long-term social outcomes.

Objectives By June 2020, to reduce avoidable technical problems with video clinics from 100% to less than 20%, in order to minimise time wasted, improve quality of video assessments, patient safety and satisfaction.

Methods All staff were trained to use video consultations by virtual workshops, online demonstration, one-to-one troubleshooting and practice runs (NHS England Attend Anywhere platform, 2020). We engaged stakeholders through regular online Skype Huddles, email and Whatsapp updates to ensure ongoing dynamic learning, ensure clear communication and discuss improvement strategies.

Our primary measure was the number of preventable technical problems (e.g. patient not receiving instructions, child moving camera, interpreter not booked). Outcome measures included patient outcomes following video consultations (discharge or follow up required), qualitative patient satisfaction feedback and clinician reported quality of consultation – satisfactory (yes/partly/no). The number of ‘Did not Attend’ episodes (DNAs) was a balancing measure.

Results Team Skype meetings and plan-do-study-act (PDSA) cycles shared learning from video consultations. In April 2020, we reviewed 188 patients (69% by video, 31% by telephone), increasing to 267 (82% by video, 18% by telephone) in May 2020, showing a sustained increase in number of video consultations. Avoidable technical problems reduced from 100% to 20% from March to mid-April, which was sustained. We were able to discharge 44% of patients following their initial video consultation, the others requiring follow up in specialty clinics or face-to-face follow-up to complete the assessment. Clinician feedback was encouraging; 55% of consultations were fully satisfactory, 35% partly (unable to examine child, poor internet connection, time consuming) and 10% were not satisfactory. Over 2/3 of patients preferred having a video consultation to face-to-face and the majority were thankful for contact, discussion and plans made. Qualitative patient feedback included: ‘This conversation is amazing, we were able to address a lot of issues despite being a video consultation.’ Some patients who forgot about the appointment were still contactable by phone and able to engage with the video consultation, due to the flexibility conferred by remote consultations. However, the overall rate of DNAs doubled from 7% in April/May 2019 to 14% in April/May 2020. This is likely due to initial challenges with instructions and accessibility of video consultations to our high number of vulnerable families, experiencing digital poverty, learning difficulties or language barriers.

Conclusions The pandemic has brought dramatic changes to all our lives and accelerated the need for development in video consultations, which will remain an integral part of our service. Quality improvement is effective in optimising video consultation compared to telephone. Further work is required to better understand and manage accessibility and risk of video consultations, as well as virtual multidisciplinary working.

British Paediatric Respiratory Society

1161

IMPROVING THE CARE OF CHILDREN PRESENTING TO THE EMERGENCY DEPARTMENT (ED) WITH A WHEEZE EXACERBATION- A QUALITY IMPROVEMENT PROGRAMME

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Background Wheeze is a common reason for children to present to the Emergency Department (ED). Management is directed by the 2019 British Thoracic Society and Scottish Intercollegiate Guideline Network (BTS/SIGN) 2019 national guideline. However, adherence to the guideline has been shown to be suboptimal. Suboptimal care is a preventable factor which, if addressed, can reduce the incidence of future exacerbations and in turn can potentially reduce ED visits.

Objectives The project aimed to (1) assess the current adherence to the guideline within a busy paediatric ED, (2) introduce iterative quality improvement (QI) measures to address areas of poor adherence, and (3) establish the impact of these measures on quality of care.

Methods Retrospective data was collected from 75 consecutive patients presenting to the ED at Southampton Children's Hospital and management analysed against the BTS/SIGN guideline. Multiple QI interventions were then employed with education sessions at the senior team and departmental team teaching, and a newly devised wheeze proforma forming the core of the programme. Subsequently, the care received by 70 consecutive patients was studied to establish the efficacy of the QI programme.

Results Initial data collection established that only 14% (3/21) of audited components of the guideline had full adherence. Following the QI programme, 39% (7/18) of non-compliant components showed statistically significant improvements including provision of a Personal Asthma Action Plan ($p=0.001$), assessment of medication adherence ($p=0.036$), discussion of triggers ($p<0.001$), assessment of parent/carer tobacco dependency status ($p<0.001$) and assessment of patient tobacco dependency status ($p=0.022$). Aspects that did not show significant improvement after the QI programme included administration of Beta-2 agonists within an hour ($p=1.000$), administration of steroids within 2 hours ($p=0.753$), inhaler technique checks ($p=0.282$), and the booking of asthma clinic follow ups ($p=0.777$).

Following the QIP introduction, the proforma was utilised in 60% of admissions. In patients where the proforma formed part of the QI strategy, 28% (5/18) of non-compliant components showed statistically significant improvements compared to those patients with no proforma. This included inhaler technique checks ($p=0.027$), assessment of triggers ($p<0.001$), assessment of medication adherence ($p=0.028$), recording of the severity of the exacerbation ($p<0.001$), and assessment of parent/carer tobacco dependency status ($p=0.001$).

Conclusions The introduction of a focussed QI programme resulted in significant improvements in adherence to the national asthma/wheeze guideline through reinforced education. A bespoke proforma proved an essential part of the programme. The proforma has been updated after feedback received, but at present further PDSA cycles are needed to show sustained change. Several important outcomes were not impacted and will be targeted in future QI cycles.