impact of related national events, such as lockdowns and school closures, on these admissions was considered.

Methods Information was collected on all patients aged <18 years who required involvement of our local CAMHS service during their hospital admission over a 26 month period, 13 months 'pre-COVID' (January 2019-January 2020) and 13 months 'post-COVID' (February 2020-February 2021). Data recorded included: age, length of stay, presenting complaint, interventions required, need for registered mental health nurse (RMN) support during admission and discharge location.

Results The total number of mental health admissions remained static during the time period (average 'pre-COVID' admissions 13.9 young people/month and 'post-COVID' 14/month) with no change in the patient average age (mean 14.5 vs 15 years).

Despite a rising trend, there was no significant increase in the rates of young people acting upon their suicidal ideations (73% pre vs 80% post, p value 0.14) or the proportion requiring active medical treatment (most commonly N-acetylcysteine) following significant overdoses (12% vs 17.5%, p value 0.18).

However, young people presenting during the pandemic were significantly more likely to require RMN support whilst an inpatient (117% increase in demand, $p \leq 0.001$) and subsequently be discharged to somewhere other than their home address (p value 0.01) - either a tier 4 psychiatric bed (2.2% 'pre-COVID' vs 6.6% post) or a social care placement (2.2% vs 5.5%).

Patient numbers requiring detention under a Mental Health Act section or chemical sedation remained low throughout (all <1% in both periods).

Conclusions Young people with mental health concerns have placed a significant demand on acute paediatric services for many years, and not just over the last 12 months of unprecedented additional societal challenges. The increased needs of cases during the pandemic, however, are putting excessive pressure on already scarce resources.

Evidencing the increase in acuity of mental health presentations during the COVID-19 pandemic is important for both forward planning of acute care services and to ensure appropriate ongoing community mental health support to this vulnerable patient group, particularly as the long-lasting health impacts remain to be determined.

REFERENCE

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Quality Improvement and Patient Safety

1230

QUALITY IMPROVEMENT PROJECT: IMPROVING SAFEGUARDING PROCESSES FOR 16- AND 17-YEAR-OLDS IN THE EMERGENCY DEPARTMENT AT NORTH MIDDLESEX UNIVERSITY HOSPITAL

Joseph Simpson, Rhiannon Fagan. *North Middlesex University Hospital*

10.1136/archdischild-2021-rcpch.494

Background In England, anyone who has not yet reached their 18th birthday is legally a child. All healthcare

organisations have a statutory duty to safeguard and promote the welfare of children and young people (Children Act 2004). In emergency departments, this includes checking the Child Protection Information Sharing (CP-IS) portal for Child Care Alerts.

At North Middlesex University Hospital Emergency Department, children under the age of 16 are seen in the paediatric department, where safeguarding processes are well established. During triage, the CP-IS portal is checked and the outcome documented in the clinical notes. This ensures that clinicians are made aware if the child is on a protection plan, or in foster care.

16- and 17-year-olds, however, are seen in adults, where prior to this project CP-IS checks were not carried out routinely. Therefore, at baseline audit, only 1.8% of 16- and 17-year-olds had a documented CP-IS check performed in the Emergency Department.

This project was considered particularly important for North Middlesex due to high levels of social deprivation in the local area, as well as previous safeguarding incidents resulting from information sharing failures.

Objectives Time specific and measurable aim:

95% of 16- and 17-year-olds presenting to North Middlesex University Hospital Emergency Department to have a Child Protection Information Sharing (CP-IS) check documented by reception, with appropriate action taken by clinicians based on the result, by 10/03/2021.

Methods Quality Improvement Methodology

The IHI 'Model for Improvement' was utilised. Techniques included:

- Stakeholder meetings
- Process mapping
- Time and motion study
- Driver diagram
- PDSA cycles

Measures

- Outcome measure: Percentage of 16- and 17-year-olds with a CP-IS check documented by reception and appropriate action taken by clinicians based on the result
- Process measures:
 - Percentage of 16- and 17-year-olds with documented CP-IS check by reception
 - Percentage of CP-IS checks appropriately actioned by clinicians
- Balancing measure: percentage of CP-IS checks recorded incorrectly by reception

Interventions

1. New protocol developed for CP-IS checking. Checks to be performed by reception staff when booking in 16- and 17-year-olds
2. Training for reception staff on performing and documenting CP-IS checks
3. Standard Operating Procedure created to help ED clinicians act appropriately on the outcome of CP-IS checks

Results

Baseline	Percentage of 16- and 17-year-olds with a CP-IS check documented and appropriate action taken
01/08/2020 - 07/08/2020	1.79%

Week beginning	Percentage of 16- and 17-year-olds with documented CP-IS check by reception	Percentage of CP-IS checks appropriately actioned	Percentage of 16- and 17-year-olds with a CP-IS check documented by reception and appropriately actioned	Percentage of checks recorded incorrectly by reception
02/11/2020	0.00%	N/A	0.00%	N/A
23/11/2020	35.29%	91.67%	32.35%	0.00%
21/12/2020	61.11%	100.00%	61.11%	0.00%
18/01/2021	57.69%	86.67%	50.00%	13.33%
01/02/2021	63.64%	95.24%	60.61%	4.76%
15/02/2021	66.67%	90.91%	60.61%	0.00%
01/03/2021	63.16%	100.00%	63.16%	0.00%

Conclusions The outcome measure showed a significant and sustained improvement. At the end of the study period, 63.2% of 16- and 17-year-olds had an appropriately actioned CP-IS check in ED, up from 1.8%.

Some inaccurate recordings were picked up via the balancing measure. This appeared to have resolved by the end of the study period.

Paediatric Mental Health Association

1231

PREVALENCE OF ADVERSE CHILDHOOD EXPERIENCES (ACE) AMONG A GROUP OF LOOKED-AFTER CHILDREN AND ADOLESCENTS FROM A NORTH-WEST LOCAL AUTHORITY

Michael Ogundele, Nasreen Zaidi. *Bridgewater Community Healthcare NHS Foundation Trust*

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Background The UK Department of Health has produced guidance on the statutory health assessment required for identifying and managing their health needs. It is well known that Children and young people (CYP) under public care are at increased risk of both mental and physical health needs compared to those living within their birth families. There are many factors known to influence the high vulnerabilities of looked after CYP to high levels of morbidities. There is a high rate of previous experience of adverse traumatic events including neglect and abuse, family deprivation, poverty, disharmony and disruption, parental vulnerability to drugs, alcohol abuse and mental health disorder, as well as genetic predisposition and subsequent instability experienced while in public care.

Objectives We aimed to identify and itemise the range of adverse or traumatic childhood experiences among the LACYP, with the intention of informing better targeted preventive measures from all stakeholders involved in their care.

Methods The healthcare records of all the CYP who were referred for the statutory Initial health assessment (IHA) between Apr 2019 and Mar2020, under the care of the Halton Local Authority were reviewed retrospectively. The audit was carried out as part of the Clinical Governance strategy and no ethical approval was required.

Results Data was available for a total of 82 LAC aged between 6 months and 19 years (averaged 8 yrs), with 51 Males/31 Females. One patient failed to attend the clinic. All the LAC had at least one or more identifiable adverse risk factors. A total of 21 socio-emotional risk factors recorded, classified into categories:

Parental (94%) such as abuse in childhood, alcohol and substance abuse, mental health problems, and Learning Difficulties;

Family-related insults (80%) such as parental neglect and exposure to domestic violence;

Prenatal insults (62%) such as intra-uterine exposure to stress, tobacco, drugs and alcohol;

Child-related factors (40%) such as physical, emotional or sex abuse, incomplete immunization and poor school attendance.

Each LACYP was exposed to an average of 5 risk factors including parental (2.5), family (1), child-related (1) and Intra-uterine (0.5).

Conclusions This audit confirms that CYP in public care have significantly higher risks of exposure to adverse traumatic experiences compared with the normal childhood population. Socio-economic deprivation and attachment difficulties in LACYP are known to significantly contribute to their development including impaired speech, language and communication (SLC) skills, which often remain largely undetected in 60% to 80% of cases.

It emphasises the need for comprehensive assessment and provision of early integrated care for LAC of all ages, working across a wide range of setting and involving multi-agency collaborations between the schools, social care, healthcare and the voluntary sectors.

It is recommended that every LACYP should be offered comprehensive multidisciplinary assessments to help identify the impact of biological, psychological and social factors on their individuality.

British Paediatric Neurology Association

1232

PARENTAL PERSPECTIVE: 'GOOGLE' DIAGNOSIS OF GENETICALLY WILLIAM-LIKE SYNDROME (MICRODELETION OF CHROMOSOME 7Q11.23)

Ihsanuddin Mohamed Muslim, Iain Marshall. *NHS Doncaster Royal Infirmary*

10.1136/archdischild-2021-rcpch.496

Background Genetic diagnosis has been increasingly made every day as part of investigation in childhood illness or neurodevelopment assessment. At its current stage, the genetic testing was more educational or scientific purposes only and parent need to understand this before agreeing to it. We interviewed the parents of a 10-year-old boy who had had genetic testing and misunderstood it with a well-known diagnosis of William's syndrome due to 'google' research.

Objectives

Nil

Methods

Case Report 10 years old boy who is known to our services for multiple clinical needs. He was first diagnosed with epilepsy at the age of 3 and required antiepileptic medication. Several years later, he was referred to paediatric community

department due to concern regarding his education and behavioural difficulties. He received support at school. Despite this, he struggled with his education and observed to have social communication difficulty as well. He was assessed for autism spectrum disorder and as part of this assessment, genetic blood testing was offered.

Results His genetic/micro array result showed deletion at the gene locus of 7q11.23, distal to the well-known area causing Williams-Beuren syndrome. Awaiting clinic appointment, the parent took it upon themselves to search into the internet and come across a syndrome described as Williams Syndrome. Without a medical background to explain such syndrome and its strong association of cardiac disease, the parents were worried and he was referred back to epilepsy service for further assessment.

Conclusions Initial perception can have a big impact on parents. Despite the 'unnamed' genetic disease has no cardiac association, it was felt appropriate to offer the child a cardiac assessment and echocardiogram to alleviate parental concern.

British Paediatric Neurology Association

1234 AN EXPERIENCE IN MANAGING A CHILDHOOD STROKE CASE ACCORDING TO THE NEW 2017 STROKE GUIDELINE: A DGH PERSPECTIVE

Ihsanuddin Mohamed Muslim, Vivek Desai, Shoma Ganguly. *NHS Doncaster Royal Infirmary*

10.1136/archdischild-2021-rcpch.497

Background Introduction: Childhood stroke, although rare, occurs and can cause significant long-term morbidity. Compared to adult's stroke, paediatric stroke is a heterogeneous entity, both of aetiology and presentation. This makes accurate and timely diagnosis challenging. In 2017, new paediatric stroke guideline, endorsed by RCPCH/Stroke Association, was published to address these challenges.

Objectives We presented 2 similar cases of childhood stroke that happened before and after the publication of the guideline. The second case demonstrated how we adapted current guidelines into the management of the patient.

Methods Case 1 (2011): 3-year-old girl presented with inability to stand and left hand weakness while playing in the garden. Examination revealed weakness to both arm and leg, with facial droop. No history of trauma. CT head was reported to be normal. She was given aspirin and arranged for transfer to tertiary centre the day after for MR/MRA imaging which confirmed stroke.

Case 2 (2020): 3-year-old girl presented with left sided facial droop, weakness of left side of her body and slurred speech during family visit to the safari park. The new 2017 guideline was used to aid assessment and management. She scored 6 of PedNIHSS and both CT and CTA was normal. Her assessment and imaging was done within thrombolysis window (4.5 hours). She was transferred to tertiary centre afterwards. MRA confirmed right MCA territory acute infarct.

Conclusions

Conclusion Despite the new stroke guideline, we encountered several challenges in managing the child in the DGH settings. The assessment and imaging were significantly delayed due to difficulty in assessing children, unfamiliarity with the new guidelines, difficulty in reporting paediatric neuroradiology imaging and absence of clear guidance with regards to

thrombolysis administration in children. This experience has highlighted the need for regional paediatric stroke assessment centre and decision-making for thrombolysis.

British Association of Child and Adolescent Public Health

1236 EMOTIONAL AND PHYSICAL HEALTH NEEDS OF LOOKED CHILDREN IN A NORTH WEST LOCAL AUTHORITY: NEED FOR MORE INTEGRATED CARE APPROACH

Michael Ogundele, Nasreen Zaidi. *Bridgewater Community Healthcare NHS Foundation Trust*

10.1136/archdischild-2021-rcpch.498

Background Children and young people (CYP) under public care are more vulnerable to mental and physical health morbidity than their peers living within birth families, due to previous experience of neglect and abuse, deprivation and poverty, genetic predisposition and subsequent instability experienced while looked-after. Previous research has shown that two-thirds of looked-after Children (LAC) are reported to have one physical complaint compared to 19% of boys and 17% of girls have a longstanding illness or disability.

Objectives We aimed to identify the profile of physical and emotional health needs among a cohort of LAC within a Local Borough of North West England.

Methods We carried out a retrospective audit of the healthcare records for all the LAC referred for initial health assessment (IHA) between the period of April 2019 and March 2020.

Results 82 LAC aged between 6 months and 19 years (averaged 8 yrs 2 months) were assessed during the one-year period. There was a male preponderance of 64% (51 males and 31 females). Each of them had an average of 4 multi-disciplinary professionals (3.8 ± 2) and three physical/mental health diagnoses (3.5 ± 2.5). The preschool children (1 to 4 years old) were the largest group of children among the cohort. The number of diagnosed problems ranged between 0 and 13. 62 (76%) of the LAC had at least one physical diagnosis, 41 (50%) were diagnosed with emotional/behavioural difficulties (EBD), 39 (48%) had disabilities/neurodevelopmental problems while 19 (23%) had perinatal disorders (Prematurity at birth, previous neonatal abstinence (withdrawal) syndrome and intrauterine growth retardation).

The commonest emotional/behavioural problems were behaviour difficulties (33%), emotional problems including anxiety (33%), Smoking (13%), other substance misuse (11%), self-harm (7%) and Attachment difficulties (2%).

The commonest physical illnesses were Dental caries (27%), overweight/obesity (21%), congenital heart defects (8%), Eczema (8%), asthma/hay fever and chronic constipation (7% each).

Perinatal problems were identified in 19 (23%) of the LAC. These included prematurity at birth (21%), neonatal abstinence syndrome (2.4%) and intra-uterine growth retardation (1%).

The commonest disabilities/neurodevelopmental disorders were visual impairment (18%), speech and language delay (15% total and% below 5 years) and learning difficulties (10%). Sleep difficulties was identified in 12 LAC (15%) with