Background Down syndrome (DS) is one of the commonest chromosomal abnormalities, overall prevalence 10/10 000 live births. Down Syndrome Medical Surveillance guidelines (DSMIG) are designed for optimal care for this group of children.

Objectives We audited our clinical practice in line with the guidelines. We also looked at the prevalence of co-morbidities and other important issues in this group in order to develop a locally agreed revised guideline.

Methods Children with DS were identified from Electronic records. Study period: January 2018-January 2019. Last two clinic letters (or one if new) were reviewed. Audit components: surveillance of cardiac disease, thyroid disorders, hearing, vision, cervical spine, growth, sleep, coeliac screen. We also looked at the prevalence of co-morbidities, educational placement and acute paediatric input.

Results 54 children were identified. Surveillance of *Cardiac*: Echocardiogram 100%, CVS examination in clinic: 55%. Prevalence of cardiac disorders: 44%; *Thyroid*: 100% of children < 2 years old vs 89% in > 2 years. 33% had thyroid disorders; *Hearing*: 100%, prevalence of hearing impairment: 33%; *Vision*: <4 years: 100%, > 4 years: 90%, prevalence of visual impairment: 81%; *Cervical spine*: 31% had evidence of discussion of warning signs; *Growth*: 88% had documented height and weight, 65% were plotted in the DS growth charts. 29% were documented underweight or overweight; *Sleep*: 70% had documented sleep history, 24% had confirmed obstructive sleep apnoea; *Gastrointestinal*: 63% had coeliac screen, 1 had a confirmed diagnosis. 11% had congenital GI anomalies; *Neurodevelopmental*: ADHD (n=1), ASD (n=4), Tic disorder (n=1). *Educational placement*: School aged children n=80%, 67% at special school.

Conclusions In addition to improving our own practice with the DSMIG, we made additional recommendations on surveillance of sleep: complete sleep questionnaire at 3–4 years of age; coeliac screen as per BSPGHAN recommendation; hip X rays if not weight bearing by 2 years of age.

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USING THE COVID-19 PANDEMIC AS A LEARNING TOOL TO SHAPE PAEDIATRIC OUTPATIENT CONSULTATIONS

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Background The declaration of a nationwide COVID-19 lockdown resulted in rapid adaptations to the NHS, including Paediatric outpatient consultations. At short notice, many Trusts converted outpatient consultations from traditional face-to-face to telephone consultations. General Practitioners have been using this method of assessment, with the backing of the British Medical Association, as a safe and acceptable practice for many years.

Objectives To establish whether changes to the Paediatric Outpatient Department during the COVID-19 pandemic can be implemented long term to improve the efficiency of the service.

Methods In our Trust, a team of two registrars and one senior house officer, with guidance from a General Paediatric

Consultant, was assigned to conduct telephone consultations for all new patients booked into General Paediatric clinics between the 24/03/2020 to 31/05/2020. Most patients had been referred and appointments booked pre-COVID, but urgent outpatient referrals were also seen.

Parents/carers were called at least 3 times on 3 different occasions over at least 2 days. If they did not answer the child was listed as 'was not brought'. Calls were made between 9am to 5pm Monday to Friday.

Any patient assessed as needing urgent medical attention was seen immediately to the Paediatric Emergency Department. Semi-urgent patients screened as having possible Covid-19 symptoms (by clinical screening questions) were seen in Paediatric Emergency Department, otherwise they were seen face-to-face in a COVID-negative (by clinical screening) outpatient area within 48 hours.

Results

During this period:

- 262 new patients had new General Paediatric Clinic appointments.
- 235 (90%) were successfully contacted.
- 27 (10%) of patients 'were not brought'. These 27 patients were excluded from on-going analysis. Over the same time period in 2019 there was a new patient 'was not brought' rate of 55 (16%).

Following one telephone consultation, 105 (45%) contacted patients could be discharged from the clinic with parental agreement. Of these 27 (11%) patients had a complaint which had resolved by the time of the appointment and 19 (8%) patients had already been seen by a private consultant or other NHS consultant. Thus 46 (20%) of the contacted patients did not need their General Paediatric appointment.

Only 7 (3%) patients needed urgent face-to face-review of which 4 were urgent 2-week wait referrals by the GP. 155 (66%) patients needed no investigations.

Conclusions The NHS is going through uncharted times. This provides opportunities to adapt and evolve services and improve efficiency of care for our patients, their families, and healthcare staff. The data above highlights that almost half of the new General Paediatric outpatients could be successfully discharged from clinic after one telephone consultation. During a time of significant anxiety and uncertainty families were able to avoid in-person hospital contact. A similar system when we return to normality could lead to fewer absences from school and less time off work for parents. Our experience suggests that initial telephone consultations with new General Paediatric patients may be an efficient way to make first patient contact.

British Paediatric Respiratory Society

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A PAEDIATRIC EMERGENCY DEPARTMENT ASTHMA ASSESSMENT TOOL TO IDENTIFY HIGH RISK CHILDREN IN ACCORDANCE WITH THE NATIONAL REVIEW OF ASTHMA DEATHS GUIDELINES

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