of good practice as well as areas of need. The information from these audits will inform a business case for a dedicated, local Down Syndrome Clinic.

Methods The current DS Database was updated to include all children living in our borough aged 0–19 years at the time of the audit (April–July 2020). Community folders, Electronic Patient Records (EPR) from hospital and community setting, as well as individual consultants' caseloads setting were reviewed to identify CYP-DS. Each record was systematically reviewed to see if routine medical surveillance as outlined by the DSMIG was being followed.

Results 100 CYP-DS were identified although complete medical records were not available for every child. 51% were girls, with representation from all ethnic backgrounds (71% BAME). Most children attend mainstream primary school (76%) but this decreases considerably at secondary school, when only 4% attend mainstream education.

63% (cf. 54% in 2013) of CYP-DS were reviewed within the recommended time frame – with specific improvements in monitoring of cervical spine instability, growth, sleep disordered breathing, cardiac symptoms and hearing and vision (see table 1). As noted in 2013, CYP-DS attending mainstream or out of borough settings are most at risk of being lost to follow up.

Conclusions There have been improvements in the follow up of our CYP-DS since 2013, due to greater collaboration between hospital and community services as well as improved education and training amongst professionals and families.

There are still shortcomings in specific medical surveillance – particularly of thyroid function and a need to further improve our surveillance of other medical issues such as hearing and vision.

To address these issues and improve the experience of our CYP-DS and their families, we have established a dedicated

Down Syndrome Clinic – primarily to target those in mainstream and pre-schoolers, with the database being maintained on EPR (RIO). Currently the clinic is doctor-led, but it is hoped in the future this can be a collaborative clinic with therapists, portage and a DS Support Group representative.

Quality Improvement and Patient Safety

1323

MOVING ON UP – ESTABLISHING A TRANSITION SERVICE FOR YOUNG PEOPLE WITH EPILEPSY

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10.1136/archdischild-2021-rcpch.557

Background Moving from paediatric to adult services is a worrying and challenging time for young people with long-term conditions. Evidence suggests effective transition between paediatric and adult services has shown to improve long-term outcomes. However, national data from the Epilepsy12 Audit in 2019, showed that for most paediatric epilepsy services there are no agreed pathways for young people to transition to adult services. This is a particular problem within secondary care settings, however there is a successful, generic transition programme 'Ready, Steady, Go', that has been implemented and adapted in many UK Hospitals, enabling young people to effectively transition to adult services.

Objectives This quality improvement project aimed to ensure that all 14–17 year olds with epilepsy will have at least one discussion about moving to adult services with the help of the Ready, Steady, Go transition programme, by the end of February 2021.

Methods A total of 28 patients aged 14 years and over with epilepsy were identified and included in the project. Those aged ≥ 16 yrs who had been referred to and were awaiting an appointment with adult services were excluded. Diagnostic tools including a process map, fishbone and histogram were completed to help define the problem further. Eligible patients had their most recent clinic letter reviewed for evidence of discussion about transition. Following this, change ideas were generated and several PDSAs were undertaken through a patient questionnaire, and setting-up a virtual transition-focused clinic, in which key areas could be impacted on (responsibility with medications, being seen alone, signposting to online resources and exploring young person and parent concerns about moving to adult services).

Results Baseline measurement showed that 54% of young people did not have any evidence of discussion about moving from paediatric to adult services, with parental concerns being the most common documented subtopic. A total of 7 questionnaires were completed, either in a general epilepsy clinic or at the beginning of a virtual transition clinic. Results showed that all patients wanted to know more about the differences between paediatric and adult services and wished to be signposted to online resources for young people with epilepsy. Importantly, the majority did not know the names, doses or frequency of their medications. Following the implementation of a virtual transition clinic, the baseline measurement increased to 57%.

Conclusions Although changes may not have been significant, there has been measurable progress in establishing a transition-focused clinic, which will now continue monthly. The focus of this clinic has enabled the paediatric epilepsy team

Abstract 1322 Table 1

Education	2013 Audit (%)	2020 Audit (%)
Mainstream Primary	64.3	76
Mainstream Secondary	0	4
DSMIG recommendations		
Timely medical review	54	63
Growth recorded	55	61
Thyroid surveillance	82.5	56
Vision	59	83
Hearing	61	75
Cervical spine enquiry	27	60
ECHO at 6 weeks	79	86
Cardiac symptoms enquiry	66.7	84
Sleep disordered breathing enquiry	77.8	88
Comorbidities		
Feeding difficulties	50.8	47
Constipation	33.3	44
Hearing aid	11.1	30
Cardiac defect on ECHO	58.7	51
Leukaemia	1.6	3
Diabetes	0	4
Social communication difficulties	20.6	33
Autism Spectrum Disorder	15.9	19

to better achieve the objectives of transition. In addition, it has provided each young person with a transition-focused task in preparation for their next appointment. The 'Ready Steady Go' programme was adapted in order to impact key areas of transition; however, further work is required to improve areas in which young people need help with such as responsibilities with medications and helping those with more complex needs.

Paediatric Clinical Leaders: Service Planning, Provision and Best Practice

1325 AMAZING MK – WHAT MAKES STAFF COME TO WORK?

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Background Usually NHS staff go through 'exit interviews' when they decide to leave their post where we ask them 'Why are you leaving us?'. This thinking is based on 'deficit based' model where we focus on things that went wrong or could be improved. Recent evidence proposes that 'asset based' model of thinking which involves shifting our focus on things that are going well is a much better approach for staff retention and wellbeing. This attitude reframes the question 'why are our staff leaving us' to 'why do our staff stay in our department' which creates a positive thinking attitude while offering a different perspective.

Staff retention and wellbeing is an important issue in the current NHS which is the largest employer in the UK with more than 1 million staff. The greatest asset of an organisation is its staff, and evidence suggests improving staff experience with a positive mindset can reduce patient mortality and increase patient satisfaction.

Objectives 'What makes you come to work?'

This was the question we asked our staff in Department of Paediatrics including nurses, receptionists, junior doctors, consultants, secretaries and domestics in spring 2020.

Our team included 3 Paediatric trainees - Fiona Seabrook, Matthew Rajan, Clare Adams and Jyothi Srinivas, Consultant Paediatrician as lead. Maude Calveley, Medical student helped edit final video.

Methods We produced a flyer with details of the project and filming to generate interest in the department. We asked our staff to write a word or sentence written on paper that describes their reason to come to work, day after day. We persuaded and encouraged staff from various roles to take part. We filmed our staff in different areas of the department and had a huge variety of answers over 2 months.

Results Many staff chose single words for filming and the most common themes 'Work Family', 'Making a Difference' and 'Team Work'. Some staff remembered incidents that had deeply affected them at work and were willing to share these experiences.

This project brought our departmental staff together and our team had fun filming the short video clips. As this was the beginning of the first wave of the pandemic, face masks were only mandatory when interacting with patients.

We were inspired by a similar project at the Royal Hospital for Children, Glasgow.

Conclusions NHS staff spend a significant amount of time at work and develop deep bonds with our colleagues over the years. We share experiences of successes and failures during our shifts. While it is important to document and investigate adverse events, it is equally important to acknowledge, appreciate, and promote the positive feelings among staff. It is easy to notice failures over successes. It is easy to be critical than to support and encourage staff when they are struggling. A positive frame of mind gives a different perspective to the issues and is well worth the effort in the current NHS climate.

We enjoyed discussing and filming with our staff the reasons they come to work every day. We hope you enjoy watching the video!

Paediatricians with Expertise in Cardiology Special Interest Group

1326 CARDIOLOGY CLINICS DURING PANDEMIC – CALL FOR A UNIFORM RESPONSE!

Pramod Nair, Vatsavai Subbaraju, Rajesh Sesham, Obinna Nwanko. *Bedford Hospital NHS Trust*

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Background During the current pandemic with Covid-19, face to face cardiology clinics were put on hold during national lockdowns. Consequently, there were increased waiting times and back log of paediatric cardiology outpatient numbers. It is currently not known as to what effect this has had on children awaiting cardiology services and whether there have been any adverse effects with the appointments being postponed. Feedback from paediatricians with cardiology expertise (PEC) would be an important exercise to learn how we have coped with outpatient cardiology work in the current pandemic and how we could prepare for the future.

Objectives To get feedback from PECs about their current joint clinic backlog and their experiences how they have managed to provide cardiology services over the past 1 year

Methods Surveys were sent to group of Paediatricians with special expertise in cardiology group via link for preset questionnaire.

Results 44 PECs responded to the survey. A range between 0–16 outreach clinics were cancelled during the current pandemic with the average being 5 clinics per PEC. About 40% of the respondents had around 50 patients awaiting appointments as a result of backlog whereas 27% had between 100–400 patients on their list. A wide variety of methods were used from seeing only the urgent patients, vetting each patient and prioritising the list, continuing with remote clinics etc. but around 18% of the respondents felt that they are struggling with their workload. Some PECs have increased their PEC cardiac clinics to cope with the increased numbers. Reassuringly 90% of the respondents did not see any increase in complaints or unexpected patient deterioration due to delayed reviews. 45% of the respondents felt that 10% of their outpatient work could be done remotely whereas 37% felt that 20–50% of their work could be completed remotely. 95% of the PECs did not see any of their cardiac patients deteriorating secondary to Covid infections and most of the respondents agreed with the RCPCH