included paracetamol overdose and depressive disorder which have risen with each year:

2019 (Paracetamol OD 20.1%, Depressive disorder 21%, eating disorder 6.1%, anxiety 15.6%)

2018 (paracetamol OD 18.3%, depressive disorder 27%, eating disorder 2.8%, anxiety 10.7%)

2017 (paracetamol OD 9.7%, depressive disorder 10.2%, eating disorder 2.4%, anxiety 4%)

Conclusions The lower mental health presentations seen during the first lockdown compared to the last four years can be explained by the effect the start of the pandemic had in the UK population. The 'stay at home' message may have provided valuable parental support to those CYP who would have otherwise presented during that period with a mental health issue. However, with the ongoing changes during the last year surrounding financial and educational uncertainty, the numbers have risen. Recent epidemiological models have predicted a spike in Covid-19 in July, this will impact the mental health numbers that emergency departments will see. Adequate provision should be put in place to support the CYP now and in the future.

Paediatric Clinical Leaders: Service Planning, Provision and Best Practice

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IMPACT OF PAEDIATRICIAN INVOLVEMENT IN NHS 111 CLINICAL ASSESSMENT SERVICES

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10.1136/archdischild-2021-rcpch.647

Background More children and young people (CYP) attend Emergency departments (EDs) each year than over-65s and CYP account for up to 40% of all primary care consultations. Many CYP seen in ED or primary care are triaged through NHS 111, which is a free telephone service, wherein all calls are initially triaged by a call-handler. Where appropriate, calls are passed on to the Clinical Assessment Services (CAS) for a call-back from a clinician. During the Covid-19 pandemic, NHS 111 experienced an increase in volume of calls offered.

Objectives To support NHS 111 providers in responding to paediatric calls during the Covid-19 pandemic, and to assess the feasibility of including paediatric expertise within NHS 111 CAS and its impact on service delivery.

Methods In May 2020, 70 paediatric clinicians, identified via the RCPCH (or locally), were on-boarded and trained to work remotely within the CAS of six NHS 111 providers in England. Across all six NHS 111 provider sites, the volunteers worked alongside existing CAS clinicians, providing call-backs to carers of paediatric cases under 16 years old, irrespective of the presenting complaint. Data were gathered from existing NHS 111 provider systems to include immediate outcomes (dispositions) and patient/carer feedback. Contributing paediatric clinicians and NHS 111 staff were surveyed by questionnaire and/or phone call.

Results 2535 paediatric cases were taken by paediatric clinicians and 137,008 paediatric cases by non-paediatric clinicians working in the six NHS 111 providers from 25th May to 4th

Abstract 1446 Table 1

		Disposition					Total
Clinician type	Paediatrician	Self-care, no onward referral (%) [*]	Attend primary care (%) ^{**}	Attend ED (%) ^{**}	Ambulance call-out (%) ^{**}	Other (%) ^{**}	
		1,740 (69)	326 (13)	319 (13)	38 (1)	112 (4)	2,535
	Non-paediatrician	58,865 (43)	40,612 (29)	24,006 (18)	5293 (4)	8232 (6)	137,008

*Chi Squared (χ^2) (df 1, N 139 543) = 667.8, p<0.01

December 2020. Disposition rates varied between the calls taken by paediatric vs non-paediatric clinicians (table 1).

******All categories significant at p<0.01 e.g. self-care versus primary care referrals χ^2 (df = 1, N = 78938) = 37.95, p<0.01

Survey data from 62/70 volunteers indicated that they enjoyed working for NHS 111. NHS 111 staff surveyed (n=14) and interviewed (n=5) reported that paediatricians contributed to improving the service delivery to young patients. Feedback from carers whose calls had been taken by paediatric clinicians at one NHS 111 provider (n=60) showed higher satisfaction rates when compared with national averages for all calls (including adults and children) (92% vs 67%), with more reporting that their problem was resolved (92% vs 26%).

Conclusions The data showed that enhanced paediatric support within NHS 111 CAS is likely to reduce the large volume of children advised to attend ED or primary care, while improving the families' experience. Further work will explore the longer term outcomes within the NHS, and more detailed carer feedback. In future, more integrated models of care for CYP needing urgent and emergency care services may be achieved by this means, and better access to alternative health-care support through hospital or community-based services, such as rapid access clinics.

Paediatricians with Expertise in Cardiology Special Interest Group

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UNRECOGNISED LONG QTC SYNDROME- CAN WE DO MORE?

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10.1136/archdischild-2021-rcpch.648

Background The congenital long QT syndrome is a disorder characterized by Q-T interval prolongation on electrocardiogram that predisposes the heart to ventricular tachycardia and fibrillation. Children with long QT are prone to life threatening ventricular arrhythmia. The condition may remain unrecognized for a long time in children who present with recurrent episodes of syncope and seizures. We report a case of congenital Long QT Syndrome being thought to have vasovagal syncope and discuss the importance of having conversations about how early recognition of this condition could be promoted.

Objectives To study the clinical profile of a patient with long QT syndrome presenting as seizures and syncope.

We aim to evaluate the patient with genetically confirmed long QT syndrome to establish the frequency of delayed recognition.

We aim to raise the awareness of the possibility of Long QT syndrome in cases of unexplained recurrent syncope with seizures.

Methods We report a 9 year old girl who presented since 2 years of age with history of intermittent syncope and seizures. The girl had multiple presentations to ED and one presentation to the paediatric ward with either syncopal episodes or short seizure like episodes secondary to painful stimuli which were thought to be vasovagal. She did have previous ECGs which were reported as being normal however retrospective analysis of one of the available ECG showed a QTc of 463 milliseconds. She had background of PUJ obstruction and came to the hospital last year for DMSA (dimercaptosuccinic acid scan). During the cannulation she had a syncopal episode with quick recovery. And an ECG done showed bradycardia with a QTc of 460 milliseconds. She was referred to the inherited cardiac care team and further genetic analysis confirmed a pathogenic KCNQ1 mutation (long QT1). Her mother (who was suffering with seizures) and brother were also diagnosed with long QT syndrome. She was commenced on Nadolol and is currently stable and doing well.

Results There are several case reports of unrecognised long QT syndrome in literature and this case is another example of the same. The case illustrates that more needs to be done by the PEC (Paediatricians with expertise in cardiology) and Paediatric cardiologists groups to ensure these are recognised early to avoid morbidity and mortality. An index case often results in diagnosis of other members in the family so has significant preventative implications for avoiding sudden cardiac arrests. Suggestions would include more education for colleagues in Emergency department, Primary care and general paediatricians about manual QTc calculations and pertinent family history, all children with syncope having ECGs vetted by PECs and more discussions in specialist group committees.

Conclusions The presence of a prolonged QT interval and sinus bradycardia along with documented ventricular tachycardia during the 'seizures' confirms the diagnosis of the Long QT syndrome. This possibility should be considered by paediatricians who see a child with seizures or recurrent syncope.

This experience emphasizes the importance of obtaining an electrocardiogram in all children with syncope or seizure disorder of unknown origin.

Paediatric Clinical Leaders: Service Planning, Provision and Best Practice

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CREATION OF A PILOT MEDICAL EQUIPMENT LOAN BANK TO FACILITATE RAPID DISCHARGE FROM A TERTIARY CHILDREN'S HOSPITAL DURING THE CORONAVIRUS PANDEMIC

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10.1136/archdischild-2021-rcpch.649

Background Children who, by definition, are classified as long stay or delayed patients are in hospital for longer periods of

time. A large proportion of these children have equipment requirement for discharge. These vary dependant on condition and clinical dependency. The majority usually require a minimum of at least a piece of equipment such as: a suction machine, saturation monitor or nebuliser. Many of the children, who would be described as children with medical complexity (CMiC), would require all of the above, plus additional pieces. All equipment would be deemed a necessity for discharge and so therefore, would be non-negotiable. Many of the children would have co-morbidities that would be perceived to have an increased risk of deterioration or fatality if exposed to infection risks, such as, Coronavirus.

Objectives We undertook a pilot medical equipment loan bank, for children where equipment was a perceived barrier to discharge

Methods The pilot equipment loan was undertaken using the creation of a medical equipment bank, which consisted of surplus medical equipment, which was commonly required for discharge i.e. suction machines, saturation monitors, portable ventilators and humidifiers. This equipment loan service was led by a Family Support Worker and Sister from The Children with Medical Complexities Team. The main stakeholders included key teams such as: Clinical Teams, Therapies and Medical Representatives. The loan was based on a rapid discharge basis, where equipment was the perceived to be a barrier to discharge. The equipment was held in a central point and carefully monitored and followed up with child's local community teams or CCG. Arrangements were made for the pieces to be returned in person or collected from places of safety, i.e. Hospices or community team offices.

Results From the start of the Coronavirus pandemic until the current day, the estimated amalgamated cost saving to the Trust is in excess of £300,000, taking into consideration the cost per item. This was based on various pieces of equipment being loaned from different specialisms and ward areas. When samples of six loans were reviewed the collective bed days saved was in excess of 1000. The bed day costs varied dependant on specialism and ward area. Some of the areas naturally demanded a higher tariff than their lower dependant counterparts.

Conclusions The Coronavirus pandemic has enabled innovation, learning and initiative to be challenged. This would ordinarily have not occurred and consequently barriers would have been formed with the biggest impact being on the child and family. The rapid medical equipment bank pilot demonstrates that by working together in conjunction with others, thinking innovatively and putting the child and family at the centre, we can effect change. The longer term goal would be how the pilot can be developed into something more substantial.

Quality Improvement and Patient Safety

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DRUG DRILLS: IMPROVING PAEDIATRIC TEAM PERFORMANCE AND CONFIDENCE WHEN PRESCRIBING AND PREPARING UNFAMILIAR EMERGENCY MEDICATIONS

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10.1136/archdischild-2021-rcpch.650