on paediatric specialties. Seizure management, asthma care and recognizing the deteriorating child was rated as useful and relevant by 70%. Among the Partnership interventions, specialty topic teaching was seen by 23% of interviewees as most valuable for their personal development and by 21% as the most important intervention for QECH.

Inter-professional sessions attended by both nurses and doctors was highly evaluated as enabling collaborative working and communication.

Feedback from BWC team showed high trainer satisfaction across all multi-professional trainers. 100% of doctor trainers were able to finalise a teaching schedule prior to arrival, whereas specialist nurse and AHP trainers were unable to timetable sessions adequately due to variable non-medical staffing levels at QECH. All BWC and QECH professionals felt that prior identification of learning needs, with a schedule advertised in advance would be most effective to ensure engagement.

Conclusions Paediatric specialty training is a highly valued aspect of BWC- Malawi Partnership, particularly for the development of specialist nurses. Multi-professional training sessions delivered by nurses and AHPs have been identified as crucial for developing holistic, specialised paediatric care. Co-development of sessions would enable delivery of training relevant to available resources and treatment options. Advance planning is required to enable attendance in resource-limited settings with considerable staffing shortages. The inter-professional sessions enables development of collaborative team behaviours and cohesive clinical practice and should be further developed.

Paediatric Clinical Leaders: Service Planning, Provision and Best Practice

1491 ROLE OF CHAMPIONS OF FLEXIBLE TRAINEE (COFT) UNDERPINNING IMPROVED EFFICIENCY IN ROTA PRODUCTION FOR SPECIALTY TRAINEES

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Background The strategic role of ‘Champion for flexible trainees’ (COFT) has been developed to promote and improve support for less than full time (LTFT) and other models of flexible training.

Listening to the trainee voice, comments were noted regarding the challenges of availability of timely rotas prior to commencing placements especially for LTFT trainees. Paediatrics has a higher number of Less Than Full Time (LTFT) trainees in comparison to other hospital specialities.

The champions of less than full time working, in collaboration with the trust human resources, completed a process mapping with the aim of identifying the steps and decision making within the sequence to improve knowledge and efficiency in this area.

By definition, a process is a series of actions taken to achieve a particular end. Process mapping is an exercise to identify all the steps and decisions of an existing process in diagrammatic form, to identify improvement opportunities for increased efficiency.

Objectives The main objective was to identify all the processes from trainee job allocation to final rota production within the trust. To successfully achieve this, secondary objectives were to clearly show the decision processes along the chain, to demonstrate the essential networks and interdependence between the personnel within each process steps, and to highlight areas of possible delay within the chain.

Methods In collaboration with personnel directly implicated in each stage of the process, we identified all the processes from trainee allocation of placement to the development of the departmental rota.

Six essential personnel/components were identified; the Local education and Training board, the trainee program director, the trust (including human resources), the college tutor/rota co-ordinator, the trainee and the rota.

A timeline was then mapped to the relevant stakeholders based on the code of practice. Relevant actions were earmarked and rate limiting steps identified. A solution was proposed to each hurdle to allow a smoother flow in the process.

For the LTFT trainees, human resources agreed to send a welcome email with a template of questions that identified the working pattern/days of work. This aided them to marry the information up to the master template. Hence it was easier to identify issues prior to completing their work schedules (trainee contract).

Results The process mapping was well received by the human resources, departments and education teams in the trust and the region. It has sketched every aspect of rota production for a trainee, especially LTFT trainee.

A pilot conducted in early part of this year showed that due to the process mapping – timely rotas were populated and sent to trainees 6 weeks in advance. This led to a positive experience for the trainees and a positive feedback during their induction especially from their rota perspective.

Conclusions COFT roles are crucial in addressing LTFT trainee challenges and working collaboratively with trusts, organisations, health education boards and trainees. We need to continue to show strong commitment in supporting trainees working LTFT and support improved working lives.

REFERENCES
1. Less than full time training – guidance RCPCH https://www.rcpch.ac.uk/resources/less-full-time-training-guidance

Association of Paediatric Emergency Medicine

1493 INFANTS ATTENDING THE PAEDIATRIC EMERGENCY DEPARTMENT WITH FEEDING DIFFICULTIES & REFERRALS TO NURSE LED INFANT FEEDING CLINIC

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Background Infants with feeding difficulties are a common presentation to the Paediatric Emergency Department (PED). Families have often seen their General Practitioner/Health
Visitor (HV) but have felt it necessary to attend the PED acutely, this has especially been an issue due to COVID with reduced access to Primary Care services. In Autumn 2020 a new pathway was introduced for PED clinicians to refer directly to a specific ‘Infant Feeding Clinic’ (IFC). This is run within the hospital by a Paediatric Nurse and HV. There are clear referral criteria and infants who have been assessed in PED are offered a virtual/face to face consultation.

**Objectives** To assess whether infants presenting to PED with feeding problems are being appropriately referred to IFC. To assess the presentation and management of infant feeding problems in the local paediatric population.

**Methods** Retrospective case-note audit on infants <6 months of age presenting with feeding difficulties over a 1 month period in Oct 2020 to the PED. Exclusions were: 1 cleft palate and 1 complex gastro issues. Notes were reviewed to assess infants referred to IFC. Referral criteria are: <6 months of age at time of referral, born at >34 weeks gestation, no known co-morbidities, no red flags as per regional Infant feeding pathway, no evidence of faltering growth.

**Results** 30 infants were identified attending with a feeding problem to the PED. Mean age was 58 days (range 3–149 days old), 25 were formula fed, 3 breast fed & 2 breast fed with formula top ups. There were a range of presenting complaints – the majority being ‘unsettled’ or ‘reflux’. 53% were first time parents, 33% had already seen their GP and 20% already attended an ED previously for the same problem. 58% of infants had no treatment, the remaining patients being prescribed hydrolysed formula (16%), gaviscon/carobel (23%) or Omeprazole (3%). Despite CMPA being 40% of patients’ final PED diagnosis only 16% were prescribed a hydrolysed formula (table 1).

Once seen at the IFC the mean number of patient reviews was 2 visits. 78% had further treatment or onward referrals (eg allergy clinic), 11% had no further action and 11% were not brought to their appointment.

**Conclusions** Feeding problems are a common presentation to the PED. GOR & CMPA are the most common diagnoses. GOR appeared to be over-diagnosed in the PED but CMPA appeared to be comparable from PED to the IFC. 58% of infants received no medication in the PED. 60% of infants were referred on to the IFC for further care with 27% discharged to their GP/HV (table 2). This audit shows that direct access from PED to an infant feeding clinic with clear referral criteria is beneficial for this group of patients and provides a valuable service.

### British Association of Child and Adolescent Public Health

**1496** **BODY MASS INDEX AND USE AND COSTS OF PRIMARY CARE SERVICES AMONG WHITE BRITISH AND PAKISTANI CHILDREN: FINDINGS FROM THE BORN IN BRADFORD COHORT STUDY**

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**Background** Obesity is associated with increased morbidly and people of South Asian ethnicity have been reported to be at a higher risk of developing cardio-metabolic conditions at a lower BMI threshold compared to White European populations. In recent decades, childhood obesity has become a global health emergency with higher prevalence leading to obesity associated metabolic conditions that were previously unusual in childhood. The prevalence of childhood obesity in the United Kingdom is among the highest in Europe with recent estimates indicating that South Asian children have higher rates compared to White British children. We examined the direct impact of obesity on the health of children from different ethnic backgrounds through assessment of their utilisation of primary healthcare services.

**Objectives** To determine the association of body mass index with primary healthcare use and costs during childhood and assess the impact of ethnicity on this association.

**Methods** Prospective longitudinal analysis of the UK White British and Pakistani children in the Born in Bradford cohort study with linked primary care records and height and weight measurements recorded at age 4–5. Incidence rates of outcomes of primary care consultations and prescriptions up to the age of 8 years were modelled using negative binomial regression. Associated direct healthcare costs were modelled using a generalized linear model with log-link function and gamma distribution. All models were adjusted for child sex, birthweight, gestational age, Mother’s BMI, mother’s age and deprivation and accounting for time at risk for each child.

**Results** There were a total of 3,469 White British and 4,346 Pakistani children. The proportion of obese children was 9.97% in White British and 10.17% in Pakistani children. Overall, the adjusted incidence rates of consultations and prescriptions were significantly higher in obese children when compared with normal weight children (consultations: incidence rate ratio (IRR) 1.19, 95% CI 1.11–1.27; prescriptions IRR 1.20, 95% CI 1.10–1.30). The adjusted direct healthcare costs were also significantly higher in obese children when compared with normal weight children (absolute difference: £19.9, 95% CI 8.2–31.7).

The adjusted incidence rates (IRs) of consultations and prescriptions were significantly higher in Pakistani children in all BMI categories compared to White British children (e.g., consultations: Pakistani obese had 2,323 consultations per 1000