British Association of General Paediatrics

1617 EVALUATION OF A MULTIDISCIPLINARY TEAM MODEL OF CARE IN PAEDIATRIC INFLAMMATORY MULTISYSTEM SYNDROME TEMPORALLY ASSOCIATED WITH SARS-COV-2 (PIMS-TS)

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Background Coronavirus disease (COVID-19) pandemic has seen the emergence of a novel paediatric condition Paediatric Inflammatory Multisystem Syndrome Temporally associated with Severe acute respiratory syndrome coronavirus 2 (PIMS-TS). Royal College of Paediatric and Child Health guidance for the management of PIMS-TS recommends early discussion with relevant specialists in a multi-disciplinary team (MDT) setting.

A regional MDT panel including representatives from cardiology, general paediatrics, infectious diseases, intensive care, rheumatology, research and pharmacy was established in May 2020 at pace with the evolution of PIMS-TS. Daily clinical decision support was provided using a video conference platform for all regional paediatric units.

Objectives We describe the evaluation of the newly configured PIMS-TS MDT, using a mixed-methods survey to capture user experience and feedback.

Methods Evaluation was conducted in July 2020. All users of the MDT service including chairpersons, panel members and referring clinicians were invited to complete the online survey. A 28-point questionnaire based on validated MDT evaluation methodology was developed and included 5 domains relevant to the PIMS-TS MDT: 1. Meeting organisation and process 2. Meeting infrastructure and logistics 3. Clinical decisions 4. Working and culture 5. Meeting feedback.

Results Survey response rate was 75%. Results from each domain is as below:

1. Meeting organisation and process: – Users (90%) were aware of referral criteria, referral processes (86%) and MDT configuration including chairperson (90%) and panel members (75%). Majority were not aware (27%) or uncertain (25%) of specific meeting structure and protocols.
2. Infrastructure & logistics: Majority (63%) found accessing videoconference platform straightforward (90%), with only (18%) reporting quality issues. Notably, nearly half the MDT users (49%) reported capacity and time restraints affecting their ability to attend the MDT.
3. Clinical decisions: Clarity of clinical recommendations was acknowledged by majority (90%). Two thirds (65%) were aware of case referral proforma, nonetheless, majority were unsure or not aware of processes around post-MDT documentation in patient records.
4. Working and culture: There was 98% agreement that MDT facilitated constructive discussion, supported learning and research and had positively impacted patient care.
5. Meeting feedback: Rapid access to specialist expertise and complex decision-making support was universally acknowledged. Areas highlighted for improvement pertained to time and capacity constraints limiting participation, and to

embed an MDT culture which encouraged inclusive, supportive behaviours and a collaborative team ethos.

Conclusions Our evaluation of the new PIMS-MDT demonstrates the process of agile adaptation to change followed by continuous learning and improvement, required to create efficient healthcare systems. User survey feedback identified excellent practice of achieving region-wide standardised care but also highlighted time and capacity constraints and the importance of fostering a supportive culture, which were subsequently incorporated in developing the MDT processes. Rapid implementation of system-wide changes at unprecedented scale and pace has been the norm during the COVID-19 pandemic, but this must be coupled with iterative cycles of learning and improvement to ensure optimal care.

Young People's Health Special Interest Group

1618 INVOLVING AND ENGAGING CHILDREN, YOUNG PEOPLE AND CARERS IN THE ECHILD PROJECT

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Background Involving children, young people and parents in research about them is essential. However, best practice specific to research involvement and engagement using administrative data is under-explored, yet particularly important given past high-profile cases of big data mismanagement and security breaches that have reduced public confidence. We describe our approach and interim findings from a programme of research involvement for the ECHILD (Education and Child Health Insight Linked Data) project. ECHILD links the Hospital Episode Statistics database with the National Pupil Database, to examine relationships between health and education for children and young people in England, with particular emphasis on understanding the impact of the Covid-19 pandemic on vulnerable groups.

Objectives We planned a programme of child, young person, parent and public involvement and engagement throughout the duration of the project. Our objectives were to i) understand the diversity of views on linking these two datasets, ii) explore how definitions of 'vulnerability' might differ to those applied by Government Departments, and iii) identify priorities for research questions that can be answered by the linked dataset.

Methods We accessed three standalone patient and public involvement groups comprising 30 children, young people and parents/carers through our partner, the National Children's Bureau (NCB). The groups were i) the Young Research Advisors, ii) the Family Research Advisory Group, and iii) FLARE, which is organised through the Council for Disabled Children and commissioned by the Department for Education. Sessions were online, semi-structured and facilitated by the NCB between August – December 2020. Content was captured through facilitator note-taking, flipchart paper with sticky notes and digital posts created by members in the groups.

Results Children, young people and parents were keen to discuss the ECHILD Covid-19 project and have further ongoing engagement with project. Young people emphasised a need to raise awareness about the data that is routinely collected about them, and how it should contribute to research. They supported the use of the linked data - when in de-identified form and with secure access - for research to improve the health and education of children and young people. The term 'vulnerability' was rejected by all groups and, while consensus on an alternative was not reached, group members generally preferred terms that reflected 'additional service needs'. Young people were particularly concerned with the impact of school closures on mental health and would like future research to address this area.

Conclusions Engagement with children, young people and parents/carers is crucial to the ECHILD project and for inspiring trust in using linked administrative data for research. Our findings highlight the need for greater awareness of research using administrative data and that engagement should span the project lifetime. We have planned further meetings with these groups and other relevant stakeholders to ensure research conducted is timely and meets the needs of children and young people accessing health and education services.

Quality Improvement and Patient Safety

1620

A QUALITY IMPROVEMENT PROJECT TO IMPROVE THE HANDOVER PROCESS IN THE PAEDIATRIC DEPARTMENT, THE ROYAL STOKES HOSPITAL

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Background Handover is key to patient safety as it provides continuity of care despite staff changes. Good quality handover is essential and will protect the safety patients and increase service satisfaction. For medical staff, a good handover will improve job satisfaction and support safe care for patients through measures to prevent doctors working excessive hours.

Objectives To employ a quality improvement methodology to improve the handover process by encouraging a fixed and strict handover time, ensuring an interruption free handover and introducing a safety briefing.

Methods A driver diagram was created to set out the aims of the quality improvement project (QIP) and a Plan Do Study Act (PDSA) cycle was adopted to help implement changes. The QIP took place over a period of five months, over four PDSA cycles in the paediatric department.

A proforma was created to measure the start, duration and end time of handovers taking place in the paediatric department. All proformas were filled in by various members of the junior doctor team and relevant stakeholders were engaged through the process. At the end of each cycle, the team had an opportunity to provide formal feedback for improvement, either verbally or by completing a questionnaire. During the data collection, feedback was continually collected through a comment box on the proforma.

After cycle one, the safety briefing was introduced. After cycle two, a poster was created and shared with nursing staff as a reminder of protected handover times. A formal time-keeper was also introduced. Throughout the process,

consultants were involved to encourage efficient and timely handover.

Results Over the course of the quality improvement project, data was collected for 122 handovers. Over the four cycles, punctual start time and handover duration (less than 30 minutes) fluctuated but overall worsened by cycle four. Despite this, late finish time improved from 71% to 60% with late finish time of more than 10 minutes improving from 29% to 20%. Non-emergency bleeps during protected time improved from 37% to 7%. After its introduction, completion of the safety briefing has become better from 17% to 50% and is a working progress.

Overall, since commencing the QIP, 86% of staff have noted a moderate to significant improvement in the general handover process, with 14% noticing no change.

Conclusions Following the quality improvement project, there has been improvement in some processes of the handover including finish times, interruption free handovers and introduction of the safety briefing. There has been much interest and engagement from all members of staff from consultants through to nurses. This quality improvement project will continue to implement changes to improve the process.

Association of Paediatric Emergency Medicine

1623

EXPLORING THE EXPERIENCE OF ADOLESCENTS IN A PAEDIATRIC EMERGENCY DEPARTMENT – TOO OLD OR TOO YOUNG?

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Background In paediatric emergency medicine (PEM), the age of transition from paediatric to adult emergency care is variable across countries. The UK has no agreed national standard on ED age limits and this arbitrary upper age limit is often set locally by commissioning groups reflecting service capacity and the population in which it serves. In Northern Ireland, adolescents often fall into the adult domain, with the regional paediatric emergency department (PED) catering for children up to fourteen years of age.

However, in response to Covid-19 surge planning, the PED age limit increased to age sixteen. This decision marked significant progress in the regional strategy to shift paediatric services to 'a target transition stage of sixteen' as well as coinciding with the NHS Long Term Plan to move towards 0–25 service models. Our retrospective survey aims to explore the experience of young people in the PED during this time and their preferred setting to receive care.

Objectives To determine the satisfaction reported by adolescents when visiting a PED and elicit the acceptability of both paediatric and adult services in this age group.

Methods A prospective 10-point survey was developed to assess adolescents' overall satisfaction with their PED experience as well as their views on the waiting room setting, clinical treatment areas and staff. Data was collected over an eight-week period from adolescents aged fourteen and fifteen attending PED. The survey was administered at point of discharge or admission to hospital and completed