

- gathering views from family members and carers who have been involved in a review process. Reviews will be conducted into the deaths of all live born children up to the date of their 18th birthday, or 26th birthday for care leavers who are in receipt of aftercare or continuing care at the time of their death

**Results** The national child death review process will be fully implemented by 1 October 2021.

Following implementation, the National Hub will collate and disseminate learning from reviews with the aims of changing future professional clinical practice, informing policy change and reducing avoidable deaths in Scotland.

**Conclusions** For the first time in Scotland, national data will be collected on the deaths of all children and young people. Working with NHS boards and local authorities, the ambition is to inform the redesign of pathways and services to ultimately reduce avoidable deaths, and where that is not possible, to improve the experiences of children, young people and their families

## George Still Forum: ADHD Disorders (ePoster presentations only)

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### ADHD ASSESSMENT IN A DISTRICT GENERAL HOSPITAL: GETTING IT RIGHT FIRST TIME

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**Background** ADHD is a common neurodevelopmental condition of childhood which persists into adulthood. There is significant burden of co-existing neurodevelopmental disorders, mental health problems and other comorbidities. A delayed or mis-diagnosis can have significant negative impact on a person's development and later social or occupational functioning.

In 2015 recurrent issues with the assessment pathway for children referred to community paediatrics with possible ADHD were identified, which were taken as a proxy for poor patient experience and system inefficiency. A Quality Improvement project was undertaken, which assessed a cohort of 50 patients and identified a range from referral to 'decision to treat' of 42–594 days, variable outcomes and poor documentation of registrar supervision. Due to complexities of patient profiles and assessment pathways, further QI targets were difficult to identify.

**Objectives** Five years on we wanted to assess whether the service was 'Getting It Right First Time' for children referred with difficulties labelled as possible ADHD, and identify where service provision could be improved. We took the same cohort of 50 patients identified in 2015 to look at whether outcomes were changing over time, amount and type of contact patients had with hospital services, and to assess presence of indicators of poor or positive outcomes.

**Methods** Data was used from the 2015 QI project as a starting point.

Electronic notes were reviewed and data collected for:

- outcome recorded in 2020 (ADHD/not ADHD)

- number of contacts with paediatric staff (clinical and clinical administration) and the Emergency Department/local Minor Injuries Unit
- 'Red flags' as identified through discussion with consultant colleagues, NICE guidance for ADHD, and a PubMed search for poor outcomes ADHD. These included: re-referral if 'not ADHD' in 2015, safeguarding concerns, significant risk or accidental harm, police involvement, substance misuse, school exclusion, progressive school failure, family or peer relationship breakdown, parent/patient dissatisfaction, problematic low self-esteem, and obesity
- Notes were made about co-occurring diagnoses and EHCP/SEN status
- Positive signs were identified and included: evidence of school achievement, positive feedback from a guardian/young person, engagement with hobbies, documentation of growth, and not being re-referred if discharged from the service

**Results** Diagnostic outcome changed in 18% of patients. These patients had significantly more clinical paediatric contacts (mean 6.5 vs 2.6,  $p=0.0134$ ) and red flags (mean 4.4 vs 1.4,  $p=0.005$ ) than where outcome was unchanged.

There was no significant difference in total number of red flags between those with or without ADHD diagnosis in 2020. However, children with ADHD were more likely to have mental health problems (24% compared to 14%), more likely to have not been brought to two or more appointments or disengaged with services (48% compared to 34%), and more likely to have evidence of family or peer relationship breakdown (43% compared to 32%).

Of those with 3+ red flags, 42% had an ADHD in 2020 and 58% did not. 58% were aged 8–13 years compared to 47%, and 33% were diagnosed with ASD within 5 years, compared to 5.3% in those with fewer red flags. 75% of those in the 3+ red flags group had EHCP/SEN support instigated since 2015, with 83% being in receipt of an EHCP/SEN support in 2020. This compared to 18% with EHCP/SEN support in the lower red flag group, with just an 8% change in this status since 2015.

**Conclusions** This project demonstrates the importance of GIRFT when assessing possible ADHD. This includes timely consideration of ASD as a co-occurrence, a potentially greater need for close follow up of children aged 8–13 years (transitioning to secondary school) with close liaison with education services, and the importance of assessing mental health in ADHD follow up.

## Quality Improvement and Patient Safety

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### A HAVEN FOR FATIGUE: STANDARDISING FIRST OUTPATIENT VISIT EXPERIENCE FOR YOUNG PEOPLE WITH CHRONIC FATIGUE SYNDROME

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**Background** Chronic fatigue syndrome (ME/CFS) is a debilitating illness that significantly impacts on a young person's physical health and mental well being. All patients accepted by the University College London Hospital multidisciplinary team should all be offered an initial comprehensive appointment

and support to meet their needs. Our initial investigation indicated wide variation in range of support that was offered. The variations were around clinician management plans and follow up management.

**Objectives** The aim of this project was to reduce variations in clinician approach and inform a standardised approach to interventions offered at the first outpatient visits for all patients diagnosed with ME/CFS including the assessment itself, offers of written information, places on education groups and follow up appointment visits with the team.

**Methods** Using the electronic health records system (EPIC), information on clinician documented plan for all patients attending the outpatients' clinic between September 2019 and July 2020 was collected. Patients who did not meet the criteria for the diagnosis ME/CFS were excluded. A baseline measure derived from 20 patients was established and measurement were collected for the next 20 patients whilst we tested changes. The measures were the number interventions recorded in the plan which included: wellness scoring; provision of written information; referral to groups; and standardised follow up visit interval. Ideas to support change were tested using PDSA cycles, so that we could detect any improvement.

**Results** Following our interventions there was a 65% improvement in provision of written information to patients, 15% improvement in wellness scoring and 40% improvement in referral of all patients to education groups. There was a reduction in variation in practice of over 50%. The median score for interventions increased from 1 out of 3 to 2 out of 3. Variation in length of time for follow up visits was also reduced.

**Conclusions** Many young people with CFS/ME undergo a long process to get a confirmed diagnosis. Having travelled a long distance to the service, it is important to them and the team that the quality of their visit is optimised and all patients receive the same standards. Our team successfully improved the process for their first visits. During this QI process seven information leaflets were completed by the team. Agreement was reached to standardise follow up time interval for all patients. The pathway for referral to education groups also improved. This process will also be useful in guiding junior doctors joining the team for the first time. There is a plan to capture patient feedback and outcomes.

## Quality Improvement and Patient Safety

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### REMOTELY ENHANCING OUR EDUCATION IN RESPONSE TO COVID (APLS AND CPRR)

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**Background** When COVID hit, ALSG had to quickly adapt their education programmes to ensure training was safe and sustainable. The RCPCH endorsed APLS course, and the RCPCH joint Child Protection (CPRR) course, have been adapted and made accessible in a remote environment, allowing for safe delivery of essential training, with learning still very much at the heart.

### Objectives

- Although the environment had changed and many restrictions on human contact were put in place, keeping learning at the heart of education was ALSG's fundamental objective.
- The candidates' experience must be enhanced by learning remotely.
- Make training available and accessible in a safe environment by evolving courses to be delivered online.
- Save lives and improve patient outcomes by continuing to provide essential training.
- As child protection presentations increased during COVID, it was important for ALSG to ensure colleagues had the skills and confidence to be able to address these.

### Methods Methods - APLS

APLS is traditionally a two day, face-to-face course with a third day doing pre-course online learning via interactive e-modules. An alternative 'remotely enhanced' APLS model was adapted which now includes:

1. One day pre-course learning (e-modules) and additional online materials such as skills, tutorials and podcasts.
2. One day remote learning – faculty-led teaching in a virtual environment, building on the pre-course learning. Case based discussions have been introduced to prepare the candidates for how their learning and practice works in the workplace.
3. One day practical face-to-face training with embedded skills which gives candidates more time to practise the illness, cardiac and trauma skills through simulations.

### Methods – CPRR

CPRR has been converted from a one-day, face-to-face course to a fully online course. The majority of the learning takes place in virtual groups of 3 or 6 candidates, in the form of discussions and role plays. As a lifesaving communications course ALSG has taken the opportunity to increase the practice of difficult conversations, introducing new, up to date role plays to reflect the increase in domestic violence and self-harm during the pandemic.

**Results** ALSG and centres around the UK have adopted the remotely enhanced model of learning and 23 courses have taken place since September 2020.

### Faculty member

'ALSG have continued to put the needs of the patients and candidates first resulting in a course [APLS] that continues to deliver first rate education. I felt that the COVID measures in place were innovative and comprehensive which meant they had minimal impact on our ability to focus on teaching.'

### APLS working group chair

'Education lies at the heart of this course, as clinicians must continue to progress their learning as well as their skills and the launch of APLS in this new format is an excellent step forward and one which will continue past the current pandemic.'

**Conclusions** ALSG's remotely enhanced courses provides colleagues with an alternative way of engaging in training whilst global restrictions are in place. It provides candidates with additional resources to support their learning and many have commented they feel much better prepared for attending the course. Remotely enhanced learning is not just for the here and now, ALSG sees a place for this in the future too.