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.