and subsequent further manipulation in theatre and reduces admission rates compared to previous audit data

- Ascertain if using entonox and intranasal diamorphine for the manipulation of forearm fractures was perceived by parents to be satisfactory pain relief for the procedure
- Ascertain if using entonox and intranasal diamorphine for the manipulation of forearm fractures provides a satisfactory patient experience

Methods A specially designed parental/patient experience survey was developed and given out to patients requiring a forearm manipulation in CED between June - October 2020.

Retrospective case notes review of all patients <16 years attending CED with a forearm fracture during the same period to identify management and outcome.

Results During the survey period 47 children attended CED with a forearm fracture requiring manipulation. Of these 21 parents completed the survey.

Overall 85% of all patients attending CED with a forearm fracture requiring manipulation had it done in CED compared to 34% in 2018.

100% of survey respondents felt their child's pain was well managed during the procedure.

Only 14% of patients with forearm fracture attending CED were admitted for manipulation in theatre during this period compared to 66% found in audit data previously.

Conclusions Use of Entonox and IN diamorphine is provides effective pain relief for manipulation of forearm fractures that is acceptable to parents. A change in practice to using this first line can reduce admission rates and subsequent theatre time for this common fracture significantly.

Child Protection Special Interest Group

630

THE NEED FOR A STANDARDISED APPROACH FOR PAEDIATRICIANS TO MANAGE CHILDREN NOT BROUGHT (WNB) TO OUTPATIENT CLINICS

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Background Children not brought to outpatient clinics pose significant safeguarding and logistical challenges. Learning from serious case reviews indicate that whilst it may indicate carers struggling to provide adequate care for their child, it is also particularly relevant for vulnerable children already on CP plans. Failure to attend medical appointments is recognised as a child protection issue within statutory definitions of neglect. Implied, therein, is the adverse consequence on health. The logistical difficulties include wasted clinic slots and extension of stretched waiting lists.

Objectives Audit our management of non-attendance (DNA/WNB) in general paediatric clinics, to highlight this important issue, and improve consistency across professionals. We expect this will reduce both the safeguarding risk and logistical burden from missed appointments.

Methods

Sample Period: 01/11/19 – 10/11/19

Criteria: All paediatric outpatient appointments across both trust sites with outcome 'did not attend'.

Relevant Sample Size: 70

Data Collection: Retrospectively from electronic patient records accessing clinic notes and letters, we assessed for presence of safeguarding alert in referral letters and information shared back to referrer following non-attendance - verifying contact details, interim management advice, assessment of safeguarding context and copy of letters to HV, school nurse or key worker.

Data was analysed for upto 3 non-attendances.

Validation: Use of Pro-forma

Exclusion Criteria: Patients who had appointments cancelled by the Trust, or were admitted as in-patients.

Results

- There was slight male gender predominance at 57%.
- Preschoolers (1–5yrs) were the most common age group at 41%, followed by teenagers (11–16yrs old) at 31%, and then primary school children (6–10yrs) at 18%.
- 84% of the new referrals were discharged after the first appointment. Yet:
- Only 13% had safeguarding or social background documented in the referring letter.
- 85% of non-attending children had letters sent to the GP and parents informing them of the missed appointment.
- 11% of letters requested GP to confirm the patient's address or contact details, 14% for the first one.
- 24% of letters were copied to the key worker, health visitor or school nurse; 30% after the second non-attendance.
- 50% of the letters had management advice for the GP or the parent.
- 10% of letters had a safeguarding reminder to GP in view of Non-attendance, only about 12% for the 3rd non-attendance

Conclusions Significant variations in management of non-attendance are evident. Safeguarding, clinical management or logistic burden of missed appointments is NOT sufficiently mitigated.

We recommend:

- Request to complete safeguarding status for referral linked to local or national referral system.
- Bespoke guideline followed by paediatrics and specialty clinicians, with clear escalation pathways.
- A standardised template that highlights previous non-attendances, safeguarding context, contact details and is copied to relevant health professionals.
- Robust guidelines followed widely, and additional context of virtual clinics would be welcome.

British Association of General Paediatrics

633

PARENT PREFERENCE: COMPARING TELEPHONE WITH FACE TO FACE CONSULTATIONS DURING THE COVID-19 PANDEMIC

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Background The Covid-19 pandemic led to a strong government response in attempts to limit spread of this virulent infectious disease. Societal measures included social distancing, hand hygiene with 'stay-at-home' advice, colloquially referred to as 'lockdown'. Medical practice had to respond quickly, respecting these measures whilst trying to offer ongoing patient services.

Objectives There has been a proliferation of virtual appointments, offered either via telephone or video call. For a paediatrics department in a major district general hospital, phone consultations were the immediately available option. Our study objective was to implement an online survey questionnaire to explore family perceptions on virtual telephone appointments.

Methods 168 families who participated in general paediatric follow up telephone consultations over a two-week period in May were contacted for consent to send them an online survey comparing telephone and face-to-face consultations. This group was targeted because they had at least one face-to-face appointment previously. The online survey consisted of 10 questions to compare different modes of consultations, including satisfaction rating using the Likert scale, and open text responses.

Results 40 families (response rate 44%) of 92 who consented, completed the online survey. 4 (10%) parents had a strong preference for face-to-face appointments, with roughly 25% each slightly preferring telephone or face-to-face appointments (9 and 12 respectively). 35% (14) did not mind either option. Despite this, if given the choice, 12 (30%) would choose face-to-face appointments in the future as opposed to 5 (12.5%) who would choose the telephone consultation. Parents rated convenience as greater for telephone appointments (33 responses, 85%). Some parents mentioned in feedback slightly better ability to remember information and ask questions. However, there was limited possibility for involving other adults and the child or young person.

Positive comments about virtual clinics included not having to pay for parking (6, 15%). Parents gave constructive feedback, saying they could be asked to be ready to provide information, for example child's current weight. Few children were involved, and this needs to be borne in mind, especially as visual cues can be missed over telephone. 3 families (8%) however did report that children were happy not to be involved in the discussions.

Conclusions Parents were grateful that some efforts had been made to maintain contact in difficult times, and responses may have been different in normal circumstances. There are some limitations to telephone consultations; mainly not being able to clinically examine or talk to children. Telephone consultations may result in silencing of the child's voice, with possible mental health and safeguarding issues. Some of these issues could be addressed with video calling. Interestingly despite convenience of telephone consultations, more parents indicated a preference for physical face-to-face consultations suggesting that, as the world returns to normal, whilst both options should be made available to them, we may not see significant changes in practice.

Going forwards it may be beneficial to ask parents after initial consultation and if appropriate, if they would like a telephone or physical face-to-face appointment in the future.

Quality Improvement and Patient Safety

636

EVALUATING THE UTILITY AND EFFECTIVENESS OF A REGISTRAR-LED RAPID ACCESS CLINIC

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Background Learning to manage patients in an outpatient setting is an essential skill for Paediatricians in training. It is also a key learning outcome for Level 3 Paediatric trainees as outlined in the RCPCH curriculum. A registrar-led Rapid Access Clinic (RAC) was introduced in a busy district general hospital (DGH) in October 2020, following feedback from trainees about a lack of exposure to outpatient care. The clinic was commenced to fulfil the training gap for trainees and also to alleviate the pressure on A&E and consultant clinics. A standard operating procedure detailing patient eligibility criteria and the referral process was created and approved by the consultant body. Letters were sent out to the Clinical Commissioning Groups to raise awareness with the local General Practitioners in September 2020. The RAC aimed to see patients within two weeks of referral.

We undertook a quality improvement project to evaluate use of the clinic and the experiences of trainees.

Objectives Our objectives were to audit the number of referrals to the RAC, the use of available slots and the number of patients seen within two weeks of referral. We also aimed to gain feedback from trainees on their experiences in clinic and whether they felt sufficiently supported.

Methods Data was collected over a 12-week period from 13/10/20–29/12/20. We retrospectively reviewed referral and clinic letters through the hospital's electronic notes system. Data collected included: number of slots used, reasons for unutilised slots, age, presenting complaints, source of referrals, number of days from referral to appointment and clinic outcomes. We also surveyed the registrars for feedback on how the clinics have impacted their training.

Results We found the overall utilisation of the clinic to be 62% (57/92 slots were used). On further examination of the reasons for low utilisation, we found that three clinic days were not used, possibly due to staffing issues and six slots were unfilled due to patient non-attendances. 17 slots were unaccounted for, likely due to a lack of referrals. 77% of patients were seen within the goal of two weeks from referral. Approximately 50% of patients were discharged from clinic, and the other half were referred onwards to another speciality, General Paediatrics or an allied health professional for follow up.

The feedback obtained from registrars highlighted other areas for further improvement. Most registrars found the clinic helpful with good levels of consultant supervision. Feedback was categorised into four areas: more time for administrative tasks, improvement in the clinic set-up, implementation of training on how to conduct a clinic, and formalising consultant feedback on management plans made.

Conclusions In conclusion, the RAC was shown to fulfil an important training need for Paediatric trainees in a DGH setting. The majority of patients were seen within the target time but slots could be better utilised by improving staffing