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

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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

levels and raising awareness within primary care. Feedback from the registrar survey has helped in planning effective interventions. Following the implementation of these changes, we will re-audit to assess improvements in the utilisation and registrar experience of the clinic.

British Society of Paediatric Gastroenterology, Hepatology and Nutrition

639 COELIAC DISEASE – ARE PATIENTS BEING EVALUATED ACCORDINGLY?

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10.1136/archdischild-2021-rcpch.114

Background Coeliac Disease represents a disease that is under-diagnosed, particularly when patients present in primary care and other non-specialist settings. Delayed diagnosis is a concern because of the potential long-term complications of undiagnosed Coeliac disease which can also impact on families and health care resources.

Objectives This review is aimed at assessing the compliance of a secondary care pediatric service to NICE guidance in the management of Coeliac disease in the pediatric population.

Methods This a retrospective analysis of medical records of pediatric patients less than 16 years of age who were diagnosed with Coeliac disease in a District General Hospital during a five-year period from May 2015 to May 2020.

Results There was a total of 41 patients diagnosed during the period of review. We were 100% compliant with two quality standards in NICE guidance which were serological testing and Specialist referral but fell short in other standards. Referrals for Endoscopic biopsy was not commensurate with the guidance with only 45% being referred, of which 62% of them had their biopsy performed within 6 weeks attributable to the unavailability of this service locally resulting in the need for tertiary referral. Annual review was documented in 85% of patients with no definite reason documented for non-attendance which reflects an area that requires improvement.

Conclusions This Audit recognized non-adherence to national guidelines in the management of Coeliac disease. Further efforts in educating the local team of appropriate investigations for Coeliac disease as well as improving awareness of the guidance are underway to improve service delivery and ensuring optimal patient care. There are also ongoing efforts to reinforce the importance of proper documentation to ensure clarity and accuracy of medical records. Another Audit will be planned to follow these efforts to hopefully be able to address improvement in local practice.

Quality Improvement and Patient Safety

641 'AUDIT ON CDOP (CHILD DEATH OVERVIEW PANEL) COVERING EAST BERKSHIRE'

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Background Child Death Overview Panel (CDOP): All Local Safeguarding Children Boards(SCBC) are required to have a CDOP in order to improve the health, safety and wellbeing of other children.

CDOP data is now electronically collected via eCDOP since 2018.

The key functions of CDOP:

Review all child deaths, excluding stillborn and planned terminations of pregnancy carried out within the law.

Determine whether the death was preventable. To identify preventable and modifiable factors and improve practice

Decide what, if any, actions could be taken to prevent such deaths happening in the future.

To disseminate learning to appropriate professionals.

Refer cases to the SCBC where there is suspicion of neglect or abuse.

To investigate all the unexpected deaths.

Usual procedure after a child dies:

Joint agency response (JAR) meeting is done within 48hrs-5 days of an unexpected death.

Morbidity & Mortality meetings or Child death review meeting(CDRM) is done NEXT usually at the hospital where the patient has died (aimed to be done in 3months).

CDOP Panel meeting (aimed to be done in 3–6 months) is done at the end when all (especially legal) work is completed and the case is usually then closed.

Objectives To collect data from eCDOP to measure compliance in line with new guidance published in 2018 and implemented in September 2019.

Methods

Sample size 32

Sample was identified by using eCDOP online data base.

Study Period Retrospective study covering a period since 01-09-2019 to 30-11-2020. It included all children who died in East Berkshire.

Results 1. Total number of deaths- 32.

Child deaths 25/32. Neonatal deaths: 7/32.

2. Expected Deaths: 23 Unexpected deaths: 9

3. Deaths in Local area: 20 Deaths whilst outside the area: 12

4. How many of unexpected deaths had a JAR meeting: 9

5. JAR held by: Local hospital: 6 Tertiary hospital: 3

6. How many Death notification forms had mentioned clearly discussion with the hospital medical Examiner:

Mentioned =21 (Needed 8, Not needed 13) Not mentioned =11

7. Did JAR identify a Key Worker?

In 9/9 unexpected cases. There was no documentation on eCDOP in expected cases.

8. Did the CDRM (Child death review meeting) or M&M meetings took place?

31/32âyes CDRM has been done. Only 1/32 cases is very recent and awaiting CDRM.

9. Duration between death à CDRM à CDOP panel:

Death à CDRM/M&M:

0–100 daysà27 101–200 daysà3 200–300 daysà2 301–365 daysà0

Death à CDOP Panel:

0–100 daysà2 101–200 daysà3. 200–300 daysà5 301–365 daysà1

10. How many have been discussed at CDOP panel à 11

Conclusions