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?

Marwa Ahmed, NHS

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 commenced 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’

Asad Nasim, Geetha Veerasamy, Wexham Park Hospital, Slough; Upton Hospital, Slough

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:

1. Review all child deaths, excluding stillborn and planned terminations of pregnancy carried out within the law.
2. Determine whether the death was preventable. To identify preventable and modifiable factors and improve practice.
3. Decide what, if any, actions could be taken to prevent such deaths happening in the future.
4. To disseminate learning to appropriate professionals.
5. Refer cases to the SCBC where there is suspicion of neglect or abuse.
6. To investigate all the unexpected deaths.
7. 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

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.
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? 31/32yes CDRM has been done. Only 1/32 cases is very recent and awaiting CDRM.
10. How many have been discussed at CDOP panel à 11

Conclusions

Abstracts

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