Mean time to triage for those who arrived by ambulance was 10:03 (mm:ss) with a maximum wait of 36:00. In comparison, those attending by other transport methods had a mean time to triage of 10:18, with a maximum wait time of 57:00. The total number of patients was significantly smaller than the previous year ruling out direct statistical comparison.

29 (15.8%) patients were brought by ambulance and subsequently triaged as category 4 or 5. None of these patients deteriorated.

Conclusions Arrival by ambulance does not always equate to acuity of presentation. The pilot demonstrated that the flow-chart is safe in paediatrics with a robust list of red flags. With the national PEWS incorporated we can safely identify low acuity patients. The next pilot introduces a 3rd arm identifying low acuity patients with normal PEWS who do not require a verbal handover. This has the potential to impact on ambulance turnaround time and improve space within the socially distanced waiting room.

Child Protection Special Interest Group

697 CHAPERONES IN PAEDIATRICS – ARE WE THINKING ABOUT IT?

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Background Since the 2004 Ayling report (1), the offer of formal chaperone during intimate examinations has been mandated in health care settings and reflected in the GMC guidance (2). The use of Chaperone Policies across NHS Trusts has considerable variability (3 4) and in practice adherence with chaperone policies is often poor (5). Within paediatrics there may be confusion about whether the presence of caregivers negates the need to offer a formal chaperone, further compounded by the absence of clearly defined age limits. **Objectives** The aim of the project was to evaluate compliance with the Trust formal chaperone policy within a tertiary paediatric hospital and to then develop strategies to improve performance.

Methods The Trust chaperone policy applies to all children and young people (CYP) under 18 years of age. The audit was conducted within the children's emergency department (CED) and children's outpatient department (COPD). Criteria for offer of a formal chaperone included unaccompanied CYP, intimate examinations (including upper torso examinations of female patients) and CYP or parents/carers with a history of difficult or unpredictable behaviour.

A prospective analysis of notes for CYP meeting the eligibility criteria was undertaken for paediatric CED attendances over a 7- day period and COPD attendances over a 2-day period in July 2019.

Data collected included:

- type of examination;
- documentation of formal chaperone offer (even if declined);
- name and designation of formal chaperone;
- gender (or gender identity) of formal chaperone and patient.

Results Of 567 attendances in paediatric ED and 118 COPD clinic attendances, 66 met eligibility criteria (9.6% of all attendances). Of these 6% were unaccompanied CYP and 94% underwent an intimate examination.

Only 10% of eligible patients in the paediatric ED and 8% in paediatric outpatients respectively had documented a formal chaperone. When a formal chaperone was documented there was >80% compliance with documentation of their name and designation and with being of the same gender/gender identity as the CYP.

Following the analysis, it was clear there were gaps in staff awareness of the policy and inconsistent documentation. A plan-do-study-act quality improvement method was used and the following interventions were implemented between November -December 2020:

- A chaperone poster was developed with staff and patient feedback and displayed in all clinical areas;
- A quick reference guide to the trust chaperone policy was created and disseminated to trainees at induction;
- An educational training video was created and presented to the consultant body and in the departmental trainee teaching;
- A chaperone sticker was introduced to be used in medical notes in paediatric ED and Outpatient departments to improve documentation.

Post-intervention evaluation is ongoing.

Conclusions The use of formal chaperone in the paediatric setting is increasingly important as a means to safeguard both young patients and the staff involved in their care. Compliance with Trust Chaperone policy in a busy Paediatric hospital was poor and highlighted gaps in staff awareness and inadequate documentation. A quality improvement approach may help to improve compliance in this challenging area of paediatrics.

British Society of Paediatric Endocrinology and Diabetes

698 THYROID DYSGENESIS IS NOT A COMMON AETIOLOGY FOR CONGENITAL HYPOTHYROIDISM

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Background Congenital hypothyroidism (CH) is one of the commonest endocrine problems in infancy. It is also the most treatable cause of mental retardation worldwide. In Hong Kong (HK), CH is screened by cord blood assay of thyroid function undertaken by the Clinical Genetic Service (CGS). Most neonates and infants with abnormal thyroid functions are referred to their birthing hospitals for further investigations and treatment if necessary.

Conventionally the subtypes of CH are identified by thyroid scintigraphy. It has been considered thyroid dysgenesis (TD) comprises the majority of cases of CH, with prevalence up to 85%, with the remaining best described as gland-in-situ (GIS), of which less than 50% is due to thyroid dysmorphogenesis (TH). However, this observation has been challenged recently, which may carry a prognostic implication on the need of lifelong thyroxine replacement.

Objectives We hereby report the prevalence of different causes of CH in Princess Margaret Hospital, a paediatric endocrinology center in HK, and compare to the data reported in the literature.