with free text space where applicable. The next stage, which is currently in progress, is to arrange teaching sessions by Pediatric A&E Consultants, developing a poster to aid with the assessment and introducing prompts in the medical e-notes/atriage notes as a reminder. Finally, the survey will be re-performed to see if knowledge-base and confidence in performing the assessment of the patients have improved.

### Results
The initial survey was completed by 20 junior doctors at Ealing Hospital and Northwick Park Hospital (London Northwest University Healthcare NHS trust), who ranged in grade from foundation year 1 to specialty trainees. Question 3, which studied how often the assessment was being done, demonstrated that 45% of clinicians never do the assessment. Question 4 was aimed to see how confident the clinicians are on doing the BMI measurement, 60% were not confident. Also, 65% felt that they would not be able to signpost patients to useful resources for support if identified as being overweight or obese. One hundred per cent of those surveyed felt a new reference poster and teaching would be helpful to their clinical practice.

The next stage (in progress) is to organize teaching, roll out the Posters and to work closely with the IT department to introduce prompts/airs in the medical e-notes to help with the assessment, this will be followed by re-performing the survey.

### Conclusion
Obesity if tackled early can result in drastic improvement in the quality of life. The initial survey suggests lack of knowledge and confidence on the methodology of BMI measurement in young patients among Northwick Park and Ealing clinicians, and demonstrated an enthusiasm for a new reference poster, teaching sessions and changes to the medical e-notes. We hope to roll out Posters, do the teaching sessions, introduce the modifications to e-notes and re-perform the survey by May 2022. Once that cycle is complete, there will be some indication as to whether a new and expanded OBESITY Assessment Poster is a useful accessory for clinicians in the overall structured assessment of Young people.

### Methods
Retrospective data about Transition clinic, was retrieved from electronic health record database called systemone.

The data collected from 4 clinics held over one year period between February 2020 to 2021. The clinic details are recorded on purpose-designed proforma for discussion in multidisciplinary meeting in transition clinic.

The proforma captures these young people complex needs and comorbidities including learning disability, motor impairment, skeletal deformity, and feeding difficulties. The data was analysed and compared using Microsoft excel 2010.

### Results
A total of 11 patients with age ranges from 15 to 19, were reviewed in Transition clinic from February 2020 to 2021. Among these cases, 6 patients had virtual consultation due to pandemic. There were higher proportion of girls about 63% compared to boys, who were about 36%, reviewed in these clinics. Among them 82% had Cerebral palsy and the rest 18% had complex congenital abnormality.

There was 100% accuracy in the clinical data entry with regards to diagnosis, medication, and general health enquiry, except clinical examination which is close to 36%. This could be due to virtual clinics held during pandemic. Other professional and therapist involvement had been documented in a separate section.

Also, there was 100% documentation on detailed plans, however only 30% had information about the relevant contact details for other services.

The statistical calculation is not possible due to small sample size.

### Conclusion
The study demonstrates that majority of these transition clinic entries followed MDT proforma. The clinical documentation does reflect the multidisciplinary discussion with focus on the young person’s complex and multiple needs during transition period and to support before transition into adult care service.

The professionals tried their best to deliver the care during the COVID pandemic, without any cancellation, also parental and carers concerns about pain and growth were taken into consideration during these virtual clinics.

All children’s and adults’ services should give young people and their families or carers information about what to expect from services and what support is available to them. Therefore, we have introduced a standardised proforma incorporating the key areas specified by NICE, which include relevant details and contact information about the available adult services. The revised transition clinic format has been created as quality improvement project to improve clinical documentation.

### Aims
The National Institute of Excellence (NICE) in 2016 guideline recommendations as per requirements of Care Act 2014, states to follow best practice for Transition from children to adults’ services for young people who are using health or social care services.

During this transition period the young people can be comprehensively prepared with adequate provision of information, services geared towards young people, person-centered planning, which is delivered by adequately trained professionals both in children’s and adults’ services, including support for parents and care providers.

Our transition clinics are attended by Paediatrician, Rehabilitation medicine consultant, other relevant clinicians, and therapists. The aim of the study is to determine the quality of Transition Clinic Multidisciplinary Team proforma completed by Community Paediatrics team.

### Methods
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need to be taken from the Methotrexate level (e.g. adjustment of the dose of Leucovorin/Folinic acid). Delay in management could increase the risk of Methotrexate associated toxicity (renal, hepatic, systemic).

We aim to ensure all Methotrexate levels are conducted, chased and acted upon within working hours by the day team who are familiar with the protocol to ensure prompt management.

Methods Retrospective data collection of 47 Methotrexate levels taken from Paediatric Oncology patients who required high-dose methotrexate from July - December 2021 from the electronic reporting system and patient notes.

Results Based on a previous audit, there has been suggestions to improve this which consisted of calling the lab prior to sending a sample, calling the lab if the result is not back by 1 hour and trying to start high dose methotrexate infusions earlier in the day.

The average (mean) time for the samples to be processed was 1.5 hours. There has been a reduction of samples that took > 4 hours (13% in the previous audit to 6%) (figure 1). Infusions are largely done within working hours; therefore, most samples are sent and can be chased within hours.

Out of the 47 samples, 45 (96%) were taken within working hours. However, there was still 5 samples in which the release of the methotrexate level came back outside of working hours. 3 out of these needed to be actioned upon out of hours. Out of the methotrexate levels that needed to be actioned on (18), there were therefore 3/18 (17%) needed to be conducted out of hours by the on-call team (figure 2) whilst the remaining 15 (83%) was done by the ward team during normal working hours.

Conclusions From the previous audit, we are able to conclude that from the interventions implemented, there has been an improvement. Samples are run and reported promptly. There has also been an improvement in ensuring that samples are taken within working hours and infusions started within hours.

However, there is still room for improvement as there were still 3 results that came out-of-hours that needed adjustments to the management to be done by the on-call team. Therefore, we have reiterated the importance to try to ensure high-dose methotrexate infusions are started earlier in the day so that levels can be taken in the first half of the day allowing sufficient time for the results to be chased. Furthermore, the lab has suggested to label samples and inform the lab if we expect the levels to be high so that they are able to conduct a neat and diluted sample together, preventing delays due to the need to do a repeat diluted samples on high levels.