

and to try translated versions of the tool to maximise the participation of respondents with limited knowledge of English in a diverse ethnic population

**Background** Patient/parent satisfaction surveys are important monitoring tools used in the national health service (NHS). Before the Urgent-and-Emergency-Care PREM tool was published by the RCPCH in October 2012 there was no standard feedback form for paediatric A&E. This new tool is a well researched and standardised tool for obtaining children/parent feedback.

**Methods** Demographic data from the census was collected which showed that our NHS trust caters for a population with a large percentage of Turkish/Greek Cypriot, African and Somalian ethnicity. There is an annual attendance of about 38000 to children's A&E. While doing the survey, we eliminated the bias due to language-barrier by translating the RCPCH tool in Turkish and Somalian, the two commonly spoken languages in our ethnic population-group. The PREM tool was translated by doctors with knowledge of the languages and was colour coded for adult or children versions. Questionnaires were given to consecutive willing parents and/or children while waiting in the department. The feedback forms were analysed on Microsoft-Excel using common statistical methods.

**Results** Total of 50 feedback forms were collected. Feedback was given by 12(24%) children, 29(64%) parents and 4(9%) by both. The study group had 19(41%) European, 9(20%) Asian, 12(26%) African and 2(4%) mixed. The main languages spoken were English 25(57%), other European 10(22%), and all other 10(22%). The main highlights of the survey was that 43 of 46 (94%) respondents were satisfied by the services, 24(49%) waited longer than expected, 15(32%) wanted better information while waiting and 4(8%) were not given adequate privacy.

**Conclusions** The introduction of feedback-forms in multiple languages has perhaps given a more unbiased feedback with more involvement of the ethnic subgroups. The results were overall satisfying but a few specific areas that need improvement were identified. The responses to individual questions will also serve as a baseline for serial monitoring after implementing changes and training in problem areas.

### G32 DEVELOPING PRINCIPLES FOR DELIVERING AND COMMISSIONING BETTER HEALTH OUTCOMES AND EXPERIENCES FOR CHILDREN AND YOUNG PEOPLE SO THEY ARE COMPARABLE WITH THE BEST IN THE WORLD

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**Aim** The development of a single set of principles to be used by providers and commissioners, across the whole healthcare system wherever a child or young person is seen. The aim is to improve the health outcomes and experiences for children and young people (CYP).

**Methods** A multi-professional team of GPs, Health Visitors, School Nurses, Paediatricians, Public health, Children's Nurses, patient and family representatives came together over a period of 6 months in a number of facilitated work-shops.

CYP and family engagement was central to this work with visits to Children's Centres, primary and secondary schools to listen to families experiences of health services. A graphic illustrator captured the key messages from each engagement event.

The principles were referenced against the Children and Young People's Outcome Forum Report and the NHS Mandate.

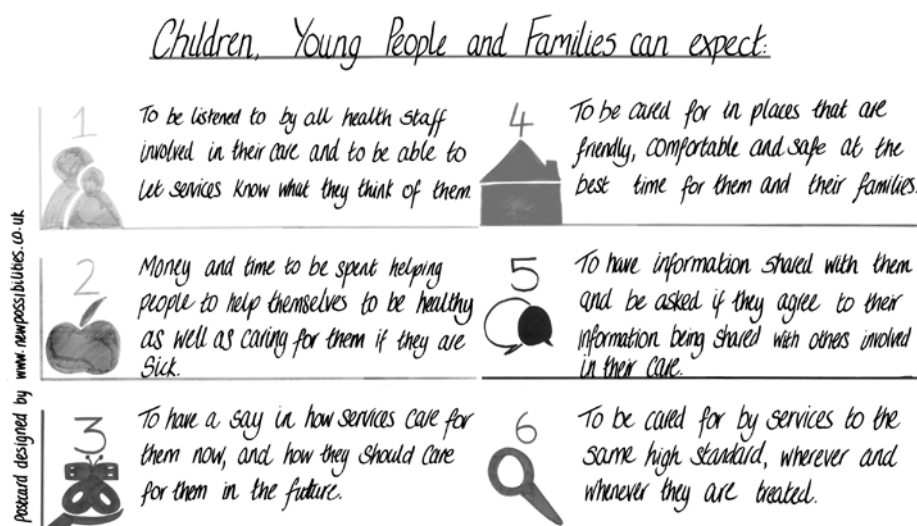
**Results** A set of 6 principles;

1. Child and Family focused
2. Health Promotion
3. Transformation
4. Settings
5. Information and Communication
6. Evidence Based and Sustainable

Each principle has an aspirational statement and then indicators to be used to evidence achievement towards a principle. They can be used to assess an existing service or to develop a new service and can be used for a condition across a pathway e.g asthma or for a service e.g. GP practise.

The principles have been developed as a single A5 poster for ease of use and are colourful and visual. A postcard has also been developed which summarises the feedback from young people and families but also translates the principles for families so that they know what they can expect from services. Figures 1, 2, 3.

Local organisations are encouraged to add their own and health-watch websites to the postcards to allow continuing feedback from families.



**Abstract G32 Figure 1** Stillbirths Figures Mbarara Hospital 2012

# What do children, young people and families want from health services?



Abstract G32 Figure 2

## Principles for commissioning and delivering better health outcomes and experiences for children and young people so that they are comparable with the best in the world.



Strategic Network for Child Health and Wellbeing in the East of England

PRINCIPLE 1	PRINCIPLE 2	PRINCIPLE 3	PRINCIPLE 4	PRINCIPLE 5	PRINCIPLE 6
<b>Child and family focussed</b>	<b>Health Promotion</b>	<b>Transformation</b>	<b>Settings</b>	<b>Information and communication</b>	<b>Evidence based and sustainable</b>
We will ensure the voices of children, young people and families are heard throughout the health care system and their needs drive planning and delivery in collaboration with clinical expertise.	We will prioritise investment and resources to improve the health and wellbeing of our children and young people.	We will invite children, young people and families to be active participants in the review and future design of services.	We will offer children, young people and their families services in settings where they feel welcome, confident, safe and where there is little disruption to family life as possible.	We will share the best information and intelligence between professionals and with children, young people and their families to allow the best possible healthcare.	We will commission and deliver services to consistent standards, informed by best practice and available evidence. All children and young people will have equitable access to services to meet their needs.
INDICATORS/EVIDENCE THAT WOULD REFLECT ACHIEVEMENT OF THE PRINCIPLE					
<ol style="list-style-type: none"> <li>Commissioning of services and decision making is informed at all stages by children, young people and families and commissioning plans are shared and understood.</li> <li>What's said is heard: there is evidence that children, young people and families are involved in decisions about their care and make informed choices.</li> <li>Services are tailored where possible to an individual or group to ensure joined up packages of care.</li> <li>Services include a measure of patient experience and there is evidence of change in response to patient feedback. Staff are trained and can demonstrate competencies in building a therapeutic relationship and communicating sensitive information honestly and with empathy.</li> <li>Young people are encouraged to see a health professional on their own as well as with their parent or carer.</li> <li>Smooth transfer occurs from children's to adult services.</li> </ol>	<ol style="list-style-type: none"> <li>Children, young people and families have an understanding of what they need to do to have good health.</li> <li>Promoting good health is coordinated across education, health and social care to ensure a consistent message.</li> <li>Adequate resources are allocated to prevention and early intervention, particularly before birth and for 0-5 year olds and their families.</li> <li>The Healthy Child Programme (0-19) is fully implemented locally.</li> <li>Health professionals are every opportunity to help children, young people and their families improve their health and wellbeing outcomes, e.g. Making Every Contact Count.</li> <li>The needs of vulnerable and disadvantaged individuals and groups are considered and addressed to reduce health inequalities.</li> </ol>	<ol style="list-style-type: none"> <li>Evidence of a critical review of current services, considering reconfiguration, integration and networked care.</li> <li>Commissioners ensure providers have critically appraised and adopted service delivery models to transform care across the health care system.</li> <li>Consideration is given to sustainability, workforce capacity, IT competency, including using the voluntary and community sector.</li> <li>Services support delivery of the Children and Young People's Outcomes Strategy Report recommendations and address needs identified in the FNU.</li> <li>Children, young people and families have the opportunity to shape service change and wellbeing outcomes, e.g. Healthwatch organisations.</li> <li>Clinical leadership for child health is evident in transformation programmes.</li> <li>The physical and emotional needs of the child and young person are forefront when designing healthcare settings.</li> </ol>	<ol style="list-style-type: none"> <li>All staff are welcoming, approachable and helpful.</li> <li>Appointment systems offer choice of date and time and where possible and sufficient time is allowed for communication with both the child or young person and their parent or carer.</li> <li>GPs practice are able to offer timely appointments to avoid unnecessary hospital attendance or admission and limit family disruption.</li> <li>Services are provided in the community wherever possible, for example ensuring access to community children's nursing services, and are only hospital based when absolutely necessary.</li> <li>Facilities are fully accessible to all and in particular those with disabilities or mobility difficulties.</li> <li>Where specialist services are required these are delivered alongside local services where appropriate.</li> <li>Leisure areas are provided in waiting rooms suitable for children and young people with a range of ages and interests.</li> <li>Adult services consider the needs of children in families where the adult is receiving care.</li> </ol>	<ol style="list-style-type: none"> <li>Children, young people and families and the professionals working with them know where to go for services and how to arrange a referral.</li> <li>Children, young people and families feel listened to and have meaningful information provided to them in a way that empowers them to make informed choices.</li> <li>Health information provided to children, young people and families is in a format that is easy for them to understand.</li> <li>Patients information is shared with informed consent between health, social care and education providers.</li> <li>Information systems and technologies are in place to facilitate the easy and secure sharing of information and communication.</li> <li>Education settings are informed and involved when a child or young person has a health need.</li> <li>Good quality information is collected and used to inform service planning.</li> <li>Staff are able to access, understand and get on information on service activity and outcomes.</li> <li>Parent held records e.g. 'All About Me' are a written record of health issues and are used routinely to ensure professionals are made aware of needs.</li> </ol>	<ol style="list-style-type: none"> <li>Children, young people and families will have an understanding of the explicit standards they should expect.</li> <li>Services are commissioned and delivered according to individual or locally agreed best practice guidelines and standards.</li> <li>Commissioners and providers can demonstrate that they are monitoring and addressing the quality of services for children and young people.</li> <li>Planning and development of services takes sustainability into account, e.g. numbers of staff required to treat the number of patients.</li> <li>All services have standards of care that are endorsed by providers and commissioners.</li> <li>Joined up packages of care are delivered through multi professional approach and a multi disciplinary team approach.</li> <li>Healthcare is readily accessible and delivered to the same standard on a 24-hour seven day a week basis.</li> <li>Care is delivered safely and particular emphasis is given to minimising medication errors.</li> <li>All those working with children and young people have the capacity, skills and knowledge to meet their specific needs, whenever they are in the health system.</li> </ol>

Abstract G32 Figure 3

**Conclusions** The principles define a common language and shared sense of purpose for professionals and families and can be used as a platform of small or large scale change and improvement. They compliment the NHS mandate and the children's and young person's outcome report and sit at the centre of the NHS change model. They are easy to use and flexible and can be used nationally and easily adapted for other services.

### G33 CHILDREN WHO DID NOT ATTEND (DNA) COMMUNITY PAEDIATRIC CLINICS. DEMOGRAPHICS AND FOLLOW UP OUTCOME

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**Aims** Non-attendance at clinic appointments puts children at risk of avoidable ill health. Wasted clinic appointments cost the NHS £700m/year with up to 6 million appointments wasted.

The aim of this study was to assess outcomes for children who DNA, following introduction of a red (urgent appointment sent), amber (further routine appointment offered), green (appointment offered only if requested by family) coding system.

**Method** Records of 100 children who DNA over a 3 month period were reviewed. Information on age, diagnosis, outcome, was recorded and analysed using Microsoft Excel (figure 1).

**Results** 55 DNA's were classified green, 43 amber and 2 red (figure 1). Diagnosis was variable: 40% ADHD, 12% ASD, 9% behaviour and 9% developmental delay

Green 55: 10 new, 45 follow up.

30 did not request further appointment, 25 requested a further appointment – 24 subsequently attended, 1 DNA for a second time.

Therefore 30 appointments were 'saved' – parents did not request further appointments. Before the red, amber, green system was introduced these families would have received another appointment.

Amber 43: 2 new, 41 follow ups.

28 subsequently attended, 15 DNA'd again.

Of these 15, on reclassification:

8 green (5 ADHD, 1 attachment, 1 anxiety, 1 ASD), 1 parent requested a further appointment and 7 did not.

6 amber, (5 had ADHD and 1 sleep difficulties). 4 subsequently DNA again and 2 attended.

1 red (developmental delay). Attended the next appointment.

Red 2 (child protection plans), attended subsequent appointment.

**Discussion** Out of 100 DNAs 30 appointments were saved as patients classified as green did not request a further appointment. The number of DNAs per year in our department (2011–2012) was 905 of 7320 appointments. Extrapolating further we are potentially saving 271 appointment slots per year (45 clinics) compared to our previous system where all DNAs were automatically offered a further appointment.

Of 43 "amber" children, 28 attended the appointment sent, 15 DNA again. Some were subsequently classified as green, those with ADHD were assumed to be no longer on medication.

The 3 "red" children all attended further appointments.

## George Still Forum

### G34 IS THERE A LINK BETWEEN ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) AND DELAYED PUBERTY?

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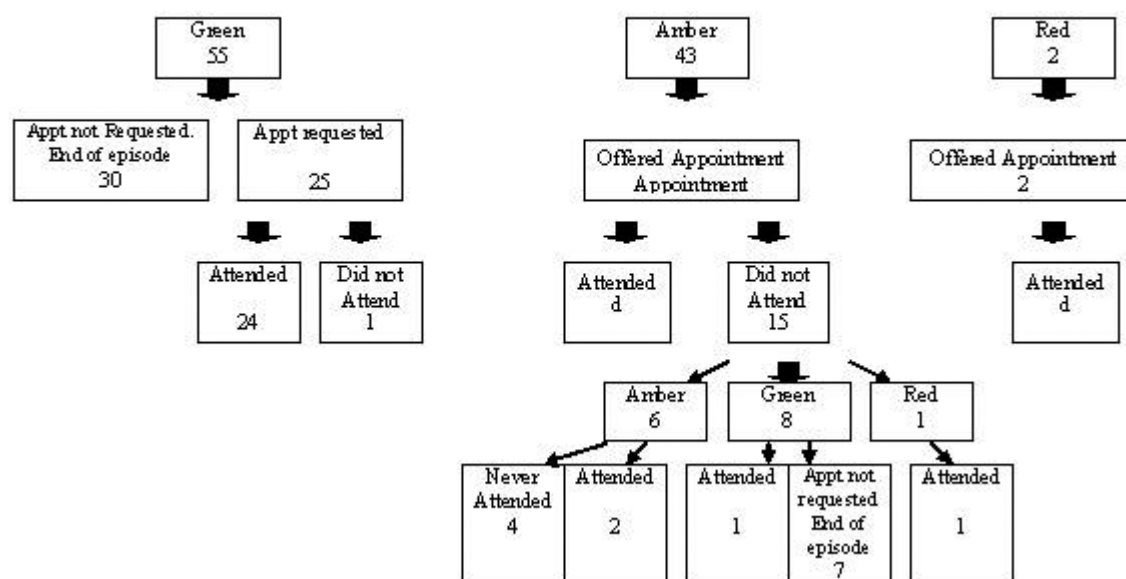
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**Introduction** Recently, our department has seen 4 boys with ADHD present with delayed puberty. Only one was on treatment for ADHD with no effect on growth. We conducted a literature search to discover if there was a documented link between ADHD and delayed puberty. The full results will be shared during the presentation but a brief summary is below.

**Methodology** A PubMed search using the terms "ADHD" [Mesh] AND "delayed puberty" found only one relevant article out of three identified. An OVID Medline and "Google Scholar" search revealed three further relevant articles.

**Discussion** Most of the literature focuses on the link between ADHD and delayed growth in the presence of stimulant medication. Few papers look also at the effect of either ADHD or stimulant medication on puberty directly. Out of the four papers found, there were conflicting opinions.

## 100 DNA's



Abstract G33 Figure 1