Shropshire Community Health
NHS Trust

QIP: Use of templates to improve the quality of health recommendations advice for Initial Health Assessments in Looked after Children

Dr Ayaz Vantra (GRID ST8 CCH Trainee) and Dr Gregory Minnaar (Community Paediatrician)

1. INTRODUCTION

The health recommendations advice for children's/young person's care plan forms an important part of the Part C section of the initial health assessment forms (IHA).

Templates were created to improve the quality of IHA reports and advice being provided, as well as save time for the team in compiling the reports.

2. AIMS

- Reduce time clinicians and admin staff spend compiling, dictating and typing reports
- Provide a tool that allows more consistent advice to be provided by the team, as well as improve the quality of advice
- To create a 'fluid' document, which can be adapted by the team as needed following suggestions

3. METHODS

1. Creation of templates, provided as part of IHA forms for clinic, for standard health recommendations, condition specific advice (e.g. asthma, epilepsy) and for unaccompanied asylum seeking children (UASC).
2. A Google Survey was sent out after 12 months, asking for feedback from admin and clinicians.

4. TEMPLATES CREATED (QR CODE)

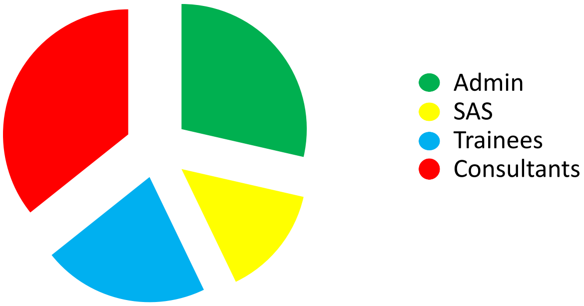
Universal   Condition Specific   UASC

BLUE – Universal health advice applicable for all children e.g. hearing, vision, immunisations, diet and exercise advice including links for websites

GREEN – Condition specific advice for children with condition such as asthma, epilepsy, eczema

RED– Advice applicable for unaccompanied asylum seeking children e.g. BBV/TB/Malaria screening , catch up immunisations

5. RESULTS



14 responses (job role as above).

100% of clinicians felt the templates were easy to use and saved time.

70% felt they improved the quality of reports being typed.

80% commented the template reminded them on issues to consider.

The mean time saved by clinicians was 15 minutes
All admin staff felt the templates made typing quicker, saving 5 minutes on average per report!

6. CONCLUSIONS

Use of templates helped to improve the quality of advice being provided for our children and young people, as well as save time for both clinicians and admin staff.

Templates also gave guidance to trainees, by highlighting key areas to consider when providing advice.

Our last two quality assurance audits demonstrated 100% compliance with above.

REFERENCES

Links for templates: Universal (https://me-qr.com/2590930)
UASC (https://me-qr.com/2590906)
Condition Specific advice (https://me-qr.com/2590901)

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Reducing Radiation Burden in the Management of Spinal Deformity

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AIM : To assess the ways in which Whole Spine X-rays (WSXR), and radiation burden, are avoided in our service.

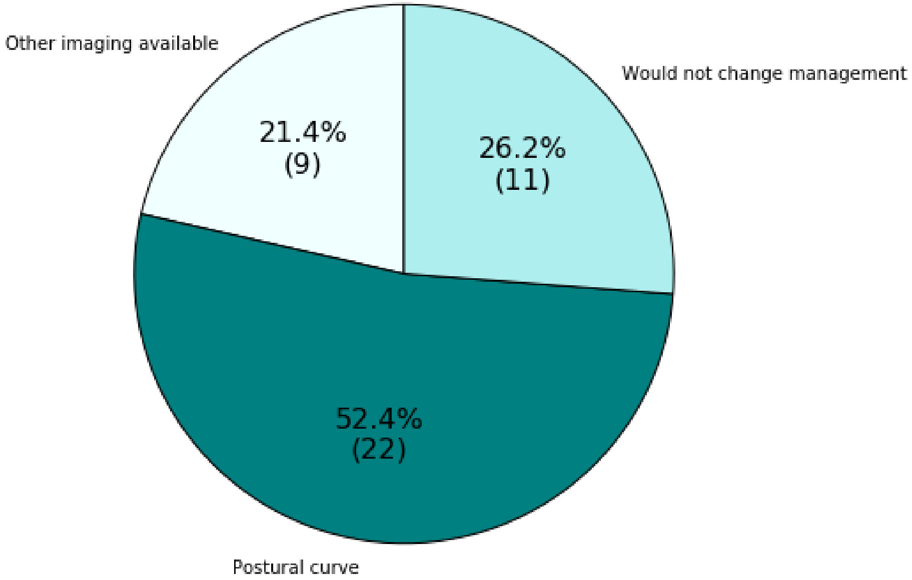
1. Introduction Children and young people (CYP) with physical disabilities accumulate a burden of radiation in the management of their complex medical issues, including spinal deformity, which our regional service (physiotherapist, surgeon, and paediatrician) manages. CYP have often had imaging elsewhere which can aid decision making in our service.

2. Methods Imaging and clinic letters for the 210 CYP seen by our service in a 12 month period (2019) were reviewed.

3. Results Most CYP required a WSXR to aid clinical management.
However 42 (20%) did not (Fig. 1):

- 22 had underlying disability but their curve was confidently diagnosed as postural.
- 11 had a curve where a WSXR would not alter management.
- 9 had abdominal or chest X-rays which provided sufficient views of the spine, avoiding further x-rays.

Figure 1: Reasoning for not carrying out WSXR during clinic attendance



4. Conclusion X-rays are vital to monitor progression of spinal deformity. When critically evaluating the need to image we have shown that where the service has clinical expertise and, crucially, opportunity and motivation to gather past images, the radiation burden can be reduced.

Referral & Diagnosis of Autism: Experiences of Parents During the COVID-19 Pandemic

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Acknowledgements: Achieving for Children, Royal Borough of Kingston of Thames and the families of those involved in the review for their cooperation and thoughtful insights

Introduction:

Managing children with Autism Spectrum Disorder ASD during the COVID-19 pandemic has been challenging.[1,2] However it is less clear what the impact has been on families going through the diagnostic pathway. Beleaguered by long waiting lists and chronic under-funding, Community Paediatric Services have laboured for many years to support children and their families through diagnosis for ASD. Without drastic changes to traditional working patterns, the pandemic will only prolong waiting lists further, compounding angst amongst families.

In our locality, conventional assessments were replaced by a new two-step strategy. First, telephone consultations enabled a history to be taken. The child was then brought into clinic for a face-to-face assessment following government COVID guidelines for safety. The interval between appointments enabled progress and development to be assessed.

This service evaluation project sought to analyse the impact of the new "two-step" pathway on waiting times, to explore the experience for parents and to guide future working practices.

Methods:

We identified 54 patients who had completed both stages of assessment. They had their first telephone appointment by a Community Paediatrician between March and July 2020 and were followed-up in person by the end of 2020. We then arranged structured telephone questionnaires between December 2020 and February 2021. Of the carers of 54 patients, 25 carers consented to be interviewed, 17 did not respond, 8 declined interview and 4 were excluded due to two siblings being assessed at the same time.

Results:

Amongst the 25 patients, the mean time from referral to first contact was 15.2 weeks or 3.6 months (range 1.1 to 6.1 months). The proportion of patients consulted within 13 weeks from initial referral was 36% (n=9).[3]

The mean time between appointments was 5.1 months (range 3.7 to 7.5 months). The mean time from referral to face-to-face assessment was 8.7 months (range 6.3 to 12 months).

Of the patients reviewed in the study, 56% (n=14) resulted in a formal diagnosis of ASD at the face-to-face assessment. The remaining 44% (n=11) were added to our local Social Communication waiting list awaiting further assessment.

The results of the structured telephone questionnaire are divided into two parts, shown in tables 1 and 2. Not all parents answered all questions.

Table 1. *Parental responses to the initial telephone consultation.*

		Strongly Disagree	Disagree	Agree	Strongly Agree
i)	"I felt comfortable that the initial consultation would be conducted by telephone" N=25	1	7	13	4
i)	"I was able to have the time and space to conduct a telephone consultation " N=25	1	7	12	5
i)	"The strategies and resources suggested at the interview were accessible" N=23	1	3	14	5
i)	"I did access these strategies and resources" N=23	4	6	10	3

Table 2. *Parental responses to the in-person follow-up consultation.*

		Strongly Disagree	Disagree	Agree	Strongly Agree
i)	"I felt safe coming into the clinic in the current COVID-19 climate" N=24	-	-	8	16
i)	"I felt the two appointments worked well together" N=23	2	2	11	8
i)	"I felt like the assessing team had a clear understanding of my child" N=24	2	2	9	11
i)	"I felt like the process was acceptable in the current climate of COVID-19" N=23	-	1	11	11
i)	"I would recommend this two-step approach to continue in the future after COVID-19" N=25	-	7	8	10

Conclusions:

Our innovative approach demonstrates a new, safe strategy to support diagnosis and assessment of ASD. 82% (N=23) of parents agreed or strongly agreed that the two-step approach worked well and 83% (N=24) agreed or strongly agreed that the assessing team had a clear understanding of their child. All parents felt safe coming into clinic for the face-to-face assessment during the COVID-19 pandemic.

Waiting times remain challenging but are probably reasonable adjusted for the pandemic. Whilst only 36% of patients received their first telephone appointment within 13 weeks (the NICE standard), we were able to offer diagnosis times below the national average of 364 days in the under 19s in many patients. [3,4]

Fortunately, 96% (N=23) felt our two-step strategy was acceptable in current climate of COVID-19 and 72% (N=25) would recommend this two-step approach for future working. With no imminent end to the pandemic, this flexible approach may end up a long-term solution to yet another dilemma that COVID-19 has given us.

References:

1.) Tokatly Latzer I, Lietner Y & Karniele-Miller O. Core experiences of parents of children with autism during the COVID-19 pandemic lockdown. Autism 2021: online ahead of print. **2.)**University of Birmingham, United Kingdom. Covid -19 and the impact on families with autistic children. Accessed from: Covid-19 and the impact on families with autistic children - University of Birmingham. Accessed on 12/3/21 **3.)** National Institute for Health and Care Excellence. Autism Spectrum Disorder in under 19s: Recognition, Referral and Diagnosis. Published 2011. Updated 2017. **4.)** NHS Digital. Autism Waiting Times Statistics Quarter 1: April to June 2020. Accessed 22/3/21

What Effect has COVID-19 has on Child Protection Medicals?

Aim: To evaluate the impact of the first COVID lockdown (1st April to September 30th 2020) on child protection medical (CPM) examinations by comparing to data from the same time period in 2019

Inclusion criteria:
All children referred for CPM from 1st April to 30th September 2019 & 2020
Exclusion criteria:

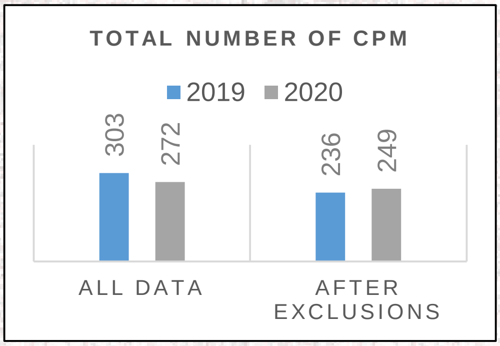
1. SARC referrals
2. No report/referral information available on system to review

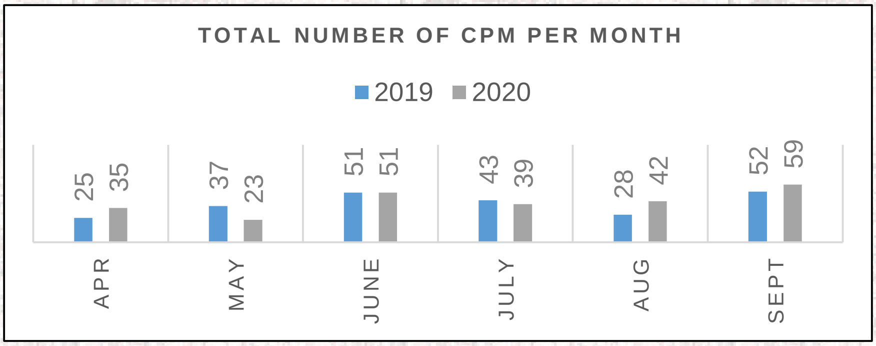
Cases identified via local databases and CPM reports reviewed to gather data on:

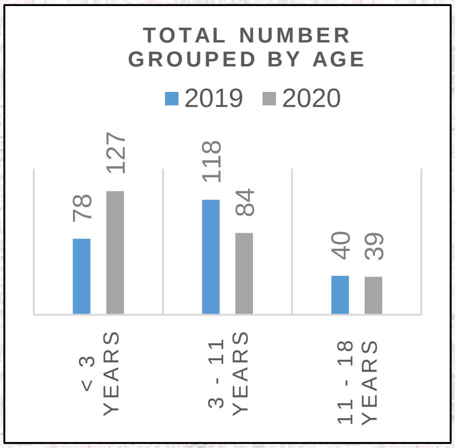
- Referral date
- Age of child
- Source of referral
- Whether child/family already known to Children's services
- Conclusion of report

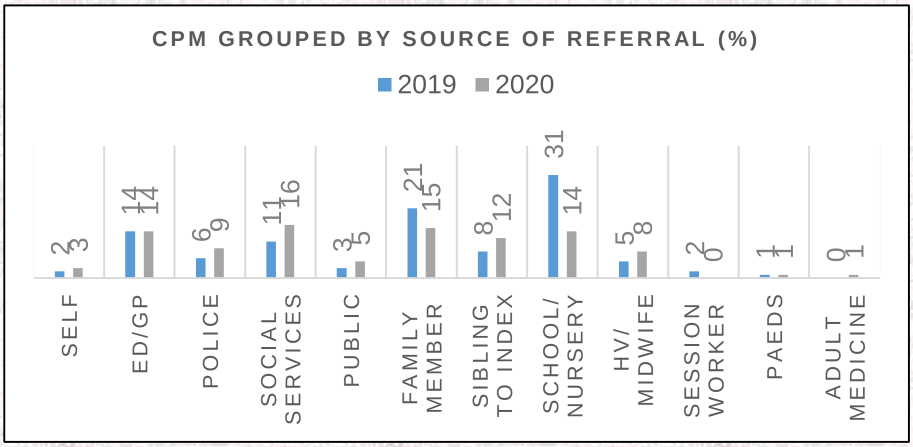
Multiple sites:

- Cardiff & Vale
- Flintshire (BCUHB)
- Wrexham (BCUHB)
- Denbighshire (BCUHB)
- Princess of Wales Hospital (CTMUHB)
- Prince Charles Hospital (CTMUHB)
- Royal Glamorgan Hospital (CTMUHB)


TOTAL NUMBER OF CPM

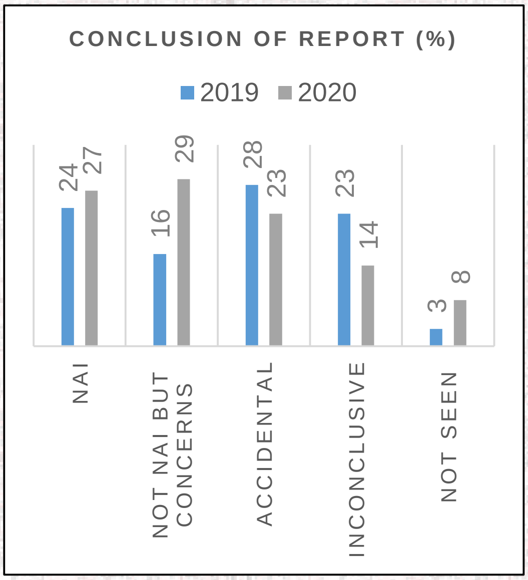

TOTAL NUMBER OF CPM PER MONTH


TOTAL NUMBER GROUPED BY AGE


CPM GROUPED BY SOURCE OF REFERRAL (%)

In 2019, 48% of referrals were unknown to social services. This reduced to 43% in 2020.

In Wrexham, data was only collected on whether children were on the child protection register. In 2019, 64% of referrals were for children not on the child protection register. This reduced to 55% in 2020.


CONCLUSION OF REPORT (%)

Summary:

- Higher proportion of referrals in < 3 year olds
- Reduction in referrals in the 3 to 11 year age group
- Large reduction in referrals from school/nursery
- Higher proportion of referrals already known to social services
- More report conclusions with an NAI or concerns outcome

An increase in child abuse was suspected due to previous research but this has not been seen here. There is also concern that abuse in school age children has been missed, especially in children not known to social services.

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Retrospective quality improvement project in remote feedback provision following an autism diagnostic assessment and diagnosis of Autism Spectrum Condition (ASC)

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1. Abstract

Introduction

With Covid-19 many non-urgent healthcare appointments were postponed or conducted remotely. There was concern about giving the significant diagnosis of Autism Spectrum Condition over the phone or video. However, to decrease waiting times and minimise physical contact it was decided to provide remote feedback following a face-to-face assessment.

Aims

The aim of this quality improvement project is to evaluate the experience of parents of children who had received a diagnosis of Autistic Spectrum Condition (ASC) remotely. Exploring the benefits and disadvantages of remote feedback will be used to inform the design of autism assessment pathways for future pandemic planning and beyond.

Methods

For this retrospective quality improvement project we identified a selection of parents of children who had received a diagnosis of ASC >1 month before from two assessment pathways in a London borough. They were interviewed via telephone using a pre-set script containing a combination of open and closed questions, some requiring a scaled response.

Results

There were 19 parental responses. Satisfaction was high, all scoring at least 8/10. Remote feedback was reported to be convenient, to feel private and safe, and to be better for the child. Technical problems were common. 7/19 would choose remote feedback even in the absence of a pandemic. Respondents were split between preferring video or phone.

Conclusion

Remote diagnosis had high levels of parental satisfaction, in part due to an ongoing relationship with a case coordinator. Parents were divided as to whether they would choose remote feedback; with many preferring remote feedback outside of a pandemic. In future, parents may be offered choice which would have implications for service planning.

2. Background

This quality improvement project looks at evaluating remote feedback provision, where the diagnosis is given via phone or video, after changes were made due to the Covid-19 pandemic. It looks to provide a retrospective analysis on family's opinions of remote feedback.

- The feedback session is part of the autism diagnosis assessment pathway conducted in Islington, an inner London borough.
- Children and young people are referred from their place of education or from a healthcare professional.
- There are 2 teams: the social communication team (SCT) for children <5y and the neurodevelopmental pathway (NDP) for those over 5y
- Both teams had set assessment pathways
    - Social communications team (SCT) <5y
        - Interview of parent/s/carers and interview and/or school/education setting
        - First meeting often nursery visit for observation accompanied by parent interview
        - Half day of assessment and feedback including Autism Diagnostic Observation Schedule (ADOS) assessment, paediatric health review and feedback session (~2.5hrs)
    - Neurodevelopmental pathway (NDP) >5y
        - Questionnaire to school/education setting
        - First family appointment with clinician and child/young person and parent/carer (~1hr)
        - School observation if required
        - Clinic day made up of ADOS assessment of child/young person, a period of child interview and observation and a parent history session.
        - Feedback 1-2 weeks later in a face-to-face appointment.

Impact of COVID-19

- As a result of Covid-19, all assessments were temporarily stopped resulting in a long waiting list.
- As services resumed, **changes were made without patient consultation,** to conduct various aspects remotely to minimise social contact.
- This had the added benefit of allowing for more face-to-face ADOS-type assessments to happen per day as the feedback session was scheduled on a different day.

3. Key Question

Looking forward, is remote feedback something clinicians should continue to offer to improve family experience

- Benefit of remote feedback
- Potential areas to improve while giving remote feedback

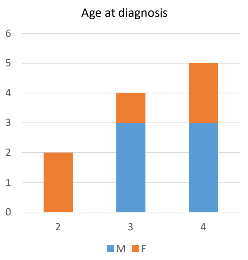
4. Methods

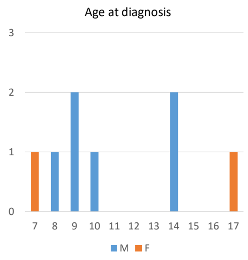
Telephone interview with 19 families having received feedback via phone or video

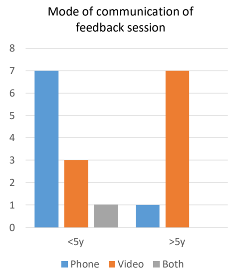
- Scripted interview using mixture of open and closed questions
- 2 sample groups (social communication team (SCT) and neurodevelopmental pathway (NDP) showing range of age of child/young person
- Interviews to occur >1 month after feedback session

5. Results

Baseline characteristics







Satisfaction scores very high; 10 out of 18 respondents gave a score of 10 out of 10. All respondents scored at least 8/10

Comments include

- It has been nice it has been the same person throughout
- There was a personal touch/relationship
- Clear plan, kept us informed every step of the way
- Approachable and very reassuring
- Able to ask all the questions I had and message later with more; Offered a further zoom chat; Lots of extremely helpful reading material provided

However, 5 families had some difficulty with technology

All from <5y (SCT) group

"first time using zoom", "not good with zoom", "zoom not working on phone"

Phone battery died

Could not open email attachment

Other comments against remote feedback sessions

"Cannot tell expression" (of person speaking to you) via phone

Easier to have a relationship if in the same room

Child/children in the home at the time; can be distracting

Comments in favour of remote feedback

Phone is a safe space at home

Pleased that (child's name) was not present. Would have been inappropriate to have child there

If (child) was present, we would need toys and another adult

Zoom easier than travelling

By phone call, (one) could react in private

Easier to focus on conversation without (child's name) there

Face to face would have made it a very long day

Nicer to be at home. Can show emotions privately

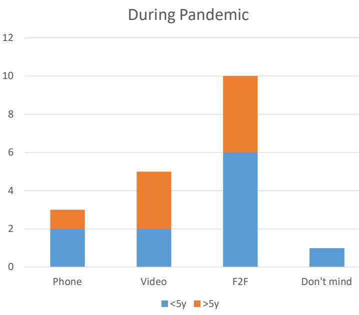
Partner (father) may have preferred video for convenience

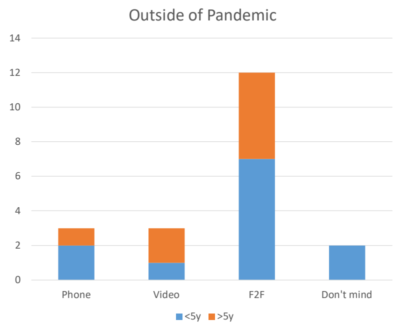
Easier to manage (child) at home

Overall, more respondents stated they would choose to receive feedback face to face given the option

- 10/19 would choose this during a pandemic and 12/19 outside of a pandemic

This still leaves 1/3 of respondents who would choose to receive a diagnosis remotely





6. Conclusions and Next Steps

Overall, families very satisfied with service

Mixture of opinion amongst parents as to preferred method of feedback

Technology remains a challenge

Benefit of case coordinator acting as main lead. Relationship strengthened by previous contacts, including face to face at the ADOS-type assessment

Offer choice where possible

Re-assessment of working and implications for face-to-face contact

Ear Bruising in Children Referred for a Child Protection Medical

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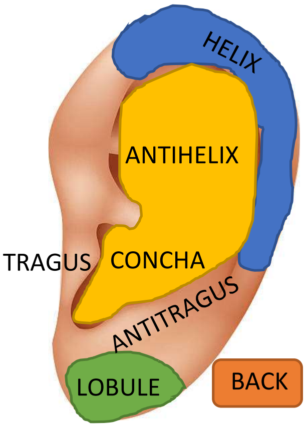
Introduction

Available data on ear bruising is limited. The Child Protection Companion '13 suggests 'abusive bruises are often located away from bony prominences...However, no site is pathognomonic and a careful history must be taken'.

Children in whom there is concern about non-accidental injury (NAI) are referred by Children's Services (CS) to a Paediatrician, who advises over the phone or organises a Child Protection medical. In some areas a referral form is completed.

Aims

To determine how common ear bruising is as a presentation of suspected NAI.
To quantify the proportion of ear bruising resulting in a final medical opinion of NAI.
To describe child protection outcomes for children with ear bruising.
To analyse the characteristics of children whose bruising was deemed non-accidental.



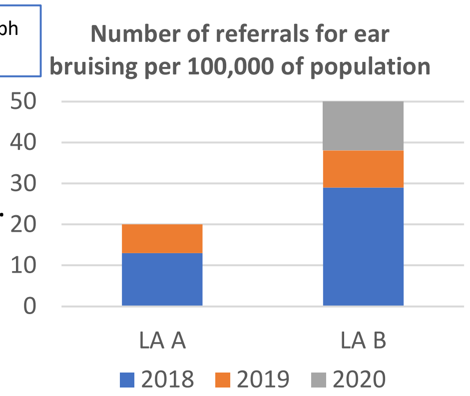
Method

Child protection (CP) medical referral forms for two local authority areas from 2018 to 2020 (33 months) were searched. Included were cases in which ear bruising was the reason for referral, and these CP medical reports were viewed. Then age, CS involvement, location of bruise, explanation for bruise, other injuries found on examination, medical opinion (accidental injury (AI)/NAI) and social outcome were analysed.

Results

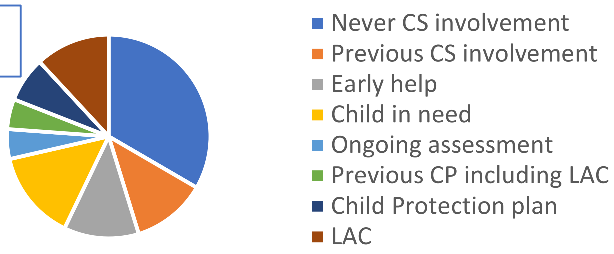
744 child protection medical referrals. 6% (42) were for ear bruises. 81% (34) these were seen for a CP medical.
There were 20 referrals/100,000 pop from Local Authority (LA) A, and 50/100,000 from LA B (**Graph 1.**).
Age range 5 months to 8 years, mean age 2.5 years.
66% had previous or current CS involvement (**Graph 2.**).
69% cases determined AI had bruising on 1 area of the ear.
62% cases determined NAI had bruising on 2 or 3 areas of the ear.
In 31% cases referred, the ear bruise was determined likely NAI (**Graph 3.**).
32% cases determined AI still underwent Children's Services investigation.
100% of those with a clear accidental explanation were determined AI.
100% of those with another injury with no story/ a concerning story were determined NAI.

Graph 1.



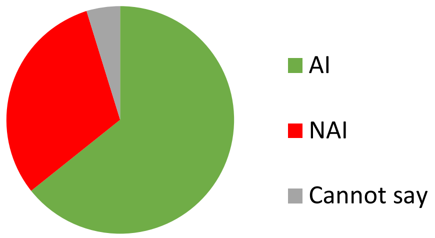
CS involvement pre-assessment

Graph 2.



Opinion given by Paediatrician

Graph 3.



Conclusions

Difference in LA referral rates highlights the need for increased awareness of the potentially serious nature of an ear bruise in LA A. We distributed a summary of the main messages of the study to social workers, health visitors and early years settings managers in both Local Authorities.

However, this study suggests accidental ear bruising is more common than inflicted ear bruising. If similar local projects were undertaken around the country the data could be collated and this conclusion tested.

The population of children undergoing a CP medical isn't representative of the general population of children but is biased towards children in whom there are already existing concerns. A study undertaken in nurseries and schools could establish a more representative number of children with ear bruising and thus a truer proportion of children at risk.

The complexity of safeguarding in an east London borough: social, economic and cultural factors

Background

Adverse childhood experiences (ACEs) are potentially traumatic events with long-term effects on physical and emotional health.[1] They include physical abuse, which is the third most common cause for a child protection (CP) referral in the UK and responsible for 7.5% of children on CP plans in 2020.[2] The WHO recommends shifting cultural norms as a strategy for prevention violence against children.[3]

This project explores the common factors experienced by families who attend child protection medical assessments (CPMA) as part of a section 47 investigation for physical abuse in a culturally diverse London borough.

Methods

CPMAs completed between 1st January 2020 to 31st December 2020 were selected. Each month in this period was divided into quadrants and one case family was chosen from each quadrant at random.
A data extraction tool was used to extract data such as demographic information, medical history and housing. The results were thematically analysed.

Results

46 case families (94 children) were selected. Ages ranged from 2-17 years. 60% of families were from ethnic minority backgrounds. 50% of the families were previously known to social services.

THEMES

Poverty

Living situation
- Overcrowded living - 43%
- Single parent households - 19%
- Council housing - 35%
- Poor living conditions - 11%

Finance and employment
- Benefits - 9%
- One parent employed - 62%
- Both parents unemployed - 22%

Parenting difficulties

Behavioural difficulties
- At home - 43%
- At school - 30%

Learning disabilities
- 11%

Neurodiversity and other developmental disorders
- 20%

Intergenerational trauma

Parents' adverse experiences as adults
- Mental health - 35%
- Substance abuse - 20%
- Domestic violence - 43%
- Incarceration - 20%

Parents' history of trauma
- Intergenerational trauma - 20%

Cultural ideas around violence

- Arranged marriage – 6%
- Extended family involvement – 5%
- Views around physical chastisement – 1 case family discussed how they considered physical chastisement a form of discipline and parenting

A case study

Asian-Bengali family with 5 children
Physical and emotional harm to children
Neglect: children had body odour and only washed once a week
Domestic violence: one child witnessed father trying to strangle mother
Father: depression and schizophrenia; refusing to take medications
Accommodation: one bedroom flat

Conclusion

In the case families examined, complex social factors were present relating to poverty and inequality. The data shows that these families are experiencing many ACEs, however there are many opportunities to intervene to prevent these cycles of violence. This means an early integrated approach between health and other agencies, to provide preventative services such as financial advice, mental health support, parenting advice and social housing support.

References

1. V J Felitti 1, R F Anda, D Nordenberg et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. American Journal of Preventative Medicine. 1998;14(4):245-58.

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Eating Behaviours and Obesity in Cared for Children

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1. The Problem…

Cared for Children are more likely to be obese than the background population and often become more overweight after entering care[1,2] .

2. Aims

- Determine trends in weight for Cared for Children in Sunderland
- Identify if those flagged as overweight were managed as per NICE guidelines[3]
- Produce an educational resource to inform carers of the best ways to support health and behaviour around eating

3. Method

- Determine the BMI from 1st August 2018 to 31st August 2019 for Cared for Children
- Review the trends in BMI from subsequent health assessments
- Review clinic letters to see if those identified as overweight were managed as per NICE guidelines[3]
- Develop case studies to identify any trends amongst those children who showed exponential weight gain
- Develop a literature review on trauma-based eating behaviours in cared for children

Figure 1: Word cloud generated from the literature review. It identified prior experience of abuse and problems with emotional development to be associated with a number of trauma-based eating behaviours

4. What we found out about weight in our Cared for Children

- 30 children were identified with a BMI >91st centile at their LAC health assessments
- 19 Male, 11 Female, aged between 8 – 18.
- 6 had a learning disability, 1 a physical disability
- When compared with the initial health assessment (available for 14 children), the BMI increased/remained the same for 10 children.

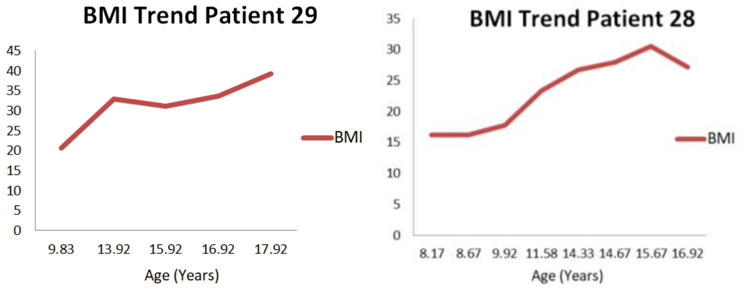


Figure 2: Example graphs taken from the case studies showing the rise in BMI. Trends identified through the case studies include: exposure to abuse and mental health problems

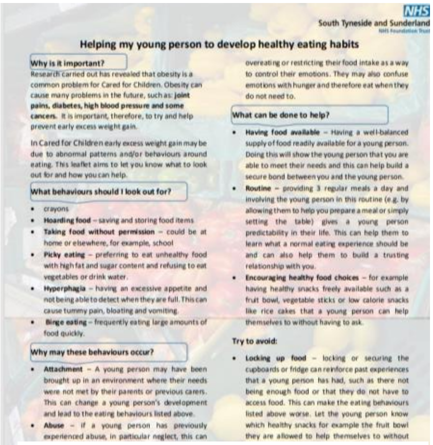
5. What trauma-based eating behaviours have been identified in Cared for Children from the literature review?

- **Pica** - eating non-food items
- **Hoarding and stealing food**
- **Picky eating** – preferring unhealthy food
- **Hyperphagia** –excessive appetite and inability to detect satiety
- **Binge eating**

6. What next?

The following actions have been set out to improve upon the findings identified:

- Education of the looked after health team regarding NICE guidelines
- liaison with the local weight management services
- production of an information leaflet for carers to support understanding of trauma-based eating behaviours and healthy eating, made in collaboration with clinical psychologists from the local Child Mental Health Teams



NHS
South Tyneside and Sunderland
NHS Foundation Trust

Helping my young person to develop healthy eating habits

Why is it important?

Research carried out has revealed that obesity is a common problem for Cared for Children. Obesity can cause many problems in the future, such as: **joint pains, diabetes, high blood pressure and some cancers.** It is important, therefore, to try and help prevent early excess weight gain.

In Cared for Children early excess weight gain may be due to abnormal patterns and/or behaviours around eating. This leaflet aims to let you know what to look out for and how you can help.

What behaviours should I look out for?

- crayons
- **Hoarding food** – saving and storing food items
- **Taking food without permission** – could be at home or elsewhere, for example, school
- **Picky eating** – preferring to eat unhealthy food with high fat and sugar content and refusing to eat vegetables or drink water.
- **Hyperphagia** – having an excessive appetite and not being able to detect when they are full. This can cause tummy pain, bloating and vomiting.
- **Binge eating** – frequently eating large amounts of food quickly.

Why may these behaviours occur?

- **Attachment** – A young person may have been brought up in an environment where their needs were not met by their parents or previous carers. This can change a young person's development and lead to the eating behaviours listed above.
- **Abuse** – If a young person has previously experienced abuse, in particular neglect, this can

overeating or restricting their food intake as a way to control their emotions. They may also confuse emotions with hunger and therefore eat when they do not need to.

What can be done to help?

- **Having food available** – Having a well-balanced supply of food readily available for a young person. Doing this will show the young person that you are able to meet their needs and this can help build a secure bond between you and the young person.
- **Routine** – providing 3 regular meals a day and involving the young person in this routine (e.g. by allowing them to help you prepare a meal or simply setting the table) gives a young person predictability in their life. This can help them to learn what a normal eating experience should be and can also help them to build a trusting relationship with you.
- **Encouraging healthy food choices** – for example having healthy snacks freely available such as a fruit bowl, vegetable sticks or low calorie snacks like rice cakes that a young person can help themselves to without having to ask.

Try to avoid:

- **Locking up food** – locking or securing the cupboards or fridge can reinforce past experiences that a young person has had, such as there not being enough food or that they do not have to access food. This can make the eating behaviours listed above worse. Let the young person know which healthy snacks for example the fruit bowl they are allowed to help themselves to without

Figure 3: Information leaflet for carers produced from the research in collaboration with clinical psychologists from the Child Mental Health teams

References

1. Hadfield SC, Preece PM. Obesity in looked after children: is foster care protective from the dangers of obesity? Child Care Health Dev2008;34:710-12.
2. "Obesity in looked after children: findings of a local audit and strategies for intervention.." The Free Library. 2011 British Association for Adoption & Fostering
3. https://www.nice.org.uk/guidance/cg189/chapter/1-Recommendations#identification-and-classification-of-overweight-and-obesity

The Community Child Health care of children with genetic diagnoses

A Burman[1], EJ Radford[2], H Dolling[3], DH Rowitch[2], FL Raymond[4], HV Firth[5], A Sansome[6]

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BACKGROUND

Many children under the care of Community Child Health Services (CCS) have genetic conditions, but for most genetic conditions there are no established care pathways.

The Next Generation Children's Project (NGC) demonstrated clinical utility of trio whole-genome sequencing (WGS) in our regional NICU and PICU[1]. For children who received a genetic diagnosis through the NGC, we examined CCS input with the following aims:

1. What proportion of children meet the threshold for CCS referral at diagnosis or are likely to within the next year
2. Whether these children were referred to and seen by CCS
3. Whether appropriate educational support is in place for those children who were seen by CCS

METHODS: A retrospective clinical audit

521 families received trio WGS through NGC

↓

36 children within CCS catchment area received a genetic diagnosis

↓

1 patient excluded: incidental diagnosis not anticipated to manifest until later life.

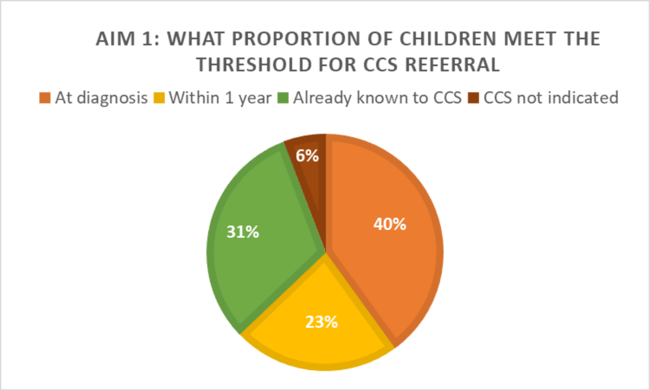
↓

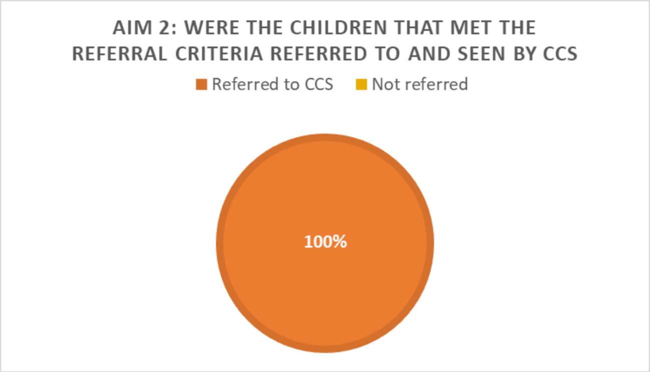
Data collection using hospital and community records

↓

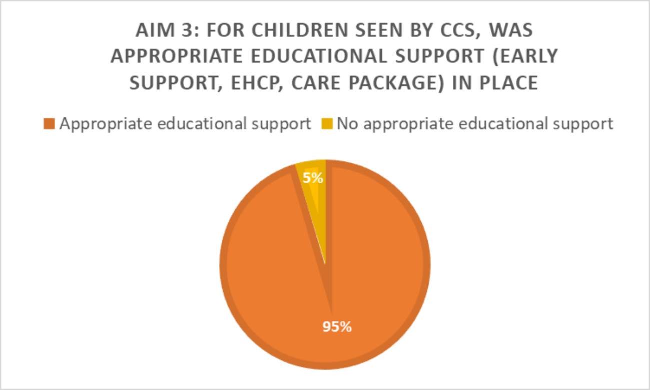
8 children excluded from analysis as referral to CCS not applicable
(6 died prior to discharge and 2 left the UK)

RESULTS





Patients known to CCS were significantly older ($p<0.05$, two-tailed T-test) at genetic diagnosis (mean age 4 years), than new referrals to CCS (mean age 4.6 months at genetic diagnosis). New referrals were received several months (mean = 7 months) after diagnosis



SUMMARY AND DISCUSSION

- The majority of children with a monogenic condition (63%) required input from CCS
- Children not known to CCS at the time of diagnosis tended to be infants CCS (mean age 4.6 months).
- Further work is required to explore whether parents would welcome an initial contact at the time of any genetic diagnosis to outline the support available (e.g. CCS) and advice on how to access the relevant services as and when they are needed, as is currently offered for particular genetic conditions (e.g., Down Syndome, muscular dystrophy).

1. French CE, Delon I, Dolling H, Sanchis-Juan A, Shamardina O, Mégy K, Abbs S, Austin T, Bowdin S, Branco RG, Firth H; NIHR BioResource—Rare Disease; Next Generation Children Project, Rowitch DH, Raymond FL. Whole genome sequencing reveals that genetic conditions are frequent in intensively ill children. Intensive Care Med. 2019 May;45(5):627-636. doi: 10.1007/s00134-019-05552-x. Epub 2019 Mar 7. PMID: 30847515; PMCID: PMC6483967.

Report on a virtual pilot of Child Protection Simulation Training in the Community during the Covid-19 pandemic

Nkiru Asiegbunam, Colette Laws-Chapman, Stacy John-Legere (email: Stacy.John-Legere@gstt.nhs.uk**)**

A. Introduction:

Conducting child protection medical assessments (CPMA) where there are concerns of non-accidental injury is a key clinical skill for paediatricians and part of the RCPCH curriculum. Child Protection (CP) simulation training was commissioned due to feedback from trainees about feeling unprepared for carrying out CP medicals

B. Aim: To increase familiarity with professional conversations in the Child Protection context. For trainees to
-be able to formulate an evidence based opinion in cases of suspected non-accidental injury
- become familiar with discussing outcomes of child protection medicals with parents/carers and social workers

C. Method:

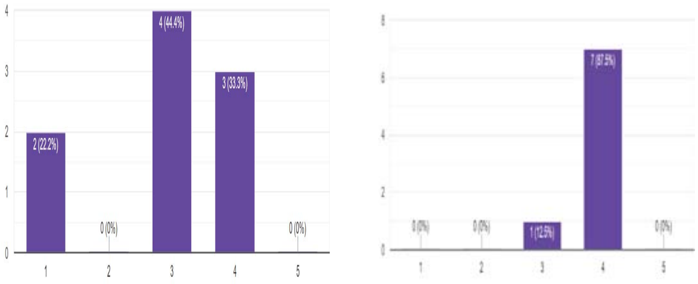
- ❖ We delivered 2 simulation scenarios on-line using the Diamond debrief model.
- ❖ Pre and post course surveys were used to gather data from participants on confidence and anxiety levels when approaching a CP medical; familiarity with and likelihood of using the HEADSSS assessment tool in this context.
- ❖ An impact survey was conducted 4 months later..

D. Results:

89% (8/9) had no previous CP simulation experience. Confidence in carrying out a CP medical rose from 33% to 87.5% and confidence in expressing concerns to parent/carer rose from 11% to 87.5% post course. 33% were familiar with HEADSSS tool pre course, 75% were more likely to use it post course. There was no change in participant anxiety levels.

I am confident in carrying out a CP Medical
1-Totally disagree → 5- totally agree

PRE –COURSE POST COURSE



E Some participant takeaways

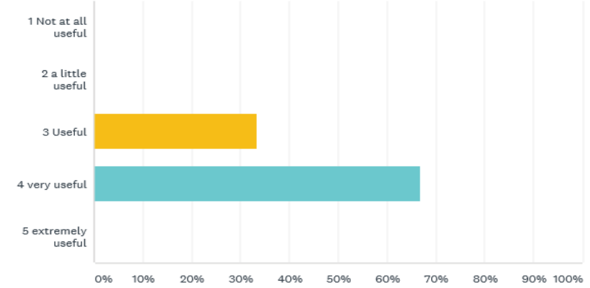
The significance of changing phraseology like *"non-accidental"* to *"I don't think this was an accident".*

"*Having a potential roadmap in mind for these consultations enables a more dynamic approach*"

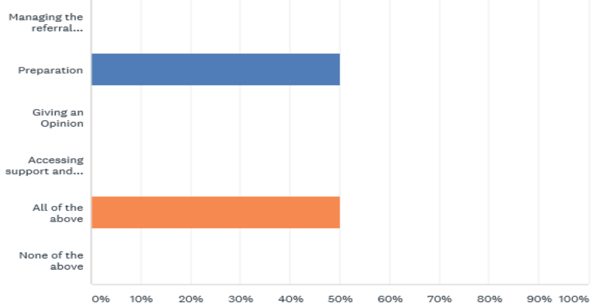
The idea of balancing the 'immediate problem' with the wider picture and what may be best for the child.
"- having the confidence to not worry too much about time … but taking the time to focus on the child and what is best for them."

F Some findings from Impact Survey 4 months later

Q1. Using a Likert scale please rate how useful the safeguarding simulation course has been in helping you carry out the CP medical?



Q4. Since the course, what specific points regarding the approach to conducting a CP medical have you been able to apply to your practice? Please select as many as apply.



G. Conclusions:

This virtual pilot during the Covid-19 pandemic was successful. Participants found it very useful and shared several learning points e.g. *"Use what you can agree on as a foundation for developing rapport."*
Some feedback comments: *"I thought the content was brilliant." "It was very useful in preparation for community."*

H. Next steps:

Participants suggested including scenarios on dealing with a hostile, defensive or aggressive parent. We will prerecord the taught component as pre reading/learning to allow more time for scenarios and build on the learning from this pilot.

Differential Attainment (DA) in Career Progression of Doctors in the UK-A rapid review

Hussain S, Hosdurga S

Veena Daga, Robert Blizzard, Anshoo Dhelaria, **Saraswati Hosdurga**, **Saba Hussain**, Spandana Madabhushi, Geraldine Sawney, Arvind Shah, Lambrini Theocharidou & Rupal Shah

Introduction

Differential attainment in career progression in the NHS is a complex issue with many interplaying factors apart from individual protected characteristics. In this rapid review, we examined the attainment gap, causes for these disparities and some recommendations to reduce the gap

Aims:

This review was conducted as part of the 'Bridging the Gap' project by the British Association of Physicians of Indian Origin to summarise key literature around differential attainment in career progression of doctors working in the UK NHS and to identify and propose solutions to address differential attainment.

Methods:

115 relevant publications and reports were identified from Google Scholar and PubMed (key word: career progression, differential attainment, NHS) and various organisations. Each paper was categorised under scale, impact, causes and solutions and subsequently reviewed by 10 authors.

Results

Protected Characteristics

- Gender[1]
- Less than full time (LTFT)
- Non-Trainees
- International Medical Graduates (IMGs)
- Ethnicity BAME
- Disability

Impact

- Scant opportunities
- Burnout and stress
- High work Intensity
- Undermined and Prejudice
- Inadequate supervision
- Discriminatory Job plan

Causes

Acculturation Facets:

1) Linguistics

2) **Lack of awareness** of locally prevalent ethical, legal and cultural norms

3) Power distance norms

Social capital

Poor relationships with seniors can lead to fewer learning opportunities and lower confidence

Stereotyping

Stereotype threat refers to the risk of confirming negative stereotypes about an individual's racial, ethnic, gender, or cultural group. It is thought to contribute to racial and gender gaps in academic performance.[2]

Bias

1) Systemic

2) Unconscious – leads to exclusion of IMGs, BAME, LTFT, and those with disabilities

Emotional and Practical Support

Lack of emotional and practical support from partners and families, relevant to IMGs ;those with caring responsibilities or disabilities.

Identity & Inclusion

A sense of loss of personal identity & Lack of inclusion (especially IMGs)

Results: Solutions

Flexibility in training
Support for LTFT working and training

Tailored support to the individual requirements

Organisational Benchmarking & Accountability of training environment

Tackling systemic bias
1) Unconscious bias training
2) Supporting disadvantaged groups

Co-production & Diversifying of training
Enhances: sense of belonging & equitable access to achievement

Conclusion:

Differential attainment in Career Progression of Doctors in the UK has been recognised consistently in metrics, published literature and in reports from several organisations for more than three decades.

It has far reaching consequences for groups not favoured by 'the status quo'. The success will require collaborative working within and between organisations and education and awareness of this issue to the directors and managers. Co-production of solutions with the affected groups should be prioritised. The interventions must be designed in a way that the evaluation of their impact can be seen.

1. Lachish S, Svirko E, Goldacre MJ, Lambert T. Factors associated with less-than-full-time working in medical practice: results of surveys of five cohorts of UK doctors, 10 years after graduation. Hum Resour Health. 2016 Oct 13;14(1):62.

2. Mountford-Zimdars A, Sanders J, Moore J, Sabri D, Jones S, Higham L. What can universities do to support all their students to progress successfully throughout their time at university? Perspect Policy Pract High Educ. 2017 Jul 3;21(2–3):101–10.

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An assessment of the ability of primary care to monitor vital signs in a paediatric population

A. Ho, N. Joglekar, J. Lee, A. Sansome
Community Paediatrics Department, Cambridge

Background

Monitoring vital signs is a key part of assessment and management of children with chronic conditions including ADHD and obesity. As 21% of children aged 10-11 in the UK are obese, assessment of these children including monitoring of blood pressure and weight is essential. We were interested to see how feasible this would be in primary care.

Aims

- To evaluate if GPs have the equipment required to adequately assess a paediatric patient.
- To understand GP's current and potential future involvement in shared care with Community Paediatrics
- To understand the prevalence of children presenting with obesity in primary care

Method

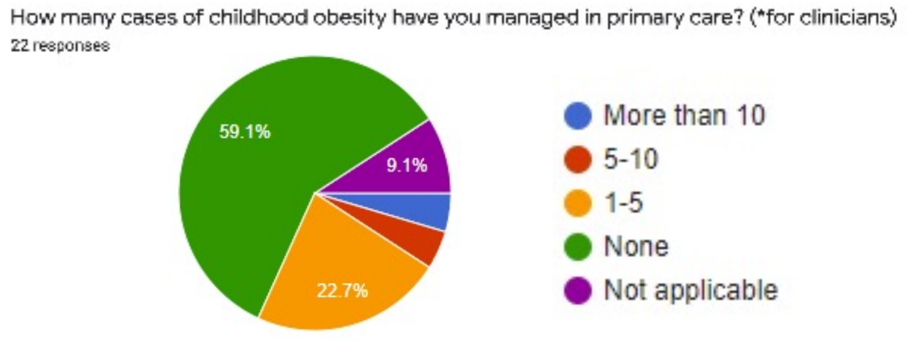
An electronic 9 question multiple choice survey was created

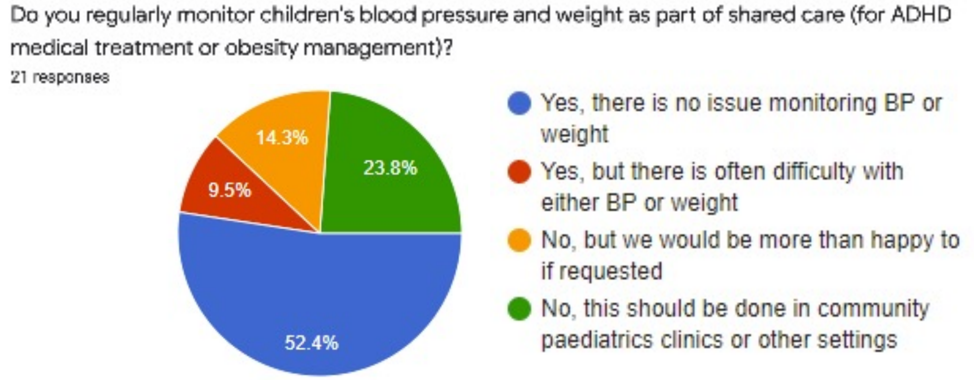
This was sent to practices via emails to practice managers and GP trainees

Responses were collated using Google forms. No incentives were offered to complete the survey

Results

The 22 responses to the survey demonstrated very mixed answers. In terms of having a full set of paediatric appropriate equipment, including weighing scales, blood pressure cuffs, saturation probes, this was not available in at least 50% of GP practices. On questioning about relevant clinical experience, 59% of GPs reported never having managed a case of childhood obesity. Further to this, 24% of respondents felt weight or BP should be monitored in community paediatrics rather than in primary care.





Conclusion

Our survey showed that monitoring equipment for children locally was not standardised and that shared care pathways may not be universally accepted.

It also indicated that GPs in this region generally had little exposure to the management of paediatric obesity.

Standardisation of the monitoring equipment in GP and developing pathways for identification and management of childhood obesity could improve the outcomes.

East Kent Hospitals University NHS
NHS Foundation Trust

Please, write to me!

Should we be addressing our outpatient letters to patients and their families in community child health?

Dr Catherine Grilli, Dr Oluwafemi Ogunbona

Introduction

Ian Paterson was a breast surgeon who subjected more than 1000 patients to unnecessary and damaging operations over a 14 year period. An independent enquiry suggested that one of the reasons this was able to happen was because the letters written about consultations were confusing and often not sent to the patients at all. A recommendation from the report was:

'***We recommend that it should be standard practice that consultants in both the NHS and the independent sector should write to patients, outlining their condition and treatment, in simple language, and copy this letter to the patient's GP, rather than writing to the GP and sending a copy to the patient***'

The academy of medical colleges (of which RCPCH is a member) recently published guidance suggesting that outpatient letters should be written directly to patients (1). Writing directly to patients is also in keeping with ' Good medical practice' which states '***You must give patients the information they want or need to know in a way they can understand'*** (2)

This is already widespread practice within psychiatry, psychology, clinical genetics and some areas of adult medicine, but to our knowledge, is not common in community paediatrics.

We completed a short pilot study to determine what the parents of community paediatric patients felt about this issue.

Methods

20 parents of patients who had been seen by community child health in April and May took part in a telephone survey. The patients were selected in chronological order from the clinic lists of 3 clinicians. They were asked the following four questions:

1. **Did you read your letter?**
2. **Did you understand your letter**
3. **Did your letter reflect the appointment you had**
4. **Would you prefer your letter to be written directly to you (with the GP copied in), directly to the GP (with you copied in) or do you have no preference.**

Results

- All 20 participants said they had read the letter they were sent
- All 20 participants said they had understood the letter they were sent
- 18 of the 20 participants felt the letter reflected their appointment. The remaining two participants stated that it 'partially' reflected their appointment.
- 15 of the 20 participants had no preference as to who their letter was addressed to, as long as they received the information. The remaining 5 preferred that the letter was addressed to them. No participants preferred that the letter was addressed to the GP (Table 1)

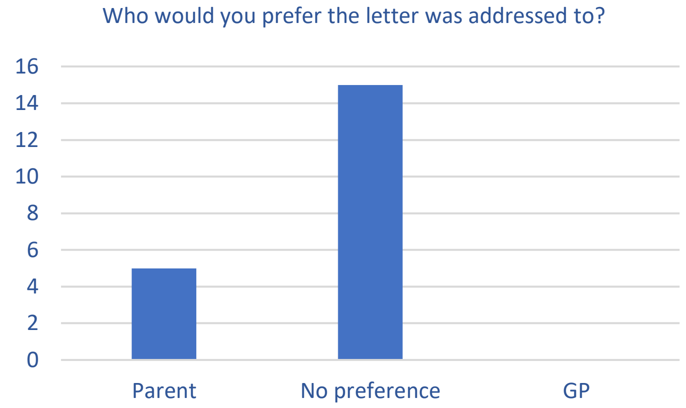


Chart 1 – Showing preferences of participants as to who their outpatient letter should be addressed to

Discussion

While the majority of patients did not have a preference about who their letter was addressed to, a significant minority (25%) would prefer the letter to come to them. Parents made comments such as:

'When it is addressed to the doctor, it is like they are more important'

'It should be addressed to us [the parents], because the GP doesn't read it. If there is something for the GP to do in the letter it never happens. I have to ring the doctor and ask for it. Everything on the letter I will have to do, so it should come to me'

Of note, none of the patients expressed a preference that the letter should go directly to the doctor.

There is some evidence that this approach may be beneficial. A Randomised trial in a haematology clinic showed that patients and referring clinicians were very positive about letters written directly to patients (3). Doctors who have adopted this practice say that their communication style has become more patient centred (4).

Conclusion

Addressing letters directly to patients and their families improves communication and puts patients at the forefront of care. Patient centred care is particularly important in community paediatrics, as our patients are often complex and nuanced.

Writing directly to patients is a growing practice in adult medicine and there is evidence that it improves communication (3,4). This small pilot study suggests it may also be beneficial in community paediatrics in some cases.

References

1. Academy of Royal colleges guidance. ' Please, write to me. writing outpatient letters to patients. 03/09/2018
2. GMC: good medical practice
3. *O'Reilly et al. Writing to patients: a randomised control trial. Clinical medicine 2006; 6: 178-82*
4. *Taylor et al. Writing letters to patients. British Journal of Renal medicine, 2013; Vol 18 No1 Supplement P21*

Joint Health and Social Care Quality Improvement Project - Report on a 6 week pilot Child Protection Strategy Discussions

Nkiru Asiegbunam, Rachel Coogan, Gul Heptinstal, Brenda Nakamya, Annelie Visser, Deborah Paton.
Email: Nkiru.asiegbunam@gstt.nhs.uk

A. Introduction:

The requirement for "health" to contribute to all Child Protection strategy discussions is enshrined in statutory guidance and policy (Working Together 2018)
Local implementation led to >500% increase in requests to community doctors. (41 in 2018/19 to 244 in 2019/20)

B. Aim:

To streamline the pathway for strategy discussions with Children's Social Care (CSC) to ensure that the health input into this process was appropriate and quality assured, avoiding unnecessary duplication but also utilizing appropriate personnel and skills from health.

C. Method:

- We **drafted and piloted a new strategy discussion pathway involving Specialist Safeguarding Nurses (SpN)** including guidelines for contributing to discussions and making entries..
- SpN, Community doctors and CSC partners were briefed.
- The 6 week pilot commenced in July 2020.
- ***SpN electronic entries were quality checked and triangulated with feedback surveys from SpN and CSC managers.***
- A random sample of strategy discussions was reviewed by an Independent quality assurance manager from Social Care.

F. Conclusions:

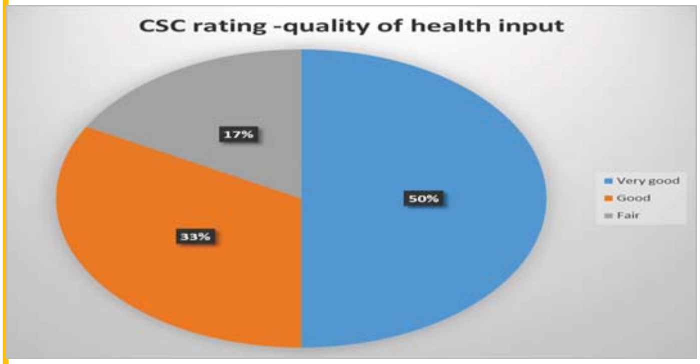
- The quality assurance process proved that the ***nurses were well equipped*** to undertake appropriate strategy discussions.
- **The piloted pathway *was successful in identifying which strategy discussions the SpN's could contribute to***: harm in the context of Domestic Violence, Child Criminal or Sexual exploitation /missing episodes etc. and Unborn.
- ***Health input by doctor or nurse contributed to positive outcomes.*** .
- The QIP streamlined the Social Care Process ensuring that health information already shared at MASH (Multi Agency Safeguarding Hub) is pulled through to the strategy discussion avoiding duplication of information sharing by staff.

G. Actions/ Next steps:

- We have ***successfully made a case for SpN to undertake some of this work.***
- The ***piloted pathway has been adopted*** with minor changes to include our local hospitals, midwifery and CAMHS teams.
- We are ***addressing the training needs identified*** by SPN e.g. thresholds for CP medicals and HAVEN/ CSA medicals.

References: Working Together HM Government 2018

D. Results



Using a Likert scale, (1- very poor; 5- Very good)

- **5/6** 83% of CSC **managers rated** the health contribution to the strategy discussion in terms of helping in decision making about a s.47 investigation or other decisions to safeguard the child(ren) as 4/5 - (***Good/Very good*)**.
- 1 /6 **17%)** gave a rating of **3- fair.** Comment: ***health isn't always available so their feedback is sometimes obtained via emails***

SPN survey response rate 4/5 (80%)

Feedback quotes

- *"An educative, reflective and good collaborative experience."*
- *"Informative, Insightful, re factors that influence decision making. Opportunity- to open discussion and add different perspectives to the table, which supported decision making."*
- *"…Open discussion, challenging pre-existing thoughts"*
- *"Leadership, broad thinking, opinion valued."*
- *"Helped to expand knowledge base"*

E. Analysis

- **5/6** 83% of CSC respondents stated that **the right health representative was present.**
- SpN felt their input was valued by CSC.
- There was **added value from SpN involvement in contextual safeguarding cases.**
- *CSC stated that the d**octor** was able to advice on actions including making **a referral to the service for assessment of risk of developmental problems** but **Nurses had a richer depth of information***
- *In the 12 cases randomly selected the independent auditor stated that " **joint contribution and information sharing from health was key to the decision making and that historical information assisted the decision making process too**.* "

Clinician's experience of conducting Child Protection Medical Assessments during the Covid-19 pandemic

Nkiru Asiegbunam Email: Nkiru.asiegbunam@gstt.nhs.uk

A. Introduction:

During the first wave of the Covid-19 pandemic, most streams of clinical work in the community were discontinued as a face to face (F2F) activity except Child Protection Medical Assessments (CPMA) for vulnerable children. Some Community Paediatricians were redeployed to acute services in line with RCPCH guidelines.

B. Aim:

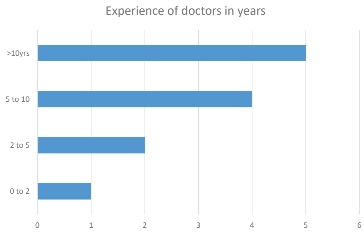
To collate information and feedback from doctors about their feelings, emotions and experience of carrying out F2F assessments during the pandemic to see how we could improve the support and supervision available to colleagues during subsequent waves.

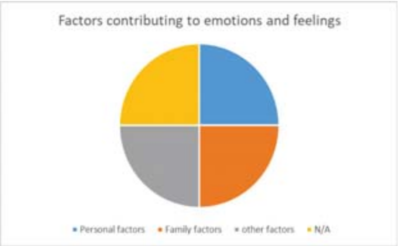
C. Method:

A survey monkey was sent to Community Paediatricians that were not redeployed but rostered to do F2F CPMA in March to July 2020. The survey explored whether doctors felt the arrangements put in place to support them were sufficient; their feelings and emotions and what could be done differently during subsequent waves of the pandemic.

D. Results:

100% (12) felt supported and protected by the arrangements in place: history via telephone, use of rooms with a 2 way mirror, and provision of adequate PPE. 66% reported CPMA provoking different emotions (negative and positive) compared to pre covid times not linked to level of clinical experience but to other factors.





Other factors:

Children's response to me wearing PPE

Restriction of social work input,

Balancing Conflicting risk factors (to see or not to see),

increased risk to children.

Necessity to maintain standards despite current issues

E. Results 2: Doctor's Feelings (Word & phrase cloud)

Scared

Nervous

Anxious

Awkward

Different

calm

Confident

Same

Added value

Safe

Alert

A need to be careful

Sad about children's difficult circumstances

Pleased to be available to children

Proud of service being available

More time consuming

Supported

Empowered

Necessary

Crucial

Unfamiliar

F. Doctors Reflections and Improvements suggested:

" Planning & preparation is key. Acknowledging that we are all afraid of the unknown, pulling together and supporting each other."

"Actually nothing to change, our team has been simply amazing. The daily huddles helped as it kept us connected and in constant dialogue."

"The fact that case conferences are by video is better way of using time."

"Hope no 2nd wave! I think we were very prepared the first time. Virtual pre-assessments helped greatly."

"Perhaps more formal set up of telephone/video consultation for history …"

"…assessments take longer with virtual /telephone component first then face to face component, so time allocation needs to reflect this"

"Closer and more robust liaison with external agencies."

"I think what we had in place worked well."

G. Conclusions and next steps:

100% of doctors felt that arrangements put in place worked well. Colleagues felt well supported including access to advice and supervision despite remote working by team members. There was a strong sense of community and commitment to children.
One ***key recommendation was to review the triage process – which children must be seen and why.***

.

Grateful Acknowledgements:

Matthew Turner, Darren Fernandes, Jacqueline Munden, Marcia Brown and the Reception Team, All Community doctors, Dr. Stacy John- Legere and Dr. Narad Mathura Joint Heads of Service; Dr. Bidisha Lahoti Clinical Director Evelina London Community Health Services.

Evelina London

Guy's and St Thomas' NHS Foundation Trust

Safeguarding Advice: What works for frontline practitioners?

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A. Introduction

Safeguarding leaders must advise teams and practitioners across the organisations and in multi-agency teams(HM Government 2015)[1].The 'webs of care 'involved in safeguarding are complex and can be highly stressful. Safeguarding has a vital role in supporting, advising and coordinating a seamless child centered approach (Rooke 2015)[2]

B. Aim

To learn from the practitioners perspective what elements of the safeguarding advice received was considered useful and why, to enable us to build on and improve practice.

C. Method

- In November 2019 we invited Southwark frontline practitioners to complete a Survey Monkey to reflect and comment on what they would consider to be 'good safeguarding advice'.
- Following this we facilitated a multidisciplinary focus group of frontline practitioners to consider emerging themes from the survey monkey exercise
- We then collated and analysed the feedback to learn and instigate change

D. Results I:

- 118 (81% response rate) staff from mixed disciplines responded to the survey (fig 1.)
- The data demonstrated that contacts for advice were as follows: 40% face to face, 40% via telephone,11% via email, and 4% in a group situation.6% responded Not Applicable (N/A). (See fig 2)
- The safeguarding advice rating on a 5 point Likert scale was as follows: 37% Very good, 38% good, 18% fair, 0% poor, 1% very poor. (see figure 3)

E. Results II: Reasons given for rating advice as very good/good

clear

Helpful

Timely

Informative

Practical

Fig. 1 Staff groups

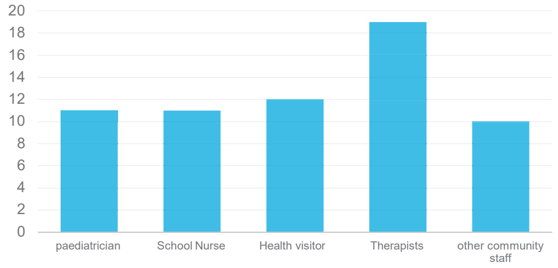


Fig.2 Mode of contact

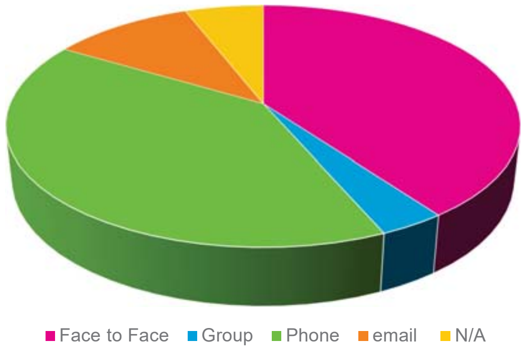
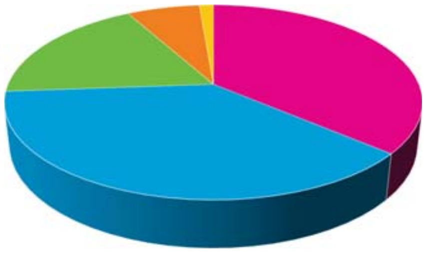


Fig.3 Advice rating



F. Value added from Focus group: How can we improve on advice giving?

- Be approachable and listen
- Acknowledge the work already done by practitioner
- Be objective and realistic
- Bring a calming influence as well as constructive challenge
- Clarify risk and help with decision making
- Signpost to other resources
- Refocus the practitioner on their role and risk to be managed
- Help frame concerns for escalation
- Share expertise including legislation and the evidence base

G. Wider suggestions for improvement

Survey Monkey	Focus Group
Write advice given on Carenotes	Provide a written plan which can be followed
Offer Supervision to the allied health professionals	Allied professional would value designated supervision sessions from the safeguarding team
Give realistic and achievable advice for adolescents	Provide regular bitesize learning. Introduce peer review and case related learning for non medics
Focus less on thresholds	Always have a no blame approach

H. Analysis, Conclusion and Next Steps

- Competencies for safeguarding leads are identified within the Intercollegiate guidelines[3]**.** A literature search conducted at the beginning of this project did not identify a nationally agreed framework for giving safeguarding advice.
- This **QIP has been helpful in validating our practice and highlighting areas for improvement**.
- Positively **75% of respondents rated the advice received as very good or good**
- We have reflected on the feedback and we are embedding the suggestions to strengthen existing good practice.
- **In phase 2 of this project, we conducted a national survey of safeguarding leads** to identify whether there is congruence between what frontline practitioners told us and what the advisors consider 'good safeguarding advice'.
- **We plan to write up and share the findings.**

References: 1.Working Together: HM Government 2015 2. Primary Health Care: Role of leadership behaviours in safeguarding supervision: a literature review; https://journals.rcni.com/primary health care . 3.Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Jan 2019. Royal College of Nursing

Cooped Up & Staring At Screens

A Paediatric Survey Studying Compliance to Attention Deficit Hyperactivity Disorder (ADHD) Medication and the Effect of the COVID-19 Lockdowns on Symptom Control

T L Perumal (e-mail: thushara.perumal@nhs.net), S Nur, M Mukherjee – Community Paediatrics, London, UK

Introduction

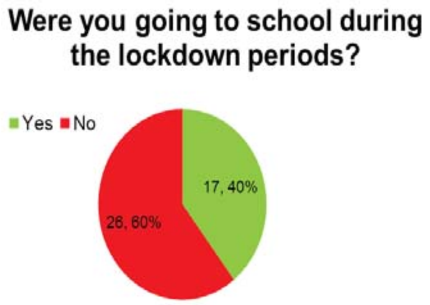
- ADHD is a neurodevelopmental disorder that often negatively impacts on school age children's learning
- Our local Community Paediatric team follow up children on ADHD medication regularly, to ensure medication compliance & symptom monitoring

Aim

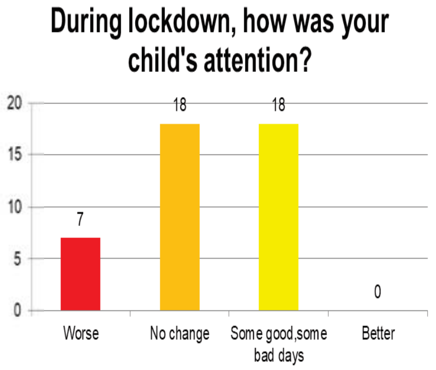
- To learn about the compliance of children on ADHD medication from December 2020 - March 2021 during the COVID-19 lockdowns and the effect on symptom control

Methods

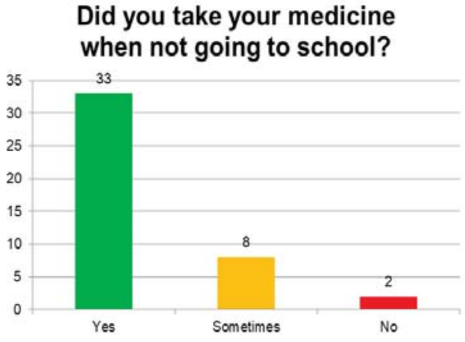
- We identified patients coded with a diagnosis of ADHD
- An initial telephone call was made to the parent/carer to request survey participation and a subsequent call a week later to obtain feedback
- A 24-question questionnaire was used relating to:
  - ADHD symptoms – inattention, hyperactivity and impulsivity
  - Sleep
  - Appetite
  - Routine
  - Learning
  - Screen time



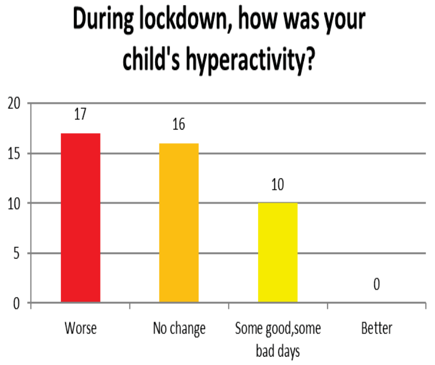
Were you going to school during the lockdown periods?



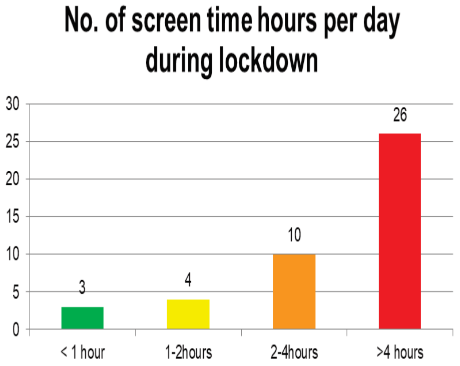
During lockdown, how was your child's attention?



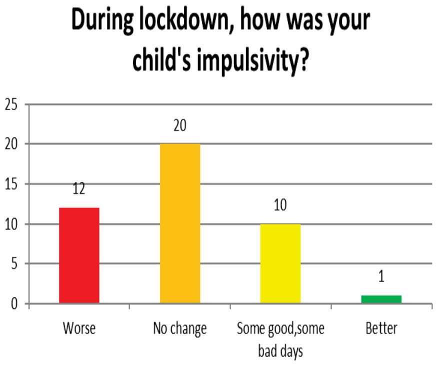
Did you take your medicine when not going to school?



During lockdown, how was your child's hyperactivity?



No. of screen time hours per day during lockdown



During lockdown, how was your child's impulsivity?

Results

- 43 families participated
- 79% (n=34) were taking their medication regularly during lockdown
- None found that their child's symptoms of inattention and hyperactivity were better, with only one family (2%) reporting an improvement of impulsivity
- 49% (n=21) described learning as "worse" during lockdown
- 47% (n=20) reported no change to sleep with 33% (n=14) saying it was worse during lockdown
- During lockdown, 53% (n=23) reported no change to their child's appetite

Conclusion

- Children on ADHD medication struggled with their symptoms and learning during lockdown
- It may be useful to signpost these families to online resources, offer interventions (e.g. text-based/telephone[1])
- In discussion with education, these children may need to be prioritised for attending school should there be need for a lockdown in future

References:

1. Shah, Ruchita, et al. "Impact of COVID-19 and lockdown on children with ADHD and their families—an online survey and a continuity care model." Journal of Neurosciences in Rural Practice 12.01 (2021): 071-079.
2. Bobo, E., et al. "How do children and adolescents with Attention Deficit Hyperactivity Disorder (ADHD) experience lockdown during the COVID-19 outbreak?." Encephale (2020): S85-S92.

The impact of acute out of hours (OOH) rota on the learning opportunities of Community Child Health (CCH) grid trainees

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Sirona care & health

Introduction

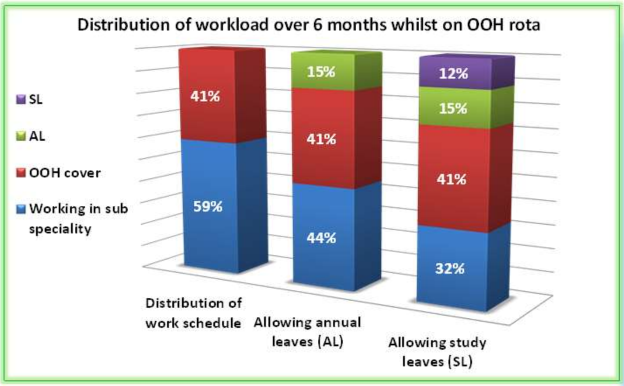
CSAC guidance states that grid trainees should spend 70% of time within the sub-specialty. An RCPCH survey found 70% of grid trainees spending less than 70% of their time in subspeciality. These trainees were more likely to report difficulties in obtaining competencies compared to the trainees working more than 70% of their time in subspecialty.

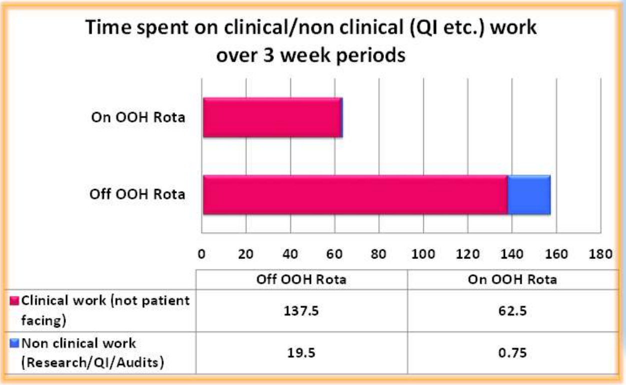
Aims

To compare the differences in learning / training opportunities for Community Child Health (CCH) grid trainees, whilst covering an acute Out Of Hour rota (OOH) and then once doing no OOH, and to identify whether this improved their training.

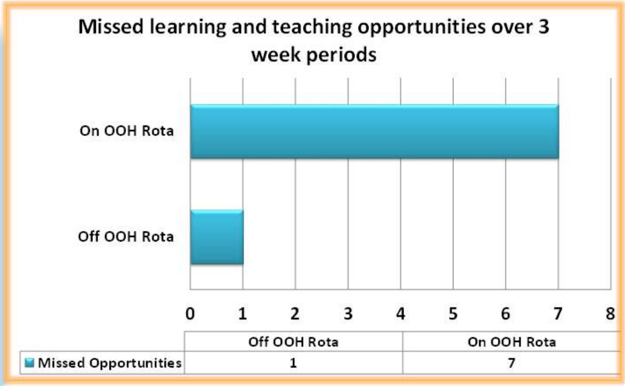
Methods:

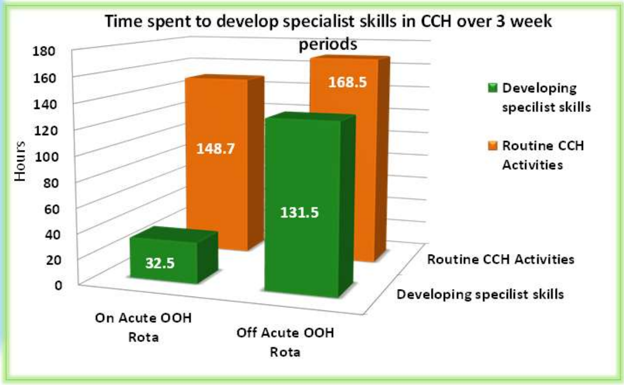
Pro-formas were completed by CCH grid trainees before and after coming off OOH for 3 working weeks on both occasions. Data was collected about hours worked in CCH and OOH; time spent in developing specialist skills, doing clinical work and non-clinical work (audit ect) ; missed learning opportunities and a free text section. Work plans for 6 month periods were reviewed.





Results: Whilst on acute rota, CCH trainees spent significant amount of time (41%) covering OOH shifts. On multiple occasions they missed learning opportunities and got less time for CCH related work. Once off OOH trainees spent all of their time in CCH, attended activities to develop specialist skills and got adequate time for clinical & non-clinical tasks.





"I should be learning to manage a consultant work load. This is very difficult when I cannot follow up patients in a timely manner. I have missed TAC meetings, seeing patients with MDT and following up on safeguarding cases "

Since coming off the on call rota, *It has been much better for my learning. I've been able to attend meetings for my patients, and feel as though I am managing every aspect of my patients' care. I have also been able to attend more teaching and work meetings. It has definitely hugely improved the quality of CCH experience I am getting."*

Conclusion:

Spending all working hours with the core specialty (unsurprisingly) significantly improves CCH grid trainees' access to relevant training and learning opportunities. This enables them to develop the specialty specific skills required to be a consultant in CCH. There is a secondary benefit to improved patient care.

We recommend that CCH trainees are given the opportunity to spend some of their training (from ST7) working solely in CCH if this reflects the work they are likely to be doing as a consultant

Reference

Knowles, Linzi. "The 70:30 split – Do Community Child Health trainees get the recommended time in community." BACCH News, December 2020, p.18-19

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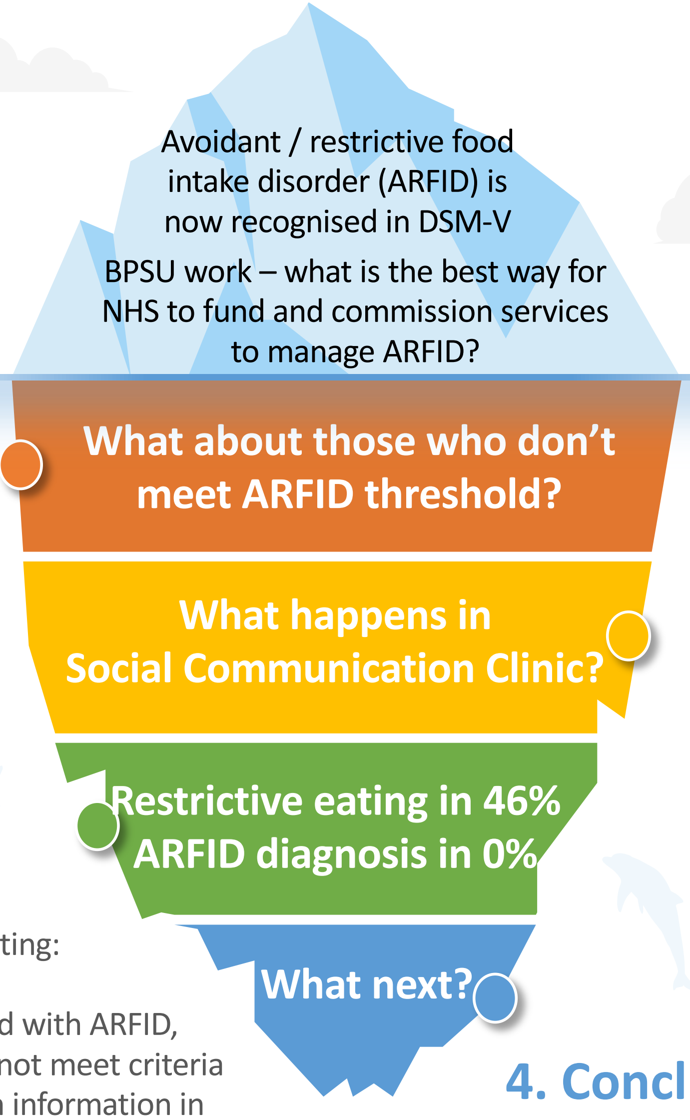
ARFID: the tip of an iceberg?

Understanding the need for and improving services offered for Community Paediatric patients with restrictive eating patterns.

Dr Eleanor Boddy, Dr Nicola Herberholz, Dr Gillian Mitchell, Dr Kim Pierson, Dr Toks Sanwo, Dr Rachel Bower
Cambridgeshire Community Service NHS Trust

1. Aims

- To understand the extent of problematic restrictive eating in pre-school-aged children referred to our Social Communication Clinic (SCC).
- Knowing that restrictive eating rates are higher in this specific group, we wanted to understand how we can improve support for this.



Avoidant / restrictive food intake disorder (ARFID) is now recognised in DSM-V

BPSU work – what is the best way for NHS to fund and commission services to manage ARFID?

What about those who don't meet ARFID threshold?

What happens in Social Communication Clinic?

Restrictive eating in 46%
ARFID diagnosis in 0%

What next?

2. Methods

Retrospective evaluation of SCC, notes reviewed for 50 random patients seen in 2019 (pre-pandemic):

- How many had restrictive eating?
- Could ARFID have been diagnosed?
- What was the eventual SCC diagnosis?
- What were the investigations and management once an eating problem was identified?

3. Results

Of those with restrictive eating:

- 74% had ASD diagnosis.
- None could be diagnosed with ARFID, either because they did not meet criteria or there was not enough information in the clinic notes.
- None had bloods requested for nutritional deficiency.
- 13% had onward dietetic referral.
- 17% were advised to take a multivitamin.
- 13% of parents were recommended resources to support their child's eating.

4. Conclusions

There is a huge variation in practice, so a guideline was developed to support positive actions within a limited time resource:

- Advice on when to consider blood tests.
- Management strategies suggested for consideration (multivitamins, threshold for dietetic referral).
- Collation of resources that are accurate, up-to-date and accessible to families.

Future aims: to understand service needs for school-aged children and whether early intervention prevents ARFID?

Scan to see our family resources for healthy eating in ASD ("Top tips" tab)

Contact: eleanor.boddy@nhs.net

This presentation has been designed using resources from PoweredTemplate.com

PROJECT CLEAR MINDS: TEEN BOYS HELP OTHER TEENS FIND MENTAL HELP SUPPORT

Introduction:

67% of young people feel COVID-19 will have a long term impact on their mental health. Yet young men are concerned about the stigma of mental health support and prefer online support. As digital can achieve comparable outcomes to face-to-face therapy, but 80% of mental health apps are low quality, this programme sought to understand how best to connect young men with safe and effective digital support.

Aims:

To understand which digital health young men want and the best methods for health providers to reach and engage with this patient cohort.

Methods:

The Organisation for the Review of Care and Health Apps (ORCHA), conducted a project led and shaped by young men. The project called 'Clear Mind', a name which the boys themselves chose, challenged the young men to select a number of health apps focussing on mental health support for young people and to promote to their peer group.

Results:

Five apps were selected from a pool of 50 that comply with safety standards. Social media was selected as the main communications channel, creating TiKTok videos and Instagram posts. A leaflet was distributed as schools and a presentation was given to 400 students through Speakers for Schools and to healthcare professionals in Cambridgeshire.

Conclusion:

The project gave a voice to young people, in selecting and communicating digital health. The digital health chosen didn't explicity target teenagers; but were condition-led and featured formats common with social media. The communications choice and format achieved significnat pick-up and HCPs valued understanding the views of the cohort.

For more information contact: hello@orcha.co.uk 01925 606542