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MATERNAL AND CHILD DETERMINANTS OF PAEDIATRIC LOW ACUITY EMERGENCY DEPARTMENT ATTENDANCES IN A LONDON HOSPITAL: A DATA LINKAGE STUDY

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Objectives Low acuity emergency department (ED) attendances (LAA) in children, typically those not requiring admission, medication or other treatment, are an increasing challenge.¹ National data shows significant geographical variation in paediatric ED attendances,² and social determinants of health vary by region. Local data on associations of LAA is crucial to inform strategies to reduce such attendances.

We aim to examine associations between child and maternal factors (collected antenatally at booking appointment) with LAA in children in a London hospital.

Methods ED attendances in a pre-pandemic cohort of children aged <5 years between September 2013 to October 2014 were linked, where possible, to Maternal antenatal data using routine operational data from separate hospital information systems.

LAA were defined as not admitted *and* assigned one of five diagnoses: 'Neonatal feeding difficulties', 'No problem identified', 'Not a specified problem', 'Paediatric parental concern' and 'Worried anxious parents, no problem'

Logistic regression analysis was performed on pseudonymised data to explore associations of LAA. Ethics approval ref:SE22/016.

Results Of 8487 ED attendances during the study period, 4686/8487 (55%) were successfully linked via NHS numbers to maternal records (limited to those children who were born in the same hospital). The median age of children was 1.2yrs, 46.5% were the first child and 55.4% were male. The median age of Mothers was 29, 7.1% reported mental health problems, 1.6% had a social worker and 3.9% were smokers.

After omitting attendances with missing diagnoses, 369/4331 (8.5%) were LAA.

Multivariable analysis showed that younger child age ($p<0.001$), smoking status ($p=0.003$) and lower parity ($p=0.02$), after adjusting for other variables, were significantly associated with LAA, with similar results for univariable analysis. The least deprived quintile had reduced odds of LAA compared with the most deprived (Odds ratio 0.39 (95% CI 0.19, 0.82)), although trend was non-significant ($p=0.08$).

Conclusion To our knowledge, this is the first study using linked antenatal data to explore associations of LAA, a potentially replicable methodology. Limitations were the relatively low rates of successful linkage and missing data.

LAA association with younger child age and lower parity is consistent with existing literature. To the best of our knowledge, this is the first study demonstrating an association with maternal smoking status.

Reducing LAA requires strengthening primary care access and supporting families in the antenatal and postnatal period in the local area. Supported by these data, funding has been secured for the *Optivita* project, (<https://www.harrowbbp.nhs.uk/>) aiming to improve preventative care in socially disadvantaged localities.

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CAN WE 'PLUG' THE RETENTION GAP? A REVIEW OF 4.5 YEARS OF RESIGNATIONS FROM THE LONDON SCHOOL OF PAEDIATRICS

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Objectives The RCPCH have made recruitment and retention one of their key strategic priorities.¹ However, the true rate of attrition of paediatric trainees is rarely documented.² The aim of this project was to determine the rate that trainees leave the London School of Paediatrics and to explore when and why trainees choose to leave the programme.

Methods Data was extracted from the Health Education England Portal and email box to find all correspondence relating to resignation from the training programme between 1st March 2018 and 4th September 2023. Those who resigned from their grace period after gaining CCT were excluded.

Results 128 trainees resigned across the 4.5 year period representing 28.4 trainees per year. With approximately 1200 active trainees registered with the London School of Paediatrics, the attrition rate is on approximately 2% per calendar year. Put another way, 19% of the trainees entering the programme resign before the end.

54% of trainees left the training programme between ST1–3, 33% left at ST4–5 and 13% resigned in higher training (ST6–8) (see table 1). ST3 was the training year with the highest number of resignations (34% of resignations).

The reasons for leaving were inconsistently documented with no reason documented for 52 (41%) of trainees (see table 2). 41 (32%) trainees resigned to take up a post in an alternative training programme including clinical genetics, cardiology, general practice, anaesthetics and haematology. For many of these, paediatrics was a planned stepping stone to another career. 29 (23%) of the trainees who left the programme no longer have a GMC license to practice and are not currently practising medicine in the U.K.

Conclusion The attrition rate amongst paediatric trainees in London is low in comparison to other programmes² and

Abstract 6533 Table 1 Stage of training when resigning

Training year when resigned from the programme	Total (%)
ST1	16 (13)
ST2	9 (7)
ST3	43 (34)
ST4	26 (20)
ST5	17 (13)
ST6	11 (9)
ST7	3 (2)
ST8	3 (2)
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Abstract 6533 Table 2 Stated reasons for leaving

Reason for leaving	Total (%)
Unknown	52 (41)
Change in speciality - paediatric cardiology	9 (7)
Change in speciality – clinical genetics	14 (11)
Change in speciality - anaesthetics	3 (2)
Change in speciality – Public Health	1 (1)
Change in speciality - Haematology	4 (3)
Change in speciality – General Practice	9 (7)
Change in speciality – audiovestibular medicine	1 (10)
Moved abroad	11 (9)
Inter-Deanery Transfer	8 (6)
Health reasons	5 (4)
Work-life balance/personal reasons	8 (6)
Pursue alternative career goals e.g tech	3 (2)
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almost a third leave for alternative training programmes. However, this project highlighted the dearth of quality data around attrition in paediatric training with the reason for leaving not documented in 41% of cases. A retention project is ongoing within the school to improve the information gathered from those who choose to leave training. A dedicated TPD for recruitment and retention is offering exit interviews to those leaving the programme. This data will allow us to provide additional support and interventions at key transition points and enable evidence-based workforce planning.

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STRENGTH IN NUMBERS: ELEVATING THE PROFILE, REPUTATION AND EFFECTIVENESS OF CLINICAL NETWORKS FOR INFANT, CHILDREN & YOUNG PEOPLE'S ACUTE SERVICES

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Objectives We explore the impact of developing a unified infrastructure and governance model for operating separate yet interdependent clinical regional networks across services for babies, children, young people and young adult. We consider whether this approach can elevate collaboration across pathway interdependencies and strength of the network voice for decision makers across the healthcare system.

Methods A reflective study of a two-year journey to build a collective of Operational Delivery Networks (ODNs; neonatal, paediatric inpatient, surgical and critical care, congenital heart disease and cancer).

We qualitatively examine the crucial steps of development, barriers to progress and the response to what has been developed.

Results Unifying the infrastructure for clinically interdependent networks has led to a significant number of tangible benefits both operationally and in terms of increasing credibility and legitimacy of CYP needs amongst prioritisation of higher-volume adult services:

1. Pooling resources
2. economies of scale in network expenditure
3. introduction of key functions (e.g. strategic leadership; analytics)
4. diversity of experience/skills across the team shared across all networks
5. Single governance mechanism
6. economies of scale in the use of senior expertise and interest
7. conception of a single oversight Board with Trust CEO chairmanship
8. executive membership; Trusts and commissioners held to account against delivery of key care standards
9. Operating with a single 'brand'
10. elevates exposure
11. increases impact and influence
12. increases strength of advocacy for babies, children, young people and young adults
13. Demonstration of respective network priorities across a single team
14. facilitates working across clinical interdependencies
15. highlights joint opportunities e.g. local echocardiography accessibility to prevent interfacility transfers of pre-term babies and children; line access; AHP & psychology coverage
16. Visibility of interdependent services
17. demonstrating sustainability and fragility challenges, particularly for local District General Hospitals (DGHs; led NHS England to commission regional 'Paediatric Sustainability Review')
18. identification of opportunities for improvements and intervention based on multi-organisation collaboration (e.g. tertiary units supporting DGH anaesthetic skill maintenance)

Conclusion Networks are commonly commissioned in isolation with limited resilience and exposure. Pooling resources has significant practical benefits; however, the compelling value proposition of this model is creating visibility of and interest in regional pathways of care across clinical interdependencies. This model presents an important opportunity within an NHS committed to planning both generalist and specialist CYP services on a locality 'integrated care' footprint – our patients are reliant on regional pathways of care and we encourage use of this model to better empower decision makers to honour this.

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MORE THAN A GOLD STAR: FFT FEEDBACK IN PAEDIATRICS

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Objectives We are all familiar with the concept of learning from our mistakes in healthcare, helping us achieve better, safer practice. However, little attention is paid to the positive feedback from patients that can be valuable for institutional learning.¹

The NHS Friends and Family Test (FFT), is a tool for feedback launched in 2013 has become the biggest source of patient opinion in the world.²

Our aim was to understand the key positive and negative themes in FFT responses across our paediatric departments in