scenarios focused on challenging clinical encounters which may be seen in paediatric practice. These included safeguarding cases, sudden unexpected death of an infant and discussions around withdrawal of care. Feedback was collected through questionnaires and focus groups conducted by the psychology team.

Results Feedback on the course was excellent. All participants found input from a diverse faculty particularly beneficial. Themes identified on analysis of the focus groups included the importance of the drama students in enhancing the fidelity of the simulations, the necessity of further non-technical skills training in paediatric training and the benefits of debrief following challenging clinical encounters.

Conclusions This course provided an opportunity for senior paediatric trainees to develop their communication skills in challenging situations. Initial feedback was excellent. We strive to establish this course as a regular training opportunity for paediatric trainees in our deanery. The course has also been adopted as an essential component of the undergraduate drama module entitled 'Drama, Health and Social Care' now offered in our local university.

G170(P) USE OF BRIEF MULTIPROFESSIONAL SIMULATION TO IMPROVE CONFIDENCE AND SKILLS IN MANAGING CHILD AND ADOLESCENT MENTAL HEALTH CRISES OUT OF HOURS

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Background The benefits of using simulation to improve skills and competence in clinical education is well established. A learning need was identified in managing out-of-hours CAMHS (Children and Adolescent Mental Health Service) emergencies, for junior medical trainees. It was recognised that learning could be augmented by widening participation across disciplines and professions. A pilot simulation delivered six months earlier to junior doctors on psychiatric rotation was well received and showed improved confidence.

Methods The session, comprised an introductory talk and two simulated scenarios, designed to address issues such as capacity, safeguarding, confidentiality and agitation.

The training was delivered by a Consultant Paediatrician, Consultant Psychiatrist, a Fellow in Medical Education, Paediatric Registrar and two external actors. A pre-session focus group with psychiatry and paediatric teams identified concerns with assessing paediatric mental health patients after hours and the logistics of referral pathways and resources. Simulation scenarios were formulated to address these concerns and mapped to the Royal College of Psychiatry and Royal College of Paediatrics and Child Health training curriculum. Pre and post session questionnaires were also completed.

Results Seven participants attended the first session that was delivered; five psychiatry trainees and two paediatric trainees. 15 participants attended the second session; nine psychiatry trainees, four paediatric nurses, one foundation trainee and one GP trainee. Individuals participated in each section of the two scenarios, increasing candidates' direct experience of the simulation.

100% of participants reported feeling confident in all the outcomes assessed, which was an improvement in all domains. 73% of all participants stated they would recommend the

course to a colleague, and that it met their learning needs. Free text qualitative feedback indicated a wider range of paediatric mental health topics to be covered.

Conclusions In future sessions more equal representation amongst the multidisciplinary and inter-professional teams will be sought. The evidence from these sessions and the previous pilot demonstrates that this is an effective, and stimulating way to improve skills in this area. Participants also benefit from sharing knowledge across disciplines and professions whilst developing collaborative working relationships.

G171(P) INNOVATIVE CORE COMMUNITY PAEDIATRICS TRAINING

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Introduction Paediatric curriculum mandates that all paediatric trainees achieve Community Paediatrics (CP) competencies as a part of their core (Level 2) training in the United Kingdom. However there are concerns that shift-based hospital training does not allow dedicated community training time.

Aim To evaluate and streamline core-community training rotations.

Methods Feedback from the community and hospital teams, showed need to improve continuous exposure in CP for better learning experience, achievement of competencies and improve patient care and safety. Using Quality Improvement Methodology key changes and ideas were implemented (table 1). Dedicated CP training was the key change in practice needed alongside supporting hospital service.

An innovative block of 4 months (instead of the traditional 6 months) training was designed and piloted. This was tailored to allow achievement of CP competencies whilst maintaining continuity and hospital requirements. Trainees spent weekdays in CP and maintained some hospital commitments out-of-hours during weekdays only.

An initial pilot was set up with 2 trainees as described above. Monthly consultant trainee forum allowed feedback from both groups trainees and consultants. This was followed by an anonymous questionnaire evaluating the training.

Abstract G171(P) Table 1 Driver diagram: pilot community paediatric training

Aim	Primary drivers	Secondary drivers	Change ideas
Dedicated community paediatric training	Better learning experience	Communication	Early trainee/supervisor identification
		Equipment/paperwork	IT paperwork
	Achievement of competencies	Clear training objectives	CP Handbook
		Linking RCPCH competencies	Formal/informal supervision
Better patient management		Hospital Service	Out of hours hospital weekdays
		Community service	4-month-block rotation