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

Results Including annual leave, the 4 month block over 18 weeks provided 608 community hours vs 503 hours in the traditional 6 month rotation over 26 weeks.

3 consultants and 7 trainees have completed the survey over the last 12 months. All felt that there was improved continuous exposure with better learning, more clinic attendance, increased assessment completion, better attendance of training opportunities. The initial trainees in the pilot felt they more likely to come in their own time to complete assessments. This was reviewed and structured timetables along with mid-supervision meetings were implemented. There were mixed views about audit completion.

Conclusion A 4 month community rotation met training needs efficiently without impacting on hospital based training and service provision. It had trainee and consultant satisfaction. A 4 month community block would also allow more trainees to be hospital-based during the busy winter season.

G172(P) ABSTRACT WITHDRAWN

G173(P) A REVIEW OF OPHTHALMOLOGICAL AND WIDER HEALTH OUTCOMES OF CHILDREN BORN TO OPIOID MISUSING MOTHERS

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Aim During pregnancy, women who are opioid misusing, are often prescribed replacement methadone as part of a monitored programme. However, poly drug misuse is often seen. Research indicates that children exposed to opioids in utero are at risk of visual complications. Such children can also show delay in reaching developmental milestones. The aim of this study is to establish the impact of drug misuse in pregnancy, particularly opioids, on the ophthalmological outcome of exposed children and to establish whether these children display difficulties in other domains of development.

Method This is a case note review of children exposed to opioids in utero at two teaching hospitals born over a 5 year period (January 2010 to December 2015). Such exposed children are routinely referred by neonatal services here for an ophthalmology assessment. Where possible, referrals from community sources such as general practitioners and health visitors are also considered. The nature of drugs exposed to and the specificities of any ophthalmological diagnoses and other health concerns are reviewed.

Results The total number of notes available for review were for 19 and 37 children at each Trust respectively. Most opioid misusing mothers took multiple drugs during pregnancy; not just opioids (79% and 51%). The percentages of children in this study with nystagmus (5% and 11.7%) and strabismus (16% and 44%) are greater than published data for the general population of children. Children with a history of in utero opioid exposure are being referred to ophthalmology from community sources with visual concerns. Children exposed to illicit drugs in utero also demonstrated difficulties

in other health domains. 46% of these children across both Trusts had evidence of speech delay or social communication difficulties and 38% showed signs of developmental delay. 53% and 84% of children respectively were known to Looked After and Adoptive Children's Health Teams.

Conclusion Children born to opioid misusing mothers are at increased risk of ophthalmic complications requiring follow up. They can also have difficulties in other areas of development and require coordinated care across specialities to allow them to reach their full potential.

G174(P) 'KIDNEY SCHOOL' AND THE 21ST CENTURY ARMCHAIR CLASSROOM – A MODEL FOR PEER SUPPORTED LEARNING USING TELECONFERENCING TECHNOLOGY

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Aim Paediatric specialist training is managed through a national GRID system with individual trainees often isolated from their peers. Collective formal teaching occurs infrequently due to the constraints of time and geographical distances. In Nephrology, a survey of thirteen GRID trainees showed that 60% desired more education sessions. Telehealth is a rapidly growing branch of medicine used to link patients with medical specialists worldwide to negate vast distances. 'Kidney School' harnesses this technology to facilitate trainee collaboration and learning. We demonstrate how the flexible 'Kidney School' model of small group peer led learning could be extrapolated for paediatric teaching within any subspecialty and across geographical regions.

Methods 'Kidney School' is an interactive and easily translatable method of small group peer led education established by UK paediatric nephrology trainees in March 2017. We designed and co-ordinated a monthly, trainee run, interactive education session using the multi-media video conferencing facility Zoom. This allows trainees to be exposed to varied case-loads depending on different local patient populations and allows trainees to share expertise on the spectrum of patients seen across the UK, helping to fulfil RCPCH curriculum requirements. Sessions are 40 min: a case presentation followed by evidence based discussion amongst the group. Files are shared using a sharing platform, allowing trainees to access material even if unable to attend a session. Anonymous feedback is completed after each session.

Results On average, approximately 50% of trainees from all four regions of the United Kingdom attended each session. The majority of trainees attended from home, but up to one third were at work or in transit. Of note, three trainees on maternity leave were able to participate. This highlights the flexibility of this learning platform. 100% of trainees found 'Kidney school' beneficial to learning and fulfilling their post graduate learning requirements. SPIN nephrology trainees also joined a session and plan to establish 'SPIN Kidney School'.

Conclusion 'Kidney School' is a successful model of small group peer supported learning using a teleconference platform. This model is currently being utilised by Nephrology trainees but would be applicable to all national GRID and SPIN training programmes within paediatrics.