G513(P) DEVELOPING A FRAMEWORK OF STAFF SUPPORT ACROSS A PAEDIATRIC HOSPITAL: THE SUPPORT (SUPPORTING PAEDIATRIC STAFF, PATIENTS AND FAMILIES TO BE ONE RESILIENT TEAM) PROGRAMME

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Aims Paediatrics is one of the most diverse and rewarding fields of medicine but also brings with it unique medical and ethical challenges. We also care for increasingly complex medical patients and are faced with ethical dilemmas that can lead to conflict with families and a challenging work environment: it can be emotionally exhausting. At our tertiary children's hospital we became aware that this was having a negative impact on our staff's wellbeing and ability to care for our patients. In particular we recognised that staff were being exposed to distressing events and then expected to continue with clinical work with no formal system to debrief or acknowledge the impact of these events. We aimed to do something to address this.

Methods We established a working group of senior nurses, executive members, Paediatricians and Psychologists to identify issues and implement change through our SuPpORT programme. Within this, we created a staff support psychologist (PSS) role (0.3 WTE) to establish a psychological debrief pathway, coordinate and run debriefs and establish/scope other supports e.g. reflective practice.

Results The group has created a staff support 'pyramid', developing new resources and bringing together activities which were already in place. This includes a robust debrief pathway following serious incidents, and Paediatric Schwartz rounds. The PSS role has been central in this process. Since the role began we have run regular reflective practice sessions in several areas, and held 71 psychology mediated debriefs. Feedback from staff has been hugely positive.

Conclusion By establishing this programme we have acknowledged that staff may feel overwhelmed by the complex medical and ethical situations in paediatric care. We are still in the early stages, but staff report feeling a different 'culture' of support at work. Crucial to this has been the commitment by our senior leadership team. We recognise that these problems are not unique to our hospital and have had interest from other hospitals in spreading this model.

G514(P) EVALUATION OF BURNOUT IN PAEDIATRIC STAFF: A PREVALENCE STUDY

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Introduction Burnout in healthcare staff has been highlighted as a concern within the NHS, as it can compromise patient safety, lead to patient and staff dissatisfaction and decreased staff retention.

Method Paediatric staff, including clinical and administrative staff, across Wales completed an anonymous questionnaire to assess their risk of burnout using a validated tool the 'Oldenburg Burnout Inventory'. Free text comments were used to investigate individuals' perceptions of risks and protective factors. Participants were asked to assess their own happiness at

work using a Likert scale. This was disseminated by lead consultants and ward managers within the local hospitals.

Results 234 paediatric staff members completed the questionnaire, of which 81 were doctors. Paediatric nursing staff comprised 92 participants.

68.8% of paediatric staff scored at high risk of developing burnout. Health care assistants had the greatest proportion at high risk with 94.7% of staff surveyed.

Doctors in training, including foundation doctors were the least happy occupational group with 6.1/10 with consultants scoring highest at 6.8/10.

It was interesting to note that a high self-reported happiness score did not necessarily equate to a low risk of burnout.

60.4% said 'no' or 'only a little' when asked if they looked forward to coming to work.

Protective factors were having supportive managers and colleagues with emphasis on meeting regularly. Barriers were environmental factors, workforce shortages and lack of team cohesion.

Conclusion Paediatric staff in Wales are at high risk of developing burnout. Previous research has shown that a systematic approach encompassing individual and organisational interventions can reduce this risk. A pilot wellbeing scheme is being trialled a local hospital, with a focus on team building, wellbeing resources and management engagement for organisational change.

G515(P) 'IN SPITE OF THE GAPS' – A MULTIFACETED APPROACH TO STAFFING A CHILDREN'S HOSPITAL

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The RCPCH UK workforce census made recommendations to ensure sufficient paediatric staffing in the future. Our Children's Hospital has embraced this model and taken a new approach to staffing that enables the provision of high quality, safe paediatric care, with a focus on paediatric training.

We have experienced significant gaps in the trainee medical workforce in recent years. Gaps are spread equitably across the region, however a 20% gap is usual. Trainees and consultants alike have felt the impact, resulting in concerns about morale, retention and burnout. The effect of receiving yet another email asking for locum cover, or informing you of out of hour's gaps, should not be underestimated.

We adopted a new approach to forecasting and managing the rota gaps. This involves the management team, rota coordinators, college tutors, trainees and medical deployment. A monthly strategic workforce meeting is held, alongside a biweekly meeting to manage day-to-day issues and on-going recruitment.

Recruitment looks 6–12 months ahead - essential when recruiting overseas doctors. We have recruited to 1–2 year posts through NHS jobs, MTI schemes and a trust-wide international recruitment programme. There is bespoke induction and a supernumerary period before starting in ST1–3 rotas. Trainees then move into ST4–8 rotas after 6 months. We support those applying for paediatric training, with anticipated longer-term gains for the regional workforce.

An innovative FY3 post with 20% QI time has been popular, with their on-call reducing locum spend.

Expansion of the non-medical workforce has begun with 5 permanent Physicians Assistants in paediatric specialties. There is expansion of The Advanced Clinical Practitioner team into general paediatrics and surgery. These roles increase patient continuity and enable trainees to access educational opportunities.

Locum spend has significantly reduced with a 60% reduction in locum shifts.

This has been achieved with strong day-to-day leadership of the rotas, alongside a management team committed to improving staffing and working lives. Dedicated staff are essential for this strategy to be sustainable.

Challenges include significant ongoing time commitment, increased educational supervision and unpredictability of international recruitment.

We suggest that this model can be used by other UK Children's Hospitals and form an important part of a regional workforce strategy.

G517(P) ABSTRACT WITHDRAWN

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British association of general paediatrics and YPHSIG (young people's health special interest group)

G519 INTEGRATED CHILD HEALTH AT SCALE: THE INREACH STORY – LESSONS LEARNT FROM THE DEVELOPMENT OF JOINT PAEDIATRIC CLINICS IN PRIMARY CARE

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Aims Over the last 3 years we have been developing and testing new models of integrated care for children and young people (CYP) in South London. As part of this we have developed a model of 'Inreach clinics' held in GP practices, jointly between GPs and Paediatricians. The overall aim is to improve care and outcomes for children. We report on our learning and successes of this journey.

Methods GP Practices were grouped into 'clusters' according to geography and population, each 'cluster' hosting one Inreach clinic per month. Initial challenges were commitment of GP time to host clinics, and shared patient notes and clinic management. Over time Paediatricians gained access to GP IT systems and notes were recorded locally. Lunch time 'lunch and learn' sessions for neighbouring practices *after* clinics were poorly attended so we developed the concept of a Patch Paediatrician (PP), giving GPs easy access for advice and referrals. We have honed referral pathways and introduced primary care prescribing by the PP. Clinics are currently jointly funded by the hospital and CCGs.

Results Currently 10 general paediatric consultants run monthly Inreach clinics in 16 patches, across 54 practices. We are conducting both service and research evaluations. Early results show reduction of ED attendances by 7% and NEL admissions by 6%. Patient satisfaction data shows that the vast majority of patients feel that the care received was good or very good. GPs report enhanced knowledge, clinical practice and confidence in managing children's health.

Conclusions Over the last 2 years we have completed several PDSA cycles responding to challenges and feedback. We have demonstrated several successes of this model of care. Our current model aligns clinics and the role of 'patch paediatrician' to the newly created Primary Care Networks, for strong GP ownership. We are further aligning these clinics with our targeted population approach to biopsychosocial care for CYP with ongoing conditions. We are now evaluating, at scale, the best possible evidence-based model of care.

G520 INNOVATIVE FUNDING STREAMS FOR CHILDREN WITH MEDICAL COMPLEXITY

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Aim The CMIC (Children with Medical Complexities) team is an innovative team which has been working within a tertiary children's hospital to support children with complex medical conditions who face a number of challenges. Our vision is to provide a pop up service tailored to the individual child and family. In doing so we support families navigating complex systems in a variety of ways. We have been fortunate to have a family support worker placed within our team for the last five years. She has been instrumental in providing support in many ways. One of the skills she has developed in the ability to look at third sector funded support to support both the child and family in getting home and staying home. In an increasingly cost driven system we looked at quantifying the monetary support she has been able to source in addition to the standard routes of disability living allowance and carer's allowance applications she helps families with as a routine.

Method We have looked back at the last 3 years of successful funding applications to third sector agencies. Results

Over the last 3 years our support worker has accessed funds from 6 additional charity funding streams. Some have been tailored to the individual child's condition whilst others provide more generic support. She has also managed to advocate for a family to have reimbursement of withheld carers allowance and personal independence payment. Over the three year period she has sourced a total of £38500. In addition to this she has been able to access experiences and pamper packs as well as smaller items for new homes and siblings.

Conclusion In an increasingly challenging financial environment, we demonstrate that with an innovative approach to provide direct support to families we can do more. We are using this knowledge and sharing it with stakeholders who support this group of children and families to further enable spread of this practice.