- 30% of the times junior doctors (SHO) were given the opportunity to intubate in comparison to 3% earlier
- Confidence in BVM ventilation among SHOs and intubation among registrars are significantly high in the repeat survey, due to continued teaching and simulation training.

Conclusions Effective simulation, training, education and perseverance in change in practice improved the intubation in neonates in DGH and confidence of doctors and nurses working in the unit. Improvement is likely to improve outcome of the babies.

British association of child and adolescent public health

G162 ADOLESCENTS AND THEIR PARENTS' EXPERIENCES OF INTERNET DELIVERED HOME TREATMENT FOR CHRONIC FATIGUE SYNDROME/ME (FITNET-NHS TRIAL)

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Aims We aimed to understand the acceptability of two internet-delivered home treatments for paediatric Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME) as part of the FITNET-NHS randomised controlled trial. The two interventions were: i) an online Cognitive Behavioural Therapy (CBT) programme (FITNET-NHS) supported by therapist e-consultations; ii) Activity Management delivered by clinicians via Skype.

Methods In-depth qualitative interviews were undertaken with families taking part in the FITNET-NHS Trial to understand the acceptability of receiving treatment at home via the internet. Participants were purposively selected for maximum variation (intervention, age and gender). Interviews followed a checklist of topics. All interviews were audio-recorded, transcribed verbatim, uploaded to NVivo and analysed using thematic analysis.

Results Interviews were undertaken with 29 families (15 FITNET-NHS arm; 14 Activity Management arm). This included 26 young people (15 females and 11 males, ranging from 12–17 years old) and 31 parents (27 mothers and 4 fathers). Four key themes and 9 sub themes emerged. Participants talked about the 1) **benefits of online treatment** including: no need to travel reducing payback, ease of use, convenience and flexibility as well as the ability to revisit online content for clarity and motivation. The 2) **disadvantages of online treatment** included: technical problems, difficulty building a rapport and feeling unable to communicate effectively online and preferring to see the therapist in person. Participants felt 3) **Contact with a therapist is essential** to give parent support and backing and provide specialist knowledge and tailored advice. The final theme highlighted how 4) **the digital interventions need to be tailored according to: age, severity and communication preference differences.**

Conclusion Young people and their parents discussed the benefits and disadvantages of online treatment for CFS/ME. Whilst some feel it is as good as face to face contact, others found it difficult to communicate through emails and Skype and would have preferred to see a therapist in person. Therapist contact is viewed as essential to provide specialist knowledge and support. Internet-delivered interventions for paediatric CFS/ME

need to be tailored to take into account individual differences such as age, severity and communication preferences.

G163 AN ANALYSIS OF HEALTHCARE COSTS IN HIGH-NEED CHILDREN AND YOUNG PEOPLE

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Aims In the context of budget pressures, the need to keep children and young people well and reduce the burden of costly interventions is growing. Little is known about how health spending is distributed amongst the population or how we can identify children at risk of requiring higher spending. Our study aims firstly to identify total health spending costs and relative differences across services for the top 5% of high cost users and secondly to characterise the features of this group.

Methods 78,215 participants aged 0–24 were randomly sampled from the Clinical Practice Research Datalink, linked to Hospital Episodes Statistics for the year 2015/16. Total costs were estimated for primary care visits, A&E and outpatient attendances, inpatient admissions, and prescriptions. The high cost group was defined as the top 5% of individuals based on total costs and the proportion also in the same group in 2014/15 was calculated.

Results 54% (£17,321,850) of the total yearly health service spending was utilised by the most expensive 5% of participants. The proportion of spending on this group was highest for inpatient costs (88%) and lower for costs relating to Emergency Departments (31%), Outpatients (44%), Primary Care (15%) and medication (38%). Those in the most deprived decile by Index of Multiple Deprivation were more likely to be in the high cost group than those in the least deprived (6% vs 4%). 29% of those in the high cost group in 2015/16 were in the same group the preceding year.

Conclusion Just over half of health service costs for children and young people were spent on only 5% of users. While unsurprisingly, much of this was explained by inpatient admissions, spending was higher across all services including prescription costs. There was significant movement into this group, with fewer than one third also in the high cost group the previous year. Proactive strategies are needed to keep children well and reduce the need for costly inpatient care, although further research is needed to understand whether this can be accurately predicted or indeed effectively reduced.

G164 NURTURE EARLY FOR OPTIMAL NUTRITION (NEON) PROGRAMME: QUALITATIVE STUDY OF DRIVERS OF INFANT FEEDING PRACTICES IN A BRITISH-BANGLADESHI POPULATION

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Aims To explore optimal nutritional care practices and their drivers within the British Bangladeshi population as an exemplar to inform a tailored, co-adapted intervention design.

Methods Qualitative community based participatory research. Multiple recruitment strategies were used to purposively sample the British Bangladeshi population. Community facilitators were an active partner in this study and worked as a bridge to the community. A total of 145 participants completed the study and were recruited to 12 focus groups and 45 semi-structured interviews, including; British Bangladeshi mothers, fathers, grandmothers and grandfathers of infants and young children aged 6–23 months; key informants and lay community members from the British Bangladeshi population and health professionals. Transcripts were then checked and were analysed using framework analysis.

Results Two overarching themes were identified during interviews and group discussions: (1) modifiable infant feeding practices that participants suggested could be targeted in order to optimise infant feeding and (2) socio-ecological factors believed by participants to influence these modifiable feeding practices. Participants discussed several infant feeding practices that may restrict dietary diversity, override infant satiety and encourage dependence on sugary or sweetened foods and impact on broader care practices such as sleeping and physical activity. Specifically, four modifiable infant feeding and care practices were highlighted: untimely introduction of semi- and solid foods, overfeeding, prolonged parent-led feeding and feeding to ‘fill the belly’. These practices were driven by factors at all socio-ecological levels, categorised as: society, culture and religion, physical and local environment and information and awareness.

Conclusions Parenting interventions need to be culturally sensitive to populations of diverse ethnicity and recognise the social and cultural norms that inform complementary feeding practices. Further, the infant feeding environment requires better regulation of marketing of foods for infant and young children. More evidence is needed to inform effective early years interventions.

G165 HEALTH SERVICES FOR LONG TERM CONDITIONS FROM THE CHILD AND CAREGIVER'S PERSPECTIVE: A QUALITATIVE ANALYSIS

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Aims The current model of hospital-centred paediatric care in high-income countries was developed to deliver acute specialist services, rather than high quality care for children and young people (CYP) with long term conditions (LTCs) that require multidisciplinary, integrated care. While the limitations of current child health services in the UK have been widely documented from the perspectives of clinicians, academics and policy makers, there is a lack of research into the lived experience of CYP receiving these services. This qualitative study explores CYP and caregivers' experiences of health services for LTCs.

Methods An inductive, qualitative design using in-depth, semi-structured interviews with children (4–16 years; n=20) and their caregivers, receiving care for one of four LTCs (constipation, eczema, asthma or epilepsy). These LTCs were chosen as they are examples of LTCs which provide

generalisable lessons about improving outcomes for other LTCs. Art-based methods were used to engage younger children in the discussions. Data was analysed using interpretive thematic analysis.

Results Families expressed several challenges associated with the healthcare they had received during the diagnostic process, including being unsure whether their symptoms warranted health intervention, a lack of specialist knowledge across primary care providers, and poor care continuity. After diagnosis, families desired further understanding around condition management, children wished to be included in discussions with health providers, and families felt there were no opportunities to discuss the psychosocial impact of the condition, particularly around the challenges managing health in school settings.

Conclusions Families reflected on the health services failures to address their needs. Psychosocial support, continuity of care and opportunities for independence play a critical role in promoting the health of children with LTC. These features are essential in the development of integrated care models, to ensure suitability of the workforce and improve care delivery.

G166 SERVICE DESCRIPTION: AN INTEGRATED PATHWAY FOR UNACCOMPANIED ASYLUM SEEKING CHILDREN

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Aims Unaccompanied asylum seeking children (UASC) in the UK have poor mental and physical health outcomes, and studies suggest that current services are failing to meet their needs. There is a lack of knowledge and expertise about UASC health management among health professionals and no standardised guidance exists for their care.

We describe a novel integrated pathway for UASC developed in a London borough and present data for a cohort of UASC receiving input from this service.

Methods

Service description: An integrated pathway for UASC was developed with a multi-disciplinary approach, coordinating input from the LAC team, primary care, infectious diseases (ID), sexual health (SH) services and CAHMS, and including a dedicated health improvement practitioner to ensure continuity and promote joined-up care.

Population: We reviewed UASC undergoing initial health assessments (IHAs) in this service between January 2016 and March 2019. Data were also collected on UASC referred from the same service to a local SH clinic and for ID screening.

Results

- 101 UASC were seen for IHA (84% male, age range 14–17, median age 16) in the integrated pathway model. Where documented, a translator was required for 87/90 (97%) of appointments.
- 92% of UASC were referred for ID screening, regardless of symptoms. 91% were offered some form of CAMHS support: 51% were referred, 20% declined referral and 20% were signposted.
- 87% of UASC were referred or signposted to sexual health services, including specialist sexual assault/abuse services if indicated.