to hospital and, therefore, delayed diagnosis of many conditions has been well documented during the COVID-19 pandemic. However, there is a paucity of data on the effect of time to cancer diagnosis in children within the UK during this period.

Sustaining time critical services such as paediatric oncology during prolonged periods of extraordinary pressure on the NHS is of key importance in patient care. Through evaluating our secondary care service, we aimed to identify learning points from the pandemic and lockdown measures.

Objectives To evaluate the following key metrics in children who received a cancer diagnosis during the COVID-19 pandemic versus an equivalent time period pre-pandemic:

1. Time from first symptom(s) onset to cancer diagnosis.
2. Time from referral to tertiary paediatric oncology service to cancer diagnosis.
3. The number of healthcare encounters between first symptom(s) to final encounter leading to cancer diagnosis.
4. Identify learning points and service improvement opportunities, to avoid future cancer diagnosis delays.

Methods The medical records of all cancer diagnoses in patients under 16 years when they presented to our NHS Trust from the date of 1st UK lockdown, 23rd March, until 31st December 2020 (pandemic cohort) were evaluated and compared to a matched control cohort (pre-pandemic cohort). Evaluation included determining:

1. Date of symptom(s) onset relating to their malignancy.
2. The number of primary healthcare encounters relating to their cancer symptoms.
3. The number of secondary healthcare encounters relating to their cancer symptoms.
4. Date of referral to tertiary centre for diagnostic investigations.
5. A breakdown of type of patient-healthcare encounters (face-to-face or virtual).

One-tailed T-testing was used to evaluate any differences in the two cohorts.

Results Our analysis showed:

	Pre-pandemic cohort (N = 21)	Pandemic cohort (N = 21)	P-value
Symptom(s) onset to diagnosis	32 days	118 days	0.03*
Tertiary centre referral to diagnosis	6 days	9 days	0.32
Average number of clinical encounters from symptom(s) onset to final diagnostic encounter	1.6	4.2	0.18

* = significant result.

We identified three cases with significant delays in cancer diagnosis during the pandemic (range = 216–599 days). Key learning points from these cases included inappropriate pathway referral, COVID-19 related cancelled appointments, and delayed referral from non-paediatric specialties.

Conclusions An increased time from symptoms(s) onset to cancer diagnosis was observed during the COVID-19 pandemic. Additionally, a trend towards an increased number of clinical encounters before cancer diagnosis was observed during the COVID-19 pandemic. This likely represents patient and carer

hesitancy in accessing healthcare services during the pandemic, as well as the possibility of diminished clinical assessment or hesitancy in onward referral at various clinical encounters. Somewhat reassuringly, the time from tertiary centre referral to diagnosis appeared unaffected during the pandemic reflecting maintenance of a consistent service during the pandemic. Overall, these findings represent important learning points to avoid delays in cancer diagnosis during any prolonged period of extraordinary pressure on healthcare systems and can inform healthcare service development and contingency planning going forward.

Quality Improvement and Patient Safety

869

POSTNATAL WARD, THE SHADED AREA: QUALITY IMPROVEMENT PROJECT EXPLORED THE NEONATAL JUNIOR MEDICAL TEAM SATISFACTION

Khadiga MF Hussien, Mohamed S Elborae. Manchester University Hospital foundation Trust (MFT) NHS

10.1136/archdischild-2021-rcpch.248

Background The postnatal ward (PNW) is a vital part of neonatal service, where well infants remained with their mothers. Neonatal PNW services in our Hospital provided mainly by Junior staff with the support of registrars and neonatal consultants. The shift involves coverage of four wards in different storeys, and a wide variety of cases with subtle presentation among presumed well babies. It also requires immediate attendance to high-risk deliveries for neonatal resuscitation. The project is shedding light on obstacles and barriers facing the PNW team in order to overcome them and increase overall work efficiency.

Objectives • To investigate the main difficulties that meet the medical team during their shift coverage in PNW and collect the proposed suggestion and recommendation on possible solutions.

- To uncover the area for improvement and provide possible titles for further QI projects.
- To estimate overall team satisfaction.

Methods We conducted a survey questionnaire for data collection distributed among staff by email. Google form used as a builder tool. The study targeted a total workforce of the PNW team, 32 staff. A total of 28 feedback over three weeks were obtained and analyzed. Seven scopes of work have been investigated thoroughly including Handover, Sepsis screening of neonate at risk, Communication & consultation, Admission procedure, Guidelines, Staff wellbeing (break time), Recommendation and future QI project suggestion.

Results The response rate was 87.5% over three weeks period. Only 43% found the handover place is convenient for them. Sepsis screening was rated the most time-consuming task by 75%, it takes up to an hour by 50%. The majority of the PNW staff found that neonatal trolleys are usually poorly stocked. Participants supported ready to screen bag idea by 100% while using a handwritten prescription was agreed by half. The majority of the participants found it easy to communicate among our team, however, more support is required from the registrars and seniors' staff. On the other hand, communication with other paediatrics subspeciality was rated as the second most time-consuming task by 57%.

About four topics were suggested as future guidelines. In the area of staff wellbeing, 14% of staff are unable to have a break during the shift, while 50% express some kind of difficulty with break coverage. Early baby registration, availability of SCBU drug system in PNW, use of chameleon for hand-over, Effective utilization of INREACH team and increase awareness among midwifery are an important area of improvement.

Conclusions The overall staff satisfaction rate was 45% between satisfied or somehow satisfied. The action plan was formulated: to install the electronic subscription system on the PNW computers, to invite a ready to screen pack and distributed among PNW neonatal trolleys, to resolve staffing issue in order to ensure adequate coverage and better collaboration with the INREACH team for even job load distribution, to provide guideline lead committee with the suggested titles, and to produce a laminated card containing important phone numbers and door codes. The targeted changes have been processed to improve the health care service.

Child Protection Special Interest Group

871

THE ADVENT OF SOCIALLY DISTANCED CHILD PROTECTION – A STUDY OF THE IMPACT OF THE FIRST UK LOCKDOWN ON SAFEGUARDING REFERRALS DURING THE COVID-19 PANDEMIC

¹Thushara Latha Perumal, ²Gopalakrishnan Venkatachalam, ²Chelvi Kukendra. ¹Northwick Park Hospital; ²Central and North West London NHS Foundation Trust

10.1136/archdischild-2021-rcpch.249

Background The National Society for the Prevention of Cruelty to Children (NSPCC) estimates that over half a million children are abused in the UK each year.¹ It is therefore important for healthcare professionals to recognise abuse and neglect and take the necessary steps to act against it. When the COVID-19 UK-wide lockdown commenced on 23rd March 2020, paediatricians faced unprecedented child protection challenges.

Objectives Our objective was to assess the impact of the first lockdown on safeguarding referrals received in our Child Development Centre (CDC).

Methods We analysed all Social Care (SC) referrals requesting Child Protection Medical Examinations (CPMEs) during lockdown and one week prior: 16th March - 1st June 2020. These were compared to all SC referrals for CPMEs during the same period the year before.

Results 6 CPMEs were completed in 2020 compared to 17 CPMEs in 2019 – a 65% reduction during lockdown.

Referral Source	2019	2020
School	9	0
Social Worker	7	4
Hospital	1	0
Individual/Family	0	2
Total	17	6

Just over half (9/17) of the referrals in 2019 stemmed from school concerns being reported to SC. Two thirds (4/6)

of the referrals in 2020 were directly from SC. Schools were closed during the first lockdown and thus, the input from this avenue was absent at our CDC. Whilst there was school provision offered to vulnerable children, attendance was low.² School provision may not have been utilised due to shielding or parents/caregivers opting out.

The main reasons for referral in both years have consistently been physical abuse and neglect.

In 2020, the most common age groups to be referred were the 2–5 year olds and the 11–16 year olds (2/6 respectively), whereas in 2019, the most frequent age group referred was the 6–10 year olds (10/17).

In 2020, 33% (2/6) of the referrals consisted of children with learning difficulties, compared to 23% (4/17) in 2019, highlighting the vulnerability of this group.

The most common conclusion to CPMEs in 2020 was the finding of an 'unclear injury and requiring further evidence before non-accidental injury could be ruled out' (83%; 5/6). In contrast, in 2019, the medical conclusion most commonly made in CPMEs was that 'no injury [had been] seen but [there was] risk of significant harm based on the story' (29%; 5/17). In both cases generally, paediatricians recommended SC and/or police investigation. Other suggestions made as part of the management plan included parenting courses and health visitor follow-ups.

Conclusions This project has demonstrated the reduction in number of child protection referrals made during lockdown, with no referrals initiated by schools. Historically, schools have been the main referrers of child protection concerns to SC. Taking into account that all children (and especially the identified vulnerable) are less visible during a lockdown, paediatricians need to adapt to meet these unique safeguarding challenges during the pandemic. Paediatricians should be constantly mindful of safeguarding risks, incorporate strong safeguarding partnerships with social workers and continue to be professionally curious when seeing children in all settings, particularly during the pandemic and most especially during lockdown.

British Association of Perinatal Medicine and Neonatal Society

872

AUDIT LESS INVASIVE SURFACTANT ADMINISTRATION (LISA) IN A DISTRICT GENERAL HOSPITAL

Rasheed Oba, Joyce Danso-Appiah. Northern Lincolnshire and Goole NHS Foundation Trust

10.1136/archdischild-2021-rcpch.250

Background Less invasive surfactant administration (LISA) Audit in Scunthorpe General Hospital

Dr Joyce Danso-Appiah, ST8 Paediatrics¹ Dr Rasheed Oba, Consultant Paediatrician¹

¹Scunthorpe General Hospital, Scunthorpe, DN15 4BH

Background

LISA with Nasal Continuous Positive Pressure(nCPAP) has been shown to reduce the need for mechanical ventilation, causes less alveolar injury and reduces incidence Brochopulmonary Dysplasia(BPD)at 36 weeks and death; and is increasingly becoming the technique of choice with application in many Hospitals, particulatly in some District General Hospitals in our region.