several drugs at the same time. However, the pragmatic trial methods which aim to ease research recruitment for the busy clinician with minimal burden to families and the excellent training resources instilled confidence in embarking on the research journey.

Informed consent process was an iterative learning journey where the theoretical understanding of consent and assent in paediatric trials was followed by a very different learning curve of real-life consent process. Understanding consent as an information cycle rather than a single process and balancing the needs of the carers of a sick child empathetically was a skill developed by observing the consent process before independently recruiting. Valuable communication skills were gained as COVID-19 visiting restrictions meant discussions with non-visiting parents and occasionally obtaining remote consent. Team working in collaboration with research nurses and pharmacists was another benefit of the research journey. Attending the regional PIMS/COVID MDT discussions where standardised treatment and research decisions were undertaken, enhanced the knowledge and experience in clinical management of these patients.

Conclusions Overall it has been rewarding to have contributed to one of the largest recruiting COVID-19 research trials, thus making a difference to children's outcomes. Furthermore, the RECOVERY trial and Associate PI scheme have provided unique research opportunities hitherto unavailable for trainees in general paediatrics and embarking on this journey has cemented our intention to continue research engagement as part of day-to-day clinical practice.

Child Protection Special Interest Group

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ESTABLISHING A WEEKLY MULTIDISCIPLINARY CHILDREN'S SAFEGUARDING MEETING DURING THE SARS-COV-2 PANDEMIC

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Background Children's safeguarding issues may be recognised by any member of the multidisciplinary team (MDT). It is important that all staff feel confident to raise such concerns.

Due to restrictions imposed on face-to-face contact during the SARS-CoV-2 pandemic it has been challenging for the safeguarding team to maintain a ward presence to advise staff. We therefore decided to establish a weekly online meeting.

Objectives To establish a friendly, and accessible COVID-19 safe forum where any staff member can comfortably discuss concerns with members of the safeguarding team or learn from other staff experience.

Methods A Microsoft Teams invitation to the weekly meeting was emailed to all members of the paediatric MDT. Meetings were chaired by a member of the children's safeguarding team. Attendance was mandatory for attending paediatrician and nurse in charge of the children's ward. Other staff were encouraged to attend as often as they wished, for their own education or bringing cases for discussion. An attendance register was maintained, and minutes distributed to attendees. Attendance at meetings counted towards safeguarding supervision.

In the first 2 months, there were between 6 and 12 attendees each week from various staff groups. A SurveyMonkey link was sent to the paediatric MDT to assess the wider staff view of the usefulness and accessibility of this forum. Mostly closed questions were asked with the facility to add comments. All responses were anonymous.

Results There were 37 respondents from staff groups across the MDT

Staff group	Number	Staff group	Number
Ward nurse	4	Consultant anaesthetist	2
Clinical nurse specialist	5	Consultant surgeon	1
Recovery nurse	1	Play specialist	1
Consultant paediatrician	6	Clinical Psychologist	1
Non-consultant paediatrician	2	Physiotherapist/Occupational therapist	12
Doctor (unspecified)	1		

- 29/37, 78% of respondents were aware of the weekly safeguarding meeting and 16 had attended at least once.
- Of the 21 who had not attended, the timing of the meeting was unsuitable for 42% (9), 4 had not yet needed to attend and only 1 said that they lacked the IT facilities.
- Of the 16 who attended meetings, 10 attended for their personal education, 7 brought a case to discuss and. 14/16, 88% attended to keep up to date with the department.
- 1 respondent was unable to participate in discussion due to technical issues, all others either contributed or were happy listening. No respondents felt uncomfortable or intimidated in the meeting.
- 9/16, 56% attendees gained information to deal with a specific case and 10/16 gained information that they could use in future cases. 50% felt generally better informed.
- Attendees found meetings friendly and welcoming. Although given the options, no respondents chose to describe the atmosphere as intimidating or non-inclusive.
- 79% of respondents were positive (definitely/maybe) about attending future meetings.

Conclusions Our objective to establish a friendly, and accessible COVID-19 safe forum was achieved.

Attendees reported no negative comments regarding the atmosphere of the forum and felt comfortable to speak or listen as they chose.

All who attended found the meeting useful, many gained information which empowered them to manage future cases.

Quality Improvement and Patient Safety

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SETTING UP A PATIENT SAFETY AND LEARNING GROUP FOR TRAINEES WITH THE MEDICAL DIRECTOR: LEARNING POINTS AND CHALLENGES

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Background Paediatric consultants are required to lead on governance issues, write statements and be expert witnesses in court. However, paediatric training may not adequately prepare trainees for these important aspects of being an assured paediatric consultant. In addition, governance is seen as a 'tick box' eportfolio exercise of the RCPCH Progress Curriculum. How can trainees prepare themselves for these important aspects of their future roles? How can we engage trainees in governance in order to make an impactful difference rather than as a tick box exercise?

Objectives Our objectives were to work with trainees and the Medical Director to set up a patient safety and learning group as a forum for trainees to learn about governance issues, in order to both improve outcomes for patients and to help empower trainees for their future roles as consultant paediatricians.

Methods This pilot project was conducted at the Royal Manchester Children's Hospital from September 2019 and is ongoing.

Two trainees interested in running the patient safety and learning forum met with the Medical Director and Governance lead to brainstorm topics of interest to trainees. Trainees based at the hospital were asked if there would be interest for such sessions, when would be the best day or time, and if there were any topics of particular interest. This generated a great deal of interest from trainees, so a series of sessions were organised.

Pre-pandemic, two face to face sessions were conducted, post-handover on a weekday. During the pandemic, all teaching was suspended for a few weeks whilst trainees worked on an emergency rota. When teaching was slowly restarted, one virtual session on patient safety was conducted.

Results Our face-to-face sessions were very successful, receiving excellent feedback from trainees who were able to attend. We discussed writing a statement through a case-based discussion by a trainee who had been asked to give a statement and what his experience of this had been. The Governance lead then explained what support would be available from the Trust and the Medical Director gave a talk on the do's and don'ts of writing a statement. Other sessions included discussions on managing complaints and investigation processes.

We faced multiple challenges in setting up this project. Due to pre-existing teaching, MDTs, and short-staffing, trainees struggled to attend teaching during the working day. Using time after evening handover meant that some trainees were excluded due to having childcare commitments, or just wanted to go home at the end of the day. Having sessions on the same weekday excluded those working less than full-time, so we tried to choose different weekdays. Whilst virtual teaching is an excellent platform, it can be difficult to facilitate discussion of some sensitive topics. As trainees rotate to different hospitals, sustaining such a project long-term has been more difficult.

Conclusions This pilot project was well received, showing that trainees are interested in learning about governance issues during training. We need to address the barriers, in order to make these important topics a regular part of the paediatric training programme and engage more trainees.

Quality Improvement and Patient Safety

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ENCOURAGING NEONATAL-MATERNAL BONDING: REDUCING SEPARATION DUE TO BORDERLINE CORD GASES

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Background Poor cord gases are a well-known indicator of poor neurological outcomes in neonates, on which NICE Guidelines for Therapeutic Hypothermia are based. Currently, any baby with a cord gas pH <7.0 meets 'Criteria A', therefore any abnormal neurology ('Criteria B') noted can result in the infant being cooled for 72 hours to reduce long-term neurological injury.

Routine practice in East and North Hertfordshire Trust's Neonatal Unit in 2018–2019 was to admit and perform 12 hours of neurological observation on any baby with cord gas pH <7.05, i.e. above the NICE threshold. A drawback of this is that otherwise well term babies are separated from their mothers for prolonged periods solely on the basis of cord gases, thus reducing neonatal-maternal bonding. In this study, the potential to reduce admissions of otherwise well babies with borderline cord gases is explored.

Objectives A quality improvement initiative to reduce admissions for term babies with borderline cord gases.

Methods BadgerNet, a program used to store information on all Neonatal Unit Admissions, was used to search for infants who were >37 weeks gestation and admitted due to poor cord gases. The search window was between 2018 to 2019. These infant records were then reviewed, and their cord gases and neurological observations collated.

Results From our search we found 27 infants were admitted to the Neonatal Intensive Care for 12 hours of observations. Of these infants, only 1 went on to have abnormal neurology at 24 hours of age, after the observations had stopped. The subsequent MRI showed features consistent with mild-moderate HIE (see table 1).

Review of the infants with cord gas pH <7.00 showed 21% had no other reason for admission, i.e. they did not require intravenous fluids or respiratory support. Comparing this to the infants with cord gases between pH 7.00–7.05, this number increased to 69%.

Conclusions Over a period of a year, we found the majority of babies admitted due to borderline cord gases remained well and required no intervention. Accordingly, a change in

Abstract 945 Table 1 A table to show the number of infants admitted to the NICU for neurological observation due to poor cord gases that went on to have abnormal neurology

	pH <7.00	pH 7.00–7.05
Normal neurology	13	13
Abnormal neurology	1*	0

*This baby who was admitted due to abnormal cord gases developed seizures at 24 hours of age (after the neurological observations had stopped).