'Covered in safeguarding', and 'A trauma-informed approach rather than the ACEs model, is better.'

Conclusions ACEs-awareness among healthcare staff working with children is suboptimal, but staff showed eagerness to learn about ACEs. This positive attitude should be further developed by incorporating effective, relatable training sessions either through in-house training, leaflets and posters to raise awareness of intervening and preventing ACEs, or via online Trust or external continuing professional development (CPD) providers' Learning Modules. As a result of our study, ACEs-training was introduced in Safeguarding induction and training. With more frontline awareness, it is hoped that protective, resilient factors that will help counteract the impact of ACEs can be implemented promptly, into the lives of affected children attending health services.

British Society of Paediatric Gastroenterology, Hepatology and Nutrition

1034 MIND THE GAP: OUT OF HOURS FEEDING TUBE PROBLEMS

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Background Children within the Belfast trust with feeding tubes, are known to attend the Paediatric Emergency Department with tube related issues, such as dislodgement. But is ED the right place for them to attend?

Objectives To quantitatively assess the attendance at the Emergency Department with a tube related issue.

Methods Community paediatric nursing records were accessed for all patients currently on tube feeds within Belfast trust. Online records were accessed via Northern Ireland Electronic Care Record (NIECR) to ascertain if the patient demographic, and whether the patient had ever attended ED with a tube related issue, and the nature, timing, date and outcome of this event.

Results 79 children were identified within the Belfast trust as currently being tube fed. 7 had inaccessible records. Of the 72 remaining, the type of tube varied, with NG being most common at 34%. This was followed closely by Mini-Button at 30%, Freka (15%), Transjejunal (9%), NJ (5%), Corflo (3%), Monarch (3%) and Mickey (1%).

53% of patients with tubes are male, 47% female.

Over half the children in this population are aged 0–5 years.

On average, the number of attendances to ED with a feeding tube related issue, is 4.2 per child, with a range of 0–30.

The highest number of attendances in the current population group occurred in 2020.

Looking closer at 2019 as a sample year, 60% of the attendances occurred on Monday-Friday, between the hours of 9am–5pm.

Limitations of the study include that it is only current case-load, and not historical cases. Also that some children's records could not be accessed.

Conclusions There is a large range in number of ED attendances, but the data shows most children will attend ED for a tube related issue in their lifetime. Many of these children

have complex medical needs and, particularly during a pandemic, ED is somewhere they should only be if absolutely necessary. So, what are the solutions to this issue?

There is a gap in the service provision for these children. We need a more permanent scheduled service to deal with semi-emergency tube needs. Service planning is currently ongoing to see how the children's community nursing team could help facilitate an accessible service, during the week, potentially with extended hours to make travelling to ED unnecessary.

Furthermore, it would be useful to evaluate parental education and training prior to leaving hospital, and also community nursing support within the first few weeks, to ascertain if there is need for improve parental confidence and support in dealing with tube related issues.

To further investigate the issue, we could evaluate data on children who historically had tube feeds, but no longer require them, or who have moved trusts, or passed away.

Child Protection Special Interest Group

1035 WHAT FOLLOWS AFTER HAVING BEEN SHAKEN? – A RETROSPECTIVE REVIEW OF CHILDREN ADMITTED TO HOSPITAL WITH A NON-ACCIDENTAL HEAD INJURY 2018–2020

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Background Children and young people (CYP) who have suffered non-accidental head injury (NAHI) are at risk of short and long term neurodevelopmental consequences; some will have clear neurological problems from presentation whilst others who appear to be neuro-typical following the injury may go on to develop sequelae later in life (Chevingyard & Lind). There are national guidelines regarding acute management and the multiagency response but information regarding best practice relating to follow up is less clear.

Objectives Our aim was to review the current literature regarding neurodevelopmental consequences for children following a non-accidental head injury and to assess whether our tertiary service reflected this through the advice and support provided throughout a child's journey from initial admission to discharge (often to an alternative placement) and the follow up arranged.

Methods We undertook a retrospective review of the notes of children recorded in our Children's Hospital Brain Injury Team database as having sustained a NAHI between 1st April 2018 and 1st October 2020 (30 months).

Results Out of a total of 290 CYP on the database in this time period, 13 were recorded to have suffered NAHI; On further detailed note analysis 1 was felt, from NAI Peer review, to have had an accidental skull fracture.

Of the 12 cases, 11 were male and there was a median age of 4.5 months. 4/12 were local with the remaining transferred in for tertiary neurosurgical care (median length of stay 8 days ; mean 8.8 days). Injuries ranged from skull fracture with no intracerebral bleed to chronic subdural haematomas and extradural haemorrhage. There was one mortality. 9 of