- Identify any barriers relating to referral to prolonged jaundice clinic
- Identify knowledge of guidelines relating to management of prolonged jaundice
- Improve understanding of referral pathways and the correct timing
- Improve communication between primary and secondary child healthcare delivery services

Methods Connecting Care for Children (CC4C) is an integrated care model focused on primary and secondary care collaboration across North West London. Through established networks, we conducted semi-structured interviews with health visitors to review knowledge of prolonged jaundice and referral pathways. These identified barriers to referral, variation in practice, and a desire for further teaching on the topic. Many did not have access to recent guidelines or referral pathways.

We created an information bundle and teaching session with information about prolonged neonatal jaundice, its treatment and investigation, and resources for parents/carers. We also focused on current referral pathways and the reasons for urgent vs non-urgent referral. Case studies facilitated further review of practice and barriers to referral. Health visitors were asked to complete pre and post-session surveys relating to prolonged jaundice, and to answer case studies one week following the session.

Results Surveys and scenario discussions identified uncertainty regarding age for referral, unease with referring to the clinic instead of ED, and that the amount of visible jaundice was being used as criteria for referral. There was good understanding of red flag symptoms. Most health visitors were not aware of current referral pathways and felt only 'somewhat confident' with management.

Two participants completed follow-up surveys which showed improved confidence, correct knowledge of age for referral, but continued uncertainty regarding referral to ED instead of clinic and use of the extent of visible jaundice as a marker for urgency of referral.

Health visitors felt that the prolonged jaundice information pack was useful for their consultations and felt it was appropriate for parents/carers.

Conclusions There are significant variations in practice between health visitors with management and referral of prolonged jaundice for investigation, and many felt that information was not easily available.

It is inconclusive if our teaching resulted in long-term improvements due to low response rates, but it is evident that there is short-term improvement in when to refer, and that there remains uncertainty of the mode of referral.

The CC4C network provides a unique model to facilitate teaching and communication, and it is clear that this would be of benefit for babies with prolonged jaundice.

British Association of Perinatal Medicine and Neonatal Society

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DO UK NICU'S USE MAGNETIC RESONANCE SPECTROSCOPY AFTER HIE?

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Background Prognostication after hypoxic ischaemic encephalopathy (HIE) is challenging for both clinicians and families. The ability to predict neurodevelopmental outcomes can be improved by the addition of thalamic proton magnetic resonance spectroscopy (MRS) to MRI.¹ Recent British Association of Perinatal Medicine (BAPM) guidance suggests where possible, MRS should be performed in assessing infants with HIE treated with therapeutic hypothermia.²

Objectives To investigate use of MRS for infants treated for HIE in the UK.

Methods Between August 2020 and February 2021, a short questionnaire was sent to all UK neonatal intensive care units (NICU's). Consultants were contacted via email and telephone. Survey responses were accepted via an online platform, post or email. If more than one response was obtained from the same unit, the first response was taken.

Results A response was received from 42 of 54 NICU's spanning England, Scotland, and Wales.

Current MRS imaging practice

Response	Number of NICU's	Percentage
Used MRS within the last year	18	43
Routinely use MRS (all babies with HIE)	13	31
MRS used but not routine	5	12
MRS not used	24	57

Of the 24 NICU's not currently using MRS, 18 reported that they did not have plans to introduce it. Equipment and expertise were the most commonly reported barriers to introducing MRS (each reported by around 50% respondents).

61% clinician respondents agreed or strongly agreed that they gave high importance to MRS findings when considering long-term prognosis. However, only 33% reported that MRS had increased their confidence when discussing prognosis with families.

9 NICU's (21%) reported their imaging practice was likely to change in response to BAPM guidance.

Free text comments from NICU's included: plans to explore MRS with their radiology department, uncertainty about the added value of MRS, concerns about sedation and acquisition time for MRS, challenges in translating research into clinical practice and comments regarding the importance of ongoing clinical developmental assessment.

Conclusions Our survey demonstrated limited current use of MRS imaging by UK NICUs, despite recommended adoption. Further education of involved professionals as to the delivery, interpretation and utility of MRS as an addition to MRI after HIE may be valuable. Neonatologists' reported experience with MRS suggests that, whilst most find it helpful for prognostication, it is not heavily relied upon when communicating with families. This is likely to reflect the fact that, whilst superior to MRI alone, MRS does not solve the issue of prognostic uncertainty in HIE and therefore conversations with families remain challenging.

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Paediatric Educators' Special Interest Group

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TRAINEE LED MEDICAL STUDENT TEACHING: SEVEN YEARS ON, WHAT HAVE WE LEARNT AND WHAT LIES AHEAD?

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Background Medical student education has witnessed seismic shifts over recent years, with changes to medical curricula and increased use of information technology. The declaration of a global pandemic in early 2020 has fundamentally changed the way in which medical students access their education and the impact of this will be felt for years to come. 'Paeds in a Day' is a voluntary movement led by senior Paediatric doctors from the East Midlands. Over the past seven years, we have led an annual face-to-face lecture series, covering the core contents of the paediatric syllabus for students at the University of Nottingham. This year, in response to social distancing restrictions, we hosted our lecture series online, allowing medical students across the UK and internationally to benefit from the course.

Objectives Our aim is to describe the trends in student feedback received over the last seven years and outline how we will adapt our course to meet future students' needs.

Methods A mixed-methods approach was used to analyse electronic feedback forms from April 2015 to February 2021. Trends in Likert-scale questions were quantified and for the qualitative data, a thematic analysis was undertaken to highlight key positives and identify areas for future development.

Results Between 2015–2021, we have conducted six lecture series, teaching 1281 medical students (range 53–653) and delivering between 10–13 lectures on each occasion. To date, all students consistently 'agreed' or 'strongly agreed' that the course was helpful for their paediatric revision. A handout has been regarded as a valuable addition, with 88 to 100% of students finding it useful, and a high proportion of the positive feedback analysed was related to this (5.9–15.6%). The interactive 'fill in the gaps' approach to the workbook received fewer positive comments in 2021 compared to 2015 (8% vs. 21%), with more calls for continuous prose and a document that is easier to edit on a computer. Pace, timings and organisation of the course seem to have improved, with more positive comments over time, however increased numbers of students requested for the series to be split over two days (3.4% in 2015 vs. 24.5% in 2021). Five percent of the critical feedback in 2021 was related to requests for access to the recordings, for those studying from home.

Conclusions Since 2015, we have consistently delivered a valuable paediatric revision course for medical students. By adapting our course in 2021, we created an online, open-access platform for a UK and international audience. We have learnt when the course is delivered online, it is harder to cover similar amounts of material in one day, likely related to students struggling with increased screen-time. Handouts

continue to be important adjuncts to learning, although more are accessing these electronically. To meet their future needs, we should consider sharing recordings of our presentations, producing a handout that is easier to edit on a computer and splitting the course over two days.

Quality Improvement and Patient Safety

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THE INTRODUCTION OF VIRTUAL BRIEFING AND DEBRIEFING IN A GLOBAL PANDEMIC

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Background Medicine is a high risk and safety critical field. Our general paediatrics department has inpatient numbers which fluctuate on average from 50–100 or more. Patients are not allocated a particular ward but according to availability, so there is a large geographical spread across many wards. The team comprises of approximately 30 people consisting of FY1–ST8 doctors, ANPs and consultants. Each day different members of the team may be allocated to different wards depending on rotas. The consultant for each week however is consistent.

There are minimal changes to the structure of the day however there are daily changes to patient complexities, continuity of staff and patient location within the hospital. Over a period of four years boards have been introduced to facilitate briefing/debriefing at the beginning and end of the working day. These were designed initially from feedback from the team; they have consequently been adapted and redesigned following PDSA cycles.

Briefing and debriefing had been a well-established part of the team before the global pandemic in March 2020 which universally changed the way the team approached the working day, for example working in smaller sub teams to facilitate social distancing. Due to the substantial amount of change within the team we recognised that the daily briefing and debriefing was not functioning effectively. As a project group we developed and reintroduced new ways of briefing/debriefing that incorporated the government advice surrounding social distancing

Objectives To re-introduce daily briefing/debriefing virtually having previously been embedded within the department in a face to face format pre Covid-19, to improve situational awareness including staff experience and patient safety using the five levels of care.

Methods SCOPE-Recognition of a lack of brief/debrief because of unforeseen changes in the 'normal' working day due to covid-19

SHAPE- a questionnaire was designed to obtain feedback from the stakeholders to evaluate their input regarding the briefing/debriefing (pre covid-19). Using feedback collated, our focus was to improve situational awareness and learning opportunities for brief and develop the opportunity for the team to debrief.

SHIFT- Developing new tools using virtual systems to enable brief/debrief to occur in a timely and safe way. Education and training was provided for members of the team. Engagement from the whole team was essential for briefing and debriefing to be sustainable.