candidates through the exam circuit. At the end of the mock exam, we gave every candidate verbal feedback in each station. Following feedback collected using an e-survey, we improved our delivery of the February 2021 Mock Exam by providing both written and verbal feedback, which was subsequently used to help inform individual coaching sessions one week prior to the exam.

Results All candidates (n=11) sitting the clinical exams in November 2020 and February 2021 agreed that the mock exams were 'extremely' or 'very' helpful in their preparation for the clinical exam. After the November 2020 Mock exam, candidates requested written and verbal feedback, which 2/3 of candidates sitting the February 2021 Mock stated was 'extremely' or 'very' helpful. Candidates sitting both exams said the video and communication stations were realistic and clear. Candidates said the development station was 'similar to the real exam' although some felt they were unclear about what the task involved. Short and extended clinical stations did receive positive feedback, with suggestions for improvement including using audio clips or images. The use of 'Zoom' received good feedback in spite of 'minor technical difficulties.' 2 candidates expressed a wish to have more time for feedback, and 2 candidates would have liked an additional clinical and history taking session. This feedback was acted upon prior to the February exam which led to a candidate mock exam satisfaction rating of 4.8/5.

Conclusions Participation in regular online teaching and the ability to sit an online mock examination prior to the COVID-Adapted Clinical exam helped our colleagues to feel more prepared, more confident and able to gain a better understanding of what was expected of a candidate sitting the new online exam format. We will continue to use feedback to develop the teaching programme and Mock Exam to ensure all our trainees feel adequately prepared.

Children's Cancer and Leukaemia Group

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MALIGNANCY IN ATAXIA-TELANGEIETASIA: A SCOPING REVIEW

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Background Ataxia-telangiectasia (A-T) is a rare autosomal recessive, multi-system, neurodegenerative disease due to mutations in the ataxia-telangiectasia mutated (ATM) gene. It causes neurological impairments, immunodeficiency leading to serious recurrent infections, and malignancy.

There are two types of A-T; the more severe classical A-T that presents in early childhood, and the less severe variant A-T that presents later in childhood, or adulthood.

People with classical A-T generally present at approximately 18 months of age with a cerebellar gait ataxia, are wheelchair-bound by 10 years and rarely live beyond their twenties, with death mainly due to malignancy or lung disease.

People with variant A-T present later in childhood, or as an adult, and have a milder phenotype with a longer survival.

Objectives To document malignancy diagnoses in A-T.

Methods 17 searches were carried out in each of 5 databases (Ovid SP (Medline), EMBASE, Web of Science, PubMed, Scopus). The Cochrane Library was also searched. The search protocol is available.

The inclusion criteria were: all dates, all languages, all ages, human subjects, and clinical relevance. The exclusion criteria were: no reference to A-T within the article, not an original article, animal studies, article not clinically relevant.

Results Search returned 194,890 articles; 14,622 titles and abstracts were reviewed after removing 180,268 duplicates.

Full text review of 1,163 articles was performed and 1,039 studies were included (13,459 exclusions, 124 excluded after full text review).

1826 malignancies were reported in 1643 cases. The most common malignancy in the classical group was non-Hodgkin's lymphoma (421 cases) and presented at a median age (n=72) of 9 years 8 months (range 6 months to 35 years 6 months, IQR 6 years 0 months to 14 years 0 months). The second most common malignancy reported was leukaemia (n= 284) presenting at a median age (n=89) of 11 years 0 months (range 1 month to 51 years 0 months, IQR 5 years 6 months to 19 years 0 months), followed by Hodgkin's disease (n=171).

The most common malignancy in the variant group was breast cancer (n=13) presenting at a median age (n=8) of 34 years 0 months (range 28 years 0 months to 44 years 0 months, IQR 12 years 0 months to 39 years 0 months), followed by leukaemia (n=10) at a median age (n=6) of 9 years 6 months (range 6 years 0 months to 46 years 0 months, IQR 8 years 3 months to 16 years 0 months).

Other results will be presented including the presenting signs and symptoms of leukaemia, non-Hodgkin's lymphoma and Hodgkin's lymphoma.

Conclusions A large variety of malignancies are diagnosed in people with A-T at a wide range of ages. Solid tumours are more common in variant A-T and haematological malignancies in classical A-T.

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Quality Improvement and Patient Safety

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AN EVALUATION OF WORKING FROM HOME PRACTICES AND EXPERIENCES ON A TERTIARY NICU DURING THE COVID-19 PANDEMIC

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Background During the Covid-19 pandemic, remote 'working from home' (WFH) practices were developed on a tertiary neonatal unit to ensure compliance with Covid-19 recommendations around shielding, self-isolating and social distancing, and mitigate anticipated junior doctor staff shortages.

Objectives

- Establish a remote working service for junior doctors unable to attend in person due to Covid-19 restrictions then develop a remote working rota and guideline.
- Enable remote staff to contribute to clinical and non-clinical tasks securely.

- Conduct a mixed-methods evaluation of remote working by practices and identify facilitators and barriers.

Methods A remote working rota allocated shielded and self-isolating staff to contribute to intensive care, postnatal duties, outpatients clinic or community calls. Staff used an electronic patient notes system that was securely accessible from home and communicated using digital technology. A guideline formalised practice.

Quantitative and qualitative data was collected as part of a mixed methods evaluation. Quantitative data was collective retrospectively from remote working rotas between March–August 2020 to analyse time worked by staff role. Data was collected prospectively via online questionnaires sent to remote working staff between 28th July–15th August 2020 to record activities undertaken on shift.

Qualitative evaluation was conducted using focus group discussions (FGDs) with staff according to whether they were working remotely intermittently or permanently. Thematic analysis of focus groups was undertaken.

Results Between 23rd March–15th August 506 hours were WFH over 274 shifts equating to a mean of 119 hrs/week (equivalent to 12 shifts). (66% ST6–8, 25% ST1–3, 8% Advanced Neonatal Nurse Practitioners (ANNPs)).

20 questionnaires were sent with 14 responses (70% response rate) covering 126 hours of WFH activities. The largest proportion of time was spent on audit/management roles, followed by ward-based work.

The table reports on thematic analysis of FGDs.

Themes	Subthemes	Staff Opinions
Communication	Communication between remote/hospital team	Communication sometimes unclear leading to inefficiency.
	Handover	
Workforce	Staff commitment/enthusiasm	Staff were enthusiastic and committed to remote working and were supported by wider team.
	Effective time management	
	Task shifting between teams	Hierarchy recognized between staff.
	Hierarchy	
Patient safety	Safe prescribing	No negative impact on patient safety.
	Clinical safety	Remote prescribing prohibited.
Work life balance/wellbeing	Benefits/drawbacks to flexible working	Group 1 described positive effects on work/life balance and improvement in emotional wellbeing.
	Team cohesion	
	Emotional impacts	Group 2 described blurring of boundaries between work/life and found continuous remote working isolating.
Training	Practical skills training	Remote working had detrimental effects on practical skills.
	Development of leadership/management in outpatient setting	
	Opportunities for non-clinical work	Remote working had positive effects on these areas of training.
	Virtual training	
Tools	Digital technology	Enabler to remote working.

Conclusions The remote workforce contributed substantially to the neonatal unit service and was broadly valued with positive impacts on junior doctors' experience. Hierarchy and communication were recognized barriers posing a risk to effective

teamwork. Promoting an inclusive handover and utilising digital technology further may mitigate this. Remote working has positive and negative impacts on training and wellbeing. It is important to recognize this and ensure staff and training remains supported.

British Association for Community Child Health

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ASSESSING THE FEASIBILITY AND COMPLIANCE WITH A LOCAL SCREENING PATHWAY FOR INFECTIOUS DISEASES IN UNACCOMPANIED ASYLUM SEEKING CHILDREN (UASC)

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Background NICE guidelines on looked after children (LAC) state that all UASC should have the necessary screening tests depending on their country of origin and these should be acted on appropriately to prevent transmission of infectious diseases.

For this purpose, a local protocol was designed in 2018 to summarise the investigations that should be done at an initial UASC assessment and when a referral is required to Paediatric Infectious Diseases for further management.

Objectives 1. To determine if UASC are investigated for infectious diseases as per the NICE recommendations following the introduction of a local screening pathway.

2. To determine if the results of the investigations are being acted on appropriately and in a timely manner

3. To identify areas of possible improvement in the care of the UASC

Methods Retrospective data collection on UASC children (< 18 years of age) seen at our hospital over the last four years (January 2017 to August 2020). From January to December 2017 there wasn't any local protocol in place. In January 2018, a local pathway was introduced. UASC were identified from the hospital UASC data base. Clinical notes were reviewed by the audit team and fully anonymised data was entered in a specifically created data collection tool. Descriptive analysis was performed. Both periods of time (prior and post implementation of the pathway) were compared.

Results A total of 91 children were assessed (20/91 and 71/91 prior and after the introduction of the protocol). The majority of patients seen in both time periods were male (80/91) with a median age of 16 years, a minimum age of 6 years and a maximum age of 18.5 years. The most frequent countries of origin were Afghanistan (14/91) and Eritrea (17/91) although the number of UASC from Vietnam increased significantly in the second period (14/91).

The proportion of patients seen who received part of the infectious diseases screening increased from 7% to 39% since the introduction of the local pathway. However even in those that the investigations were done, there was significant variability in which tests were ordered. For those patients who had investigations requested, 37.5% of them had their results available to the LAC team. The others' results were not available to the LAC team and were still in the hands of the GP.

The proportion of patients who received the complete infection screen was much lower at 29.5% (21/71) with only