- 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

1288

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

Jaspreet Kaur Sokhi, Laura Ferreras Antolin. *St George's Hospital*

10.1136/archdischild-2021-rcpch.532

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

9.5% (2/21) of those patients having all their results available to the LAC team.

GPs were requested to carry out revaccination in most cases but there was no clear feedback and registration as to whether this was actually done in 89.3% of cases.

Conclusions 1. The introduction of a local protocol was effective but still sub-optimal, highlighting the need for parallel actions such as access to results and collaboration between primary care services and the hospital.

2. Subsequent to this audit a new pathway agreed by the team was generated and a re-audit process will take place in 6 months' time after introduction and training on the pathway.

Child Protection Special Interest Group

1289 SAFEGUARDING DURING COVID 2020 LOCKDOWN – A LOCAL PERSPECTIVE

Elizabeth Leith, Tsitsi Chawatama. *Chelsea and Westminster NHS Foundation Trust*

10.1136/archdischild-2021-rcpch.533

Background During the first COVID-19 UK lockdown, there was concern that vulnerable children and young people (CYP) were less visible to support services and healthcare professionals due to reduced societal safety nets, increased alcohol sales and domestic violence. This resulted in a widespread reduction in safeguarding referrals but an increased proportion of serious incidents. Nationally safeguarding referrals fell by a fifth but serious safeguarding incidents increased by 27%.

Objectives A local, district general hospital, perspective on the effect of the COVID-19 lockdown on; numbers of safeguarding referrals in the Emergency Department (ED); proportion of mental health and eating disorders; referrals related to substance abuse and domestic violence (DV) and severity of safeguarding presentations.

Methods A qualitative retrospective cohort analysis was undertaken reviewing electronic records of all cases referred to the ED psychosocial meeting with safeguarding concerns for CYP during the first lockdown until children returned to school (23/3/2020 – 6/9/2020). Comparison was made with cases referred during the same period in 2019. Following an initial feasibility study of 50 cases from each dataset, 1 in 5 patients were randomly selected and analysed until data saturation was achieved. In total, 200 cases were reviewed. Data collected included demographics, date and mode of presentation, presenting complaint, the outcome of the attendance and referrals made.

Results There was an 18% reduction in numbers of referrals from 384 in 2019 to 314 in 2020. Although there was no increase in the rate of presentations due to mental health crises or eating disorders, there was an observed rise in paediatric suicide attempts. Amongst CYP, there were similar numbers of referrals for substance abuse but there was an increase in the number of parents referred for substance abuse during lockdown. Additionally, DV related referrals halved during the lockdown.

Although there was a reduction in referrals for suspected child abuse, there were increased presentations with physical abuse and an absence of reports of neglect, emotional and sexual abuse. Of the physically abused, the COVID lockdown group were younger at presentation with a median age of 10

months (IQR 11 days – 4 years) compared to 4 years old (IQR 1 – 11 years). Safeguarding presentations were more severe during lockdown including significant fractures and traumatic head injury. Of the cohort reviewed, 3 of 11 children were removed from their primary carer during lockdown compared with 2 of 16 in 2019.

Conclusions Our data mirrors the safeguarding data nationally, with reduced referrals but an increase in severity. There has been a rise in the rate of substance misuse in adults and a higher rate of referrals for physical abuse with children being removed from their parent or carer. These vulnerable children need to be seen and it is the responsibility of all those working in the children's sector to be proactive and seek out those missing.

British Association of Perinatal Medicine and Neonatal Society

1291 A QUALITY IMPROVEMENT APPROACH TO IMPROVING ADMISSION TEMPERATURES AND DELAYED CORD CLAMPING IN INFANTS ≤ 32 WEEKS GESTATION ADMITTED TO HILLINGDON NEONATAL UNIT

Jennifer Dale, Armina Bajric, Choihoong Mui, Ana Alcobia, Sieweng Tng, Curlene Wilson, Katherine Coles, Helena Nash, Shabana Syed, Suetmei Yoon, Devangi Thakkar. *Hillingdon Hospitals NHS Foundation Trust*

10.1136/archdischild-2021-rcpch.534

Background Hypothermia in preterm infants has been associated with significant adverse effects. Neonatal unit (NNU) admission temperatures have been shown to be a strong predictor of future morbidity and mortality in all gestations.

NNAP (National Neonatal Audit Programme) standards state that admission normothermia should be met for $\geq 90\%$ of babies; however national rate of compliance is well below this target.

Delayed cord clamping (DCC) in preterm infants is shown to reduce mortality, and immediate cord clamping has also been associated with adverse outcomes. DCC ≥ 1 minute was added as a NNAP standard in 2020.

Objectives

- To use Quality Improvement Methodology to increase the percentage of preterm babies being admitted to Hillingdon NNU with normothermia in order to meet national standards.
- To introduce the concept of DCC of ≥ 1 min at Hillingdon, alongside improving documentation of whether DCC was undertaken.

Methods Patients for inclusion were identified from the Badgernet database. Retrospective data for all admissions ≤ 32 weeks gestation to Hillingdon NNU was analysed for 5 months from April-August 2020 (pre-intervention), noting admission temperature and whether DCC was performed.

Key stakeholders for the QI project were identified including midwifery staff, paediatric trainees, neonatal consultants, nursing and obstetric teams. Using the BAPM (British Association of Perinatal Medicine) normothermia toolkit, areas for improvement and appropriate interventions were identified. An MDT education programme was implemented in September 2020. Education methods included teaching sessions and