

Methods After training and attendance at the RCPCH Epilepsy Quality Improvement Programme (EQIP), a driver diagram, fishbone analysis, 5-whys methodology and patient questionnaire were used to understand the patient pathway. An EEG leaflet explaining the procedure is already sent to patients. However, it was noted that there was little information or avenue for families to ask questions or to allay fears and anxieties before attending. This highlighted the need for improved preparation in addition to the standard EEG leaflet before arrival to the hospital.

A Model for Improvement with 4 PDSA (Plan, Do, Study, Act) cycles was employed to test change. Patient families were contacted several days before the EEG to discuss needs, anxieties and ways of working that might improve the experience and thereby the quality of the EEG recording eg room layout, staff in uniform, toys, Wifi availability etc.

The later PDSA cycles highlighted logistical problems in telephoning all paediatric patients. Therefore, an addendum to the patient leaflet was sent to the patient. This signposted useful online material and other resources. Department photographs were also available on request.

Results An improvement was seen in the number of quality EEGs recorded. The percentage of paediatric patients with full quality EEGs was seen to be consistently above 95% after introduction of the telephone call and leaflet addendum. No EEG recordings were abandoned. Very favourable feedback was gained from families about increased flexibility to tailor the EEG investigation. The Covid-19 pandemic unfortunately affected EEG wait times.

This was a multidisciplinary quality improvement project resulting in rewarding, collaborative links to enable future dialogue and multidisciplinary working.

Conclusions Quality of EEG recordings was improved by increased communication between families before appointment, either by discussion over the phone or by signposting to online resources

Quality Improvement and Patient Safety

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VIRTUAL CONSULTATIONS IN PAEDIATRICS – WHAT HAVE WE LEARNT?

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Background With the current pandemic there have been many changes in the way we work. The most obvious one is use of remote clinics with the likelihood that this would remain with us in the long term. There has been widespread acceptance of this way of working in a very short time with benefits in cost efficiency and patient attendance described. Remote consultations in paediatrics has its own challenges and this would be a good time to analyse how it works, the practical challenges and to see if any changes are needed with the how it is provided in the future.

Objectives To get feedback from paediatricians regarding their use of remote consultations so that we could plan our services for future

Methods A questionnaire Survey was sent to paediatricians regarding their experience of use of virtual consultations and their responses were analysed

Results 66 doctors responded to request for feedback and provided answers to the questions. 78% of the respondents were paediatric consultants, 6% were neonatal consultants, 6% community consultants and 10% were specialist registrars. 94% of the respondents hadn't done remote clinics before the pandemic. Over 60% of the respondents had done more than 50% of their outpatient clinics over the last one year remotely. 75% of the respondents also provide specialist clinics apart from general clinics. 15% of the respondents used only video clinics, 28% only telephone clinics and 50% did both video and telephone clinics. 27% of the general paediatric patients and 39% of the speciality paediatric patients seen remotely were called in for a face to face consultation subsequently. Main problems with telephone clinics were calls not being answered, safeguarding concerns not being evident, difficulty in diagnosis and patient rapport. Amongst video clinic users, difficulty with use of technology and network issues were the most frequent problems encountered. 55% would prefer face to face clinics in comparison to remote clinics. 73% used NHS attend anywhere platform for video consultations. The overall prediction was that 37% of the general and 31% of the speciality paediatric outpatient consultations could be done remotely in future. 55% of the respondents reported that the non-attendance rate has gone down with use of virtual clinics

Conclusions In our survey, virtual consultations were done by most paediatricians over the last 1 year with the majority doing a mix of video and telephone clinics. There were practical difficulties with use of both telephone and videos amongst the respondents with approximately a third of the patients being called for face to face consultations subsequently. More than half of the group would prefer face to face over virtual consultations as it ensures better communication, rapport, review of safeguarding concerns and better diagnostic results. However, there is a vast proportion of consultations which could be easily completed remotely thereby reducing patient journeys and improving attendance rate. An agreed list of conditions where remote consultations are equally effective would be a helpful way forward along with attempts to improve current technology

RCPCH Trainees Committee

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MUSIC, PHOTOS & LOTS OF BANTER: BRINGING THE WIDER PAEDIATRIC FAMILY TOGETHER THROUGH VIRTUAL QUIZ NIGHTS DURING THE COVID-19 PANDEMIC

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Background After the onset of the COVID-19 pandemic, the government issued national lockdown restrictions. This was soon after the March 2020 changeover, meaning many paediatric trainees were working in new, unfamiliar hospitals with strict social distancing rules. This impaired the normal

development of workplace relationships at a time where peer-support was pivotal.

The risk of poor mental health and moral distress is well recognised in healthcare professionals. With isolation and restricted peer-support, this was likely to increase. The regional Trainee Support Network launched a series of pan-regional virtual Quiz Nights to combat this.

Objectives To organise virtual quiz nights that provide a safe environment for paediatric trainees, consultants and the wider deanery 'paediatric family' to see each other and have fun, in order to improve workplace relationships and boost staff morale.

Methods A 32-week project using plan-do-study-act (PDSA) cycles was completed (table 1). We evaluated interventions via mixed quantitative and qualitative questionnaires assessing whether people would attend again, would recommend the quiz to friends, and whether attendees reported improvement in workplace relationships and morale.

A total of 6 virtual quiz nights were hosted across an 8-month period from May to December 2020.

Results The quiz was attended by a mixture of clinical, non-clinical, senior and junior paediatric staff and their families. Attendance ranged from 20–40 per quiz, peaking during lockdown. We received a total of 39 responses to our questionnaire.

100% (n = 39) reported they would attend again and would recommend the quiz to a friend or colleague. 97% (n = 38) reported they agree or strongly agree that the quiz boosts staff morale. 92% (n = 36) reported it improved workplace relationships. When asked whether they preferred the quiz to be only trainee or consultant based, 100% (n = 39) reported they wanted it to be open to all.

Attendees reported that it was a 'great initiative' that allowed people to 'connect with colleagues' at a time where this was 'not possible in groups outside of work due to COVID.' They 'loved the banter' and the 'imaginative rounds.' Thematic analysis demonstrated that what people valued most was the 'chance to see friends' from 'around the region,' 'getting everyone together,' and the 'community feel' created by these events through the 'light-hearted entertainment.'

Abstract 1301 Table 1

PDSA Cycles

- 1 Launch of Quiz Night. Variety of questions, including region specific ('Name the Hospital' and 'Guess the Consultant' childhood photo rounds) and general rounds.
- 2 Further promotion, including a regional twitter hashtag. Addition of attendee requested rounds (continuing mixture of deanery specific and general rounds)
- 3 Head of School and TPDs invited to guest host rounds and addition of further innovative (COVID face mask) photo rounds
- 4 Quiz Night held in conjunction with regional PAFTAS award ceremony evening
- 5 Special edition quizzes (Back to School, Christmas Quiz)

Conclusions Through innovative photo rounds, guest hosts, and friendly competition, the quiz was a 'wonderful way to get trainees and consultants of the region together,' improving staff morale and workplace relationships. Hopefully one day we can 'do it in a pub.'

British Association of Perinatal Medicine and Neonatal Society

1302 THE CORRELATION BETWEEN EARLY GENERAL MOVEMENT ASSESSMENT AND 2 YEAR NEURODEVELOPMENTAL OUTCOME IN HIGH RISK INFANTS

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Background Prechtl General Movement Assessment (GMA) is a reliable tool for identifying babies at risk of neuromotor deficit. We have previously compared our GMA results with standardised 2 year neurodevelopmental outcome for high risk infants, but our numbers were small.

Objectives Our aim therefore was to increase our study population and reassess this correlation.

Methods High risk infants born between 2016 and 2018 who received their neonatal care in a level 3 NICU were retrieved from neonatal databases. Those infants who had GMA were extracted and the GMA and 2 year assessments were compared.

Results 83 infants born during our study period had GMA and 2 year assessments. The infants' gestation ranged from 23⁺⁶ to 42⁺² weeks and birth weights from 488g to 4410g. All had GMA between 10 to 17 weeks of age. Most infants had 2 assessments during this time plus an early GMA between 2 to 8 weeks. All had assessments at a corrected age of 2 years using either the Bayley's III tool or a combination of telephone interview, general health and motor function questionnaire plus PARCA-R questionnaire. Of the 83, 66 (80%) had normal 2 year outcome and 63(96%) of the 66 had normal 10 to 17 week GMA; 3(4%) of the 66 had equivocal 10 to 17 week GMA. None of the 66 had absent fidgety movements. 34(52%) of the 66 had GMA between 2 to 8 weeks and 20(59%) of these were a normal pattern with 14(41%) having a poor repertoire. 6(7%) of the 83 infants had severe global disability at 2 years and in all of these fidgety movements were absent at 10 to 17 week GMA. All 6 had abnormal GMA at 6–8 weeks; 4 with poor repertoire and 2 showing a cramped synchronous pattern. 7(8%) of the 83 infants had moderate or severe motor disability without significant other disability at 2 years and a diagnosis of cerebral palsy. 6(86%) out of the 7 had absent fidgety movements at 10 to 17 weeks and 1(14%) had equivocal fidgety movements. 4(57%) of the 7 had 6 to 8 week GMA; 2(50%) of the 4 displayed poor repertoire and 2(50%) showed a cramped synchronous pattern. 4(5%) of the 83 infants had significant cognitive or language disability at 2 years but no motor deficit and all these had normal fidgety movements.

Conclusions Our study demonstrates a high level of correlation between absent fidgety movements at 10 to 17 week GMA and motor disability as assessed by standardised methods at 2 years. There is a weaker association between 6–8 week GMA and motor problems and this is well recognised in published literature. However it is notable that all children in our study with severe motor problems at 2 years and who had a 6–8 week GMA demonstrated either a cramped synchronous or poor repertoire pattern. We advocate the use of GMA for high risk neonates as a means of early prediction of