that a simulation session would be useful. Following the introduction of the Safeguarding Passport, 100% of ST1 trainees (n=18) uploaded the passport to their ePortfolio and all had demonstrated achieving level 3 children's safeguarding competence, with most logging more than the minimum required evidence.

Conclusions A new safeguarding training package, developed by way of a TNA, was successful in improving trainees' confidence in key areas of children's safeguarding. The results also show that the introduction of a Safeguarding Passport has been successful in ensuring ST1 trainees evidence meeting mandatory children's safeguarding requirements. Further evaluation over a longer period of time is needed to fully optimise the delivery of safeguarding training to all levels of paediatric specialty trainees in the North East and to assess the benefits of using a Safeguarding Passport in the ARCP process.

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Association of Paediatric Palliative Medicine

1313

IDENTIFICATION OF CHILDREN WITH LIFE LIMITING CONDITIONS WITHIN THE BELFAST TRUST AND THEIR USE OF SHORT BREAKS

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Background Children with life limiting conditions are an important group of patients within Paediatrics. Life limiting conditions or life threatened conditions encompass a wide range of presentations. They include conditions for which treatment may be feasible but could fail, chronic conditions which increased susceptibility to poor health and progressive conditions which will result in an early death. Current data on the numbers of children with life limited conditions in Northern Ireland is lacking. Short breaks are often utilised by patients within this group. Short breaks are services which allow the carers to have a break from caring responsibilities. They can be in a variety of formats including residential stays or carers coming into the home to help the primary carers. Short breaks have many benefits which have been identified through previous research.

Objectives We aimed to identify the numbers of children living with life limited conditions within the Belfast health and social care trust (BHSCT). Cedar in Reach, the Northern Ireland children's hospice and Forest lodge provide short breaks within the trust. Cedar in Reach provides a short break within the home through carers coming in. Both Forest Lodge and the NI Childrens Hospice provide residential short breaks. We aimed to identify the use of these services within this group of patients.

Methods We started with a list of children on the community children's nursing (CCN) caseload. Additional children were identified through children who had been referred to the Northern Ireland Childrens Hospice. We also contacted specialist medical teams for details of appropriate patients. These

patients' details were reviewed and duplications deleted. We used their electronic care record to record use of the services identified in the objectives. We looked at service use within 2019.

Results The number of children identified as having a life limiting condition within the Belfast trust was 126. 35% of these children accessed short breaks in the form listed above within the year 2019.

Conclusions Only 35% of children within the identified cohort of life limited children currently utilise short breaks. The Public Health Agency (PHA) plan to do further work on access to short breaks within Northern Ireland, to look at barriers to access for parents and how some carers utilise them. Identifying the number of children with life limited children who could potentially benefit from short breaks is important for shaping future services within the trust. There are limitations with this work due to some services struggling to identify patients retrospectively and this has opened discussions about potential for prospective collection of data about this group of children to gain better data in future.

British Association of General Paediatrics

1314

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.

British Paediatric Respiratory Society

1316

A NEW WAY TO REVIEW PAEDIATRIC PATIENTS WITH WHEEZE AND ASTHMA DURING COVID-19; VIDEO GROUP CLINICS

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Background The Paediatric Asthma Team previously ran face-to-face group clinics and when the Covid-19 meant that outpatient appointments moved to telephone and we wanted to see if Video Group Clinics were more time efficient for the clinicians and provided positive learning opportunities to parents managing wheeze.

Objectives Our objective were to see if VGCs improved the following:

For Patients

- Allow families to learn from each others experiences
- Allow more time for teaching and questions
- Increase confidence of parents and children managing wheeze at home
- Improve convenience by having No travel time and therefore reduce WNB rate

For Clinicians

- Improve time efficiency
- Reduce repetition with teaching
- Allow time to cover questions
- Add variety in working week

Methods

- 2 hour training

- Wrote and edited appointment letters and pre-clinic questionnaires
- Developed a consent and confidentiality agreement specific to online groups
- Information Governance permission to use Microsoft Teams
- Called patients to get their email addresses to send out information pre clinic
- Practice runs
- Prepare Power Points on VIW/Asthma/Transition
- With the initial high WNB rate we contacted the parents who DNA'd to get feedback and as a result changed our letter to email and forms online, provided a leaflet on discharge from the ward and increased the numbers we invited.
- We tried different patient groups <5y new, >5y new, <5 fu, >5 new and transition clinic.
- We kept a record all patients that were invited, those that attended, cancelled and DNA'd
- Patients filled out an online feedback form

Results

- 11 clinics
- Over 6 months (July-December 2020)
- 62 patients booked
- 31 patients attended
- 8 cancelled
- 23 WNB – 37% WNB rate

VGC Negative:

- Our administrator typically spends more time contacting parents before the clinic compared with a 1:1

VGC Positives:

- Time efficient for clinician (1.5 hours for 4–8 patients vs 3.5 hours for 5 in individual face to face clinic).
- More time for teaching/peer learning compared with a 1:1 appointment
- Positive experience for the clinicians
- Positive feedback:
 - 'Much easier to attend than a walk in appointment'
 - 'No travel was a bonus'
 - 'It was really helpful to be in a group setting and hear experiences from other parents of kids with asthma...'
 - 'I found it useful to hear other people's experiences and how they cope with some of the difficulties encountered.'
 - 'The session was very well facilitated and space felt completely safe..'
 - 'Also some of them asked relevant questions that i might not have thought of on my own' Helpful 'Thank you so much for all the support with my little princess, it was very helpful for me'

Conclusions After the initial set up challenges we found the VGC worked best for follow up of 'new' patients with pre-school wheeze requiring A+E or hospital admission; we found the time spent for education and recognising wheeze was hugely beneficial. We had consistent positive feedback from parents about the benefits of a group clinic and how much they learnt from peers, we also found it time efficient as a clinician. We will be continuing VGCs beyond the Covid-19 pandemic.