to better achieve the objectives of transition. In addition, it has provided each young person with a transition-focused task in preparation for their next appointment. The 'Ready Steady Go' programme was adapted in order to impact key areas of transition; however, further work is required to improve areas in which young people need help with such as responsibilities with medications and helping those with more complex needs.

Paediatric Clinical Leaders: Service Planning, Provision and Best Practice

1325 AMAZING MK – WHAT MAKES STAFF COME TO WORK?

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10.1136/archdischild-2021-rcpch.558

Background Usually NHS staff go through 'exit interviews' when they decide to leave their post where we ask them 'Why are you leaving us?'. This thinking is based on 'deficit based' model where we focus on things that went wrong or could be improved. Recent evidence proposes that 'asset based' model of thinking which involves shifting our focus on things that are going well is a much better approach for staff retention and wellbeing. This attitude reframes the question 'why are our staff leaving us' to 'why do our staff stay in our department' which creates a positive thinking attitude while offering a different perspective.

Staff retention and wellbeing is an important issue in the current NHS which is the largest employer in the UK with more than 1 million staff. The greatest asset of an organisation is its staff, and evidence suggests improving staff experience with a positive mindset can reduce patient mortality and increase patient satisfaction.

Objectives 'What makes you come to work?'

This was the question we asked our staff in Department of Paediatrics including nurses, receptionists, junior doctors, consultants, secretaries and domestics in spring 2020.

Our team included 3 Paediatric trainees - Fiona Seabrook, Matthew Rajan, Clare Adams and Jyothi Srinivas, Consultant Paediatrician as lead. Maude Calvey, Medical student helped edit final video.

Methods We produced a flyer with details of the project and filming to generate interest in the department. We asked our staff to write a word or sentence written on paper that describes their reason to come to work, day after day. We persuaded and encouraged staff from various roles to take part. We filmed our staff in different areas of the department and had a huge variety of answers over 2 months.

Results Many staff chose single words for filming and the most common themes 'Work Family', 'Making a Difference' and 'Team Work'. Some staff remembered incidents that had deeply affected them at work and were willing to share these experiences.

This project brought our departmental staff together and our team had fun filming the short video clips. As this was the beginning of the first wave of the pandemic, face masks were only mandatory when interacting with patients.

We were inspired by a similar project at the Royal Hospital for Children, Glasgow.

Conclusions NHS staff spend a significant amount of time at work and develop deep bonds with our colleagues over the years. We share experiences of successes and failures during our shifts. While it is important to document and investigate adverse events, it is equally important to acknowledge, appreciate, and promote the positive feelings among staff. It is easy to notice failures over successes. It is easy to be critical than to support and encourage staff when they are struggling. A positive frame of mind gives a different perspective to the issues and is well worth the effort in the current NHS climate.

We enjoyed discussing and filming with our staff the reasons they come to work every day. We hope you enjoy watching the video!

Paediatricians with Expertise in Cardiology Special Interest Group

1326 CARDIOLOGY CLINICS DURING PANDEMIC – CALL FOR A UNIFORM RESPONSE!

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Background During the current pandemic with Covid-19, face to face cardiology clinics were put on hold during national lockdowns. Consequently, there were increased waiting times and back log of paediatric cardiology outpatient numbers. It is currently not known as to what effect this has had on children awaiting cardiology services and whether there have been any adverse effects with the appointments being postponed. Feedback from paediatricians with cardiology expertise (PEC) would be an important exercise to learn how we have coped with outpatient cardiology work in the current pandemic and how we could prepare for the future.

Objectives To get feedback from PECs about their current joint clinic backlog and their experiences how they have managed to provide cardiology services over the past 1 year

Methods Surveys were sent to group of Paediatricians with special expertise in cardiology group via link for preset questionnaire.

Results 44 PECs responded to the survey. A range between 0–16 outreach clinics were cancelled during the current pandemic with the average being 5 clinics per PEC. About 40% of the respondents had around 50 patients awaiting appointments as a result of backlog whereas 27% had between 100–400 patients on their list. A wide variety of methods were used from seeing only the urgent patients, vetting each patient and prioritising the list, continuing with remote clinics etc. but around 18% of the respondents felt that they are struggling with their workload. Some PECs have increased their PEC cardiac clinics to cope with the increased numbers. Reassuringly 90% of the respondents did not see any increase in complaints or unexpected patient deterioration due to delayed reviews. 45% of the respondents felt that 10% of their outpatient work could be done remotely whereas 37% felt that 20–50% of their work could be completed remotely. 95% of the PECs did not see any of their cardiac patients deteriorating secondary to Covid infections and most of the respondents agreed with the RCPCH

guidance of clinically extremely vulnerable group in regards to classification of children with complex congenital heart disease. Most PECs wore standard PPE (surgical mask & plastic apron) during echocardiography.

Conclusions The current pandemic has thrown in some unexpected challenges on how we deliver the paediatric cardiology services. There were great variations on how different professionals managed their work during this period. Reassuringly no increase in complaints or sudden unexpected deterioration were reported which is likely to be due to the painstaking vetting, prioritisation and diligent overview amongst our colleagues. Having a joint statement from specialist groups would be helpful in future to ensure uniformity of services and safeguarding of professionals from medico-legal challenges. There are some aspects of our work which can be delivered remotely and we need to study the pros and cons of this approach.

Paediatric Educators' Special Interest Group

1327

NEONATAL SIMULATION FORTNIGHT: USING SIMULATION TO IMPROVE NEONATAL RESUSCITATION SKILLS

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Background Junior doctors understandably find performing resuscitation skills a considerable source of stress (Scott et al, 2013). This is increased for those required to deliver neonatal life support but are unfamiliar with paediatrics, such as GP or foundation trainees. While resuscitation training is often incorporated into induction, research has shown that frequent reinforcement is necessary to maintain these skills (Berdin et al 1993). Previous research has demonstrated that simulation allows for faster learning and greater retention of knowledge (Knowles 2013). The implementation of an induction neonatal sim for non-paediatric doctors resulted in increased confidence in attending deliveries (Peacock et al 2016).

In our hospital, basic NLS forms part of GP/foundation trainee induction. However, as significant time may pass before these skills are utilised, we incorporated a refresher neonatal resuscitation simulation programme halfway through the rotation.

Objectives We wanted to ascertain whether the introduction of an intensive neonatal simulation programme primarily aimed at GP and foundation trainees would improve confidence and skill in neonatal resuscitation.

Methods Simulation scenarios were developed using common neonatal emergencies and local incidents. Simulation sessions were held post-handover each morning for 2 weeks. Though scenarios were primarily aimed at GP and foundation trainees, all members of the neonatal resuscitation team were involved, including registrars, SCBU nurses and midwifery team members. The simulations were facilitated by medical education fellows trained in debrief, with expert clinical input provided by Paediatric Consultants. Key learning points were themed, summarised, and shared with the team. Daily feedback was collated, and written feedback was obtained after completion.

Results Feedback was extremely positive, with juniors feeling more confident immediately after, as they were 'allowed to make mistakes in a controlled environment' and learn from them. Simulation was unanimously preferred after handover, due to improved access and minimal clinical obligations. All juniors agreed 'it was great learning' and suggested it continue for the new SHO's. Learning points included: communication, role allocation and calling for help early. We later received written examples of how simulation had positively influenced personal clinical practice. One participant reflected on a neonatal emergency, stating 'what helped me the most through this resus was remembering that I would just have to go through it the way I'd gone through it in sim'. Other positives included an appreciation for the opportunity to practice with an MDT approach and reiteration of key learning points. Main barrier identified centred on the tension between service delivery and education.

Conclusions Neonatal SIM Fortnight allowed key learning to be revisited in short, daily sessions over a 2-week period. Feedback and subsequent influence on clinical practice demonstrated the effectiveness of Neonatal SIM Fortnight via behavioural change and clinical results, as per levels 3 and 4 of Kirkpatrick's evaluation model (1959). The simulation programme has been adapted for additional use at the beginning of rotations to support new junior trainees. We anticipate that neonatal simulation fortnight will continue to improve the neonatal resuscitation skills of junior doctors in paediatrics.

Quality Improvement and Patient Safety

1328

IMPLEMENTING NEUROPROTECTIVE DEVELOPMENTAL PROCEDURAL TECHNIQUES IN NEONATOLOGY: EMBRACING CHANGE – A QUALITY IMPROVEMENT PROJECT

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Background Integrative developmental care in neonates promotes neuroprotective interventions for optimum neurological growth and development. Adherence to neuroprotective techniques ensures high quality individualised care during routine procedures. However, common procedures like capillary blood sampling are often done by junior doctors and nurses without proper training. This can result in inadequate sampling volumes, false laboratory results and complications such as pain and bruising.

Objectives This project aims to develop systems in place, embedding developmental care procedures in practice, to ensure safe and family integrated care in the neonatal environment.

Methods A learning pack was developed to use evidence-based developmental care practice of capillary blood sampling and lumbar puncture on the neonatal unit. Training sessions were organised to familiarise newly posted GP/FY2, speciality doctors and nurses to the developmental care techniques. YouTube videos, social media and online conferencing tools were used to disseminate and reinforce teaching and training along with competency assessments. Quality improvement methodologies such as PDSA cycles and implementation of evidence-based interventions were used to drive improvement and implement