

(n=4), leading a busy out of hours shift: 12% (n=2), delegation: 6% (n=1), and complaints: 0% (n=0).

Post-course survey results showed that 100% (n=23) of trainees felt they had a better understanding of what is expected of a new Registrar after attending the day. Trainees found it useful reflecting on the potential challenges of stepping up and having time to discuss these with more senior trainees (100%; n=23), and stated that they felt less anxious and more confident about stepping up after attending the day (96%; n=22). Comments included 'reassuring to hear that a lot of the worries I have about stepping up are common', 'useful hearing personal accounts from current registrars, obstacles they faced and strategies to overcome them', and 'helped me plan how I am going to approach these situations with greater organisation, situational awareness and a more holistic approach - thank you!'

Conclusions We have developed a new, trainee-led day to support trainees in our region with the transition to working as a Paediatric Registrar. Feedback demonstrates that trainees found the day valuable, resulting in reduced anxiety and improved confidence about the transition. Trainees found the near-peer support aspect of the day especially useful, in addition to the practical tips relating to topics such as resuscitation, leading busy shifts, safety-netting, delegation, complaints, and wellbeing. The Transition day will be embedded within our regional teaching programme; additional work to further boost peri-transition support is in progress.

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IMPACT OF INTERNATIONAL HEALTHCARE WORK ON WEST MIDLANDS PAEDIATRIC TRAINEES

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Background The West Midlands Deanery (WMD) offers paediatric trainees an Out Of Programme Experience (OOPE) in Malawi, via the Birmingham Women's and Children's Hospital (BWC) – Malawi partnership. This registrar placement includes ward work, on-calls and clinics in a busy Paediatric department at the Queen Elizabeth Central Hospital, Blantyre, Malawi.

Objectives To assess the impact of working in a low-middle income country on paediatric trainees in the domains of: clinical, communication, leadership, teaching, governance, leadership, and also the personal impact the placement has had on individuals.

Methods All seven of the WMD paediatric trainees who underwent OOPEs in Malawi between 2013–2018 were interviewed virtually in 2020 as part of an evaluation of the BWC-Malawi partnership using a detailed standardised proforma. One trainee had a 12-month placement and another had to return after one month due to health issues; the remainder stayed for six months. Qualitative data was analysed using grounded theory.

Results All trainees were overwhelmingly positive about their OOPE in Malawi. Three of the seven already had an interest in infectious diseases and valued the vast exposure to and clinical knowledge of tropical medicine gained in working in sub-Saharan Africa.

Table 1 identifies the positive impact of the OOPE on individual trainees in the different domains.

Abstract 1383 Table 1 Positive impact on trainees

Clinical	Increased knowledge of tropical medicine Improved acumen in the absence of investigations Improved decision-making skills and procedural skills A calmer approach to sick patients
Communication	Improved communication where language, health beliefs and understanding is difficult Understanding how to manage calls from juniors overnight
Leadership	Increased confidence leading arrest calls Experience in mentorship (each registrar is assigned a medical student to mentor) Wanting to create a positive working atmosphere
Teaching	Increased confidence in teaching abilities Developed strategies for engagement Flexibility of teaching methods to suit audience
Governance	Led to first publication for some trainees An interest in research
Personal	Renewed enthusiasm for medicine Appreciation of how resilient people can be Ability to appreciate the little things Adaptability to different environments

One trainee mentioned the benefit of a renewed passion for a career in paediatrics, without which an individual may have considered leaving training; thus demonstrating the wider benefit for the WMD. The only negative mentioned was that the trainee with health issues struggled with signposting for medical care when they became unwell.

Three of the interviewed trainees have since gained their certificate of completion of training (CCT); all mentioned their OOPE at consultant interview and felt it gave them a unique talking point.

Conclusions The benefit of this OOPE for WMD paediatric trainees is considerable. The partnership will address supervision and signposting for the placement, as trainees cannot be left unsupported during this time. In an era where many trainees are suffering from burnout, we would recommend that all Deaneries offer something similar to their trainees, where they can learn in a different environment.

'It made me realise why I did medicine. It was the best medical placement I have ever done.'

Quality Improvement and Patient Safety

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EVALUATION OF INTERAGENCY SAFEGUARDING REFERRAL FORMS FOR CHILDREN AT A DISTRICT GENERAL HOSPITAL

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Background Child protection and safeguarding is paramount to the role of all paediatricians. Recognising, communicating, and addressing safeguarding concerns effectively is necessary to protect vulnerable children and their families from harm. This ensures children 'grow in a safe environment' as described by the RCPCH.

Objectives The aim of this quality improvement project was to review the interagency safeguarding referrals completed at a district general hospital before and after the implementation of the project's initiatives. The quality of the referrals was evaluated based on the accuracy and clarity of documented information. The project also focused on evaluating how long after the patient encounter the referrals submitted. These were assessed against Working Together for Safeguarding Children 2018 and the NICE Clinical Guideline CG89 Child Maltreatment: when to suspect maltreatment in under 18s.

Methods During the first cycle, sixteen interagency referrals (IAR) submitted in March 2020 through the local electronic records system were retrospectively reviewed using a previously devised proforma from 2016. Following analysis, the electronic IAR on the local care records system was modified by simplifying the questions and specifically asking about concerns and outcome if no action were taken. Healthcare professionals were presented with the initial results and received an education session about using the form. In the second cycle, nineteen IAR forms were retrospectively reviewed in August 2020.

Results Nursing staff and junior doctors completed majority of the forms. In March 2020, 75% of the forms used clear language with no medical jargon and this improved to 100% of the forms submitted in August 2020. In terms of accuracy, school's and family members' details were commonly missing. In March, school name was documented in 25% of referrals and following intervention this improved to 37%. There was an increase in accuracy of completing parent and carer details which increased from 75% to 83% as well as documentation of communication needs of the child and family, increasing from 81% to 95%. In addition, there was a significant improvement in the clear documentation of concerns from 38% in March to 79% in August. The description of the risk to the child if no action was taken, also improved from 13% to 26%.

Prior to interventions, all forms were completed within 48 hours of patient encounter and 63% within 24 hours. After the interventions were implemented, 94% of the forms were submitted within 24 hours. The only exception was a delay in a form submitted following repeated missed attendances which raised safeguarding concerns.

Conclusions These interventions facilitated the social care team in risk-stratifying patients and optimising management of safeguarding in children. Completing a re-evaluation has also surfaced further areas of improvement; in particular communicating the anticipated detrimental consequences to a child if the seriousness of the concern is not conveyed appropriately. Overall, this project successfully targeted education to relevant healthcare professionals and improved accuracy and timeliness in the completion of IARs.

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Association of Paediatric Emergency Medicine

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VIRTUAL URGENT CARE FOR CHILDREN: A PROOF OF CONCEPT TRIAL

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Background Telemedicine is increasingly used internationally to provide clinical services when patient and clinician are not in the same room. In anticipation of limited physical capacity to meet patient activity within our Paediatric Emergency Department (PED) during the Covid-19 pandemic, we developed a video-consultation urgent care model. We describe the process developed, results and lessons learned from a proof of concept trial.

Objectives As an innovative model for the UK we sought to test feasibility, safety and acceptability for clinicians, patients and carers at a type 1 PED.

Methods Our model was developed by our clinical, IM&T and Innovation teams following workshops with colleagues delivering similar models internationally. The trial was conducted over 4 weeks on non-consecutive days based on the availability of trial clinicians who were senior PEM-trained clinicians. Patients who did not require immediate resuscitation based on our usual nurse eyeball assessment were invited to participate in a video-consultation trial. Carers who volunteered were registered on the hospital Patient Administration System (PAS) and received an automated text message link to join a video-consultation on NHS Attend Anywhere using their own device. The clinician was based remotely on a video-equipped laptop or desktop. The patient did not have any triage or physiological observations measured prior to video-consult. A range of outcomes was available to clinician and carer as described in the Results. Clinicians documented directly into the PAS.

Clinician and patient-carer feedback was solicited at the end of consultations.

Results 31 patients were seen. Age range 1 month – 15 years; 12 female: 19 male.

Presenting complaints included rash, headache – both new and chronic, cough, sore throat, difficulty breathing, diarrhoea or vomiting, eye conditions, allergy, suspected UTI, musculoskeletal complaints and injuries.

25% (8 patients) were brought to ED for further action: 4 patients for x-ray or physical examination; 2 for urine dipstick and 2 to issue a prescription.

1 patient (3.2%) returned within 7 days with same problem with overnight admission for observation only. This is comparable to our usual re-attender rate. Clinical assessment and advice during video consult was reviewed and deemed appropriate.

There were no other unplanned returns in the 2 weeks following initial attendance.

Feedback suggests video-consultation is acceptable to carers, especially when waiting times are long.

Conclusions 75% of patients were safely managed with verbal advice only. Of those that needed to attend the PED for