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

investigation or prescription, local options could be implemented to reduce need to travel.

Virtual urgent care is feasible, safe and acceptable for clinicians and carers of infants, children and young people. Based on the range of presenting complaints seen during the trial, a significant proportion of attendances to our type 1 PED could be effectively managed through this model.

Association of Paediatric Emergency Medicine

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THE BREAKS BOARD – AN INITIATIVE TO EMPOWER STAFF TO COORDINATE AND TAKE THEIR BREAKS IN A BUSY CHILDREN'S EMERGENCY DEPARTMENT

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Background Tired doctors make mistakes and excessive workload is a key driver to burnout, creating exhausted, cynical and ineffective individuals. The RCPCH, RCEM and BMA recognised this, having designed a framework for managing fatigue and stipulated rest break entitlements according to hours worked.

But how does this translate to the realities of a busy emergency department (ED)? Despite written and verbal encouragement about break entitlements, doctors reported challenges to the timely access to all entitled breaks. With additional pressures of a global pandemic, we recognized the importance of having a well-rested workforce. We therefore set out to identify and address challenges our ED staff were facing in taking breaks.

Objectives To introduce a break-system that ensures doctors have a 30-minute break for every 4 hours worked in a Children's Hospital ED.

Methods We undertook a 36-week project using plan-do-study-act (PDSA) cycles. Each intervention was evaluated to assess reported percentage of time breaks were taken and time required to coordinate breaks. Qualitative data was collected to inform interventions and subsequent cycles.

PDSA Cycles

1. P Survey designed: quantitative questions to identify baseline; qualitative questions to identify barriers, ideal time to take breaks, and staff suggestions
 - D Staff surveyed
 - S Results analysed
 - A Intervention 1: Introduction of the 'breaks board,' which facilitated allocation of break slot(s) at start of shift. Launch accompanied by creation of guideline for use and staff

Abstract 1387 Table 1

Reported average:	Percent of time 1st break taken	Percentage of time 2nd break taken	Time taken to coordinate each break
Pre-Initiative	90%	32%	4.5 min
Post-Initiative	97%	51%	2.2 min
Improvement	7%	19%	2.3min

education. Details incorporated into induction program to make it the usual practice for new starters.

2. P Design of resurvey to evaluate intervention
 - D Staff surveyed
 - S Results analysed
 - A Intervention 2: printing of permanent boards for both COVID and non-COVID sides of ED; staff education; incorporating breaks allocation into template of daily board round/huddle.

Results Introducing a formalised breaks system via a break(s) allocation board resulted in a greater percentage of time staff reported taking both their first and second break, and reduced the time required to coordinate each break (see table 2). It did however demonstrate that the taking of a 2nd break in a 10-hour shift is still a challenge, requiring further attention.

88% of people reported the breaks board helped them coordinate and take breaks. Staff reported that it '*has been an excellent initiative*' ensuring '*the team are proactive about everyone having their break.*'

Our future work will focus on ensuring the longevity of the change, by creating a culture change in order to get the '*whole team to fully adopt it.*' For the next cycle we plan to do this by introducing break champions or seniors who encourage '*everyone to put their times at huddles/handovers.*'

Conclusions The Breaks Board initiative reduces time required for staff to coordinate their breaks, increases people taking their breaks, and is felt by the majority to be a helpful breaks system.

British Paediatric Respiratory Society

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EVALUATION OF AVAILABILITY OF SPECIALIST PSYCHOLOGICAL SERVICES FOR PAEDIATRIC CYSTIC FIBROSIS PATIENTS IN DISTRICT GENERAL HOSPITALS AND TERTIARY CENTRES

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Background Cystic Fibrosis (CF) is a life-limiting genetic disorder. Given the chronic, progressive and disabling nature of CF, it is well recognised that living with CF can have an emotional and psychological impact. A significant number of CF patients report experiencing stress, anxiety, low mood and difficulties in managing their treatments. The morbidity and mortality factors pose cognitive, emotional and behavioural challenges for many children with CF and their families. NICE (National Institute of Clinical excellence) guidelines recommends that the specialist cystic fibrosis multidisciplinary team should include Specialist Clinical Psychologist (SCP) who have specialist expertise in managing psychosocial problems in children and young people with CF.

Objectives We conducted an online national survey across England to evaluate the services available for psychological assessment of CF patients in District General Hospitals and Tertiary Paediatric Respiratory Centres.

Methods We contacted paediatric tertiary centres (n=21) and District General Hospitals (n=33) CF specialist teams across England. A questionnaire exploring current psychologist services was emailed to them.