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.