on the mental health of young people. There have been a notable increase in the number of mental health cases presenting to Paediatric Emergency Departments, and this is a problem predicted to persist for the foreseeable future. Caring for these young people in both Emergency Departments and on General Paediatric wards is a challenge.

To ensure that healthcare professionals are well-equipped to care for these young people and their families, it is vital that the multidisciplinary team (MDT) receive relevant training, and feel well-supported themselves. The introduction of in-situ simulations with focus on Child and Adolescent Mental Health, has highlighted effective methods for the management of challenging cases. The collaboration with airline pilots in facilitation of the Human Factors debriefs has contributed to creating an open environment for safe learning.

Objectives

- To encourage training focused on child mental health through in-situ simulation during the time of the pandemic.
- To focus on Human Factors training through involvement of airline pilots.
- To encourage MDT contribution through creating a 'safe learning space' for participants.

Methods This was a qualitative study. High fidelity in-situ simulations were performed in real clinical environments, with primed actors. Clinical faculty focused on the technical aspects, whilst uniformed airline pilots provided feedback on Human Factors. To encourage participation from all team members, there was significant emphasis on psychological safety throughout. The key learning points were written up and shared with the wider MDT.

Scenario examples:

- Ligature – management of patient collapsed in the toilet with ligature tied around their neck, with a distressed parent present.
- De-escalation – patient with an overdose threatening to leave the ward prior to Mental Health assessment.
- Acute psychosis– de-escalation of agitated patient, necessitating an MDT approach, including the involvement of security.

Results The simulations encouraged closer analysis of the technical aspects of managing acute presentations of young people with psychiatric presentations. Moreover, they provided a safe training space for staff to reflect on the difficulties faced, with facilitation from airline pilots, and parallel aviation examples. Key Human Factors themes were identified by the pilots, with particular focus on workload management, when dealing with a distressed patient and also an anxious relative. The feedback from these sessions was unanimously positive, with 100% of participants reporting they would like to participate in more.

Conclusions The creation of a safe learning environment for the management of challenging mental health presentations has been extremely valuable in the training of the MDT. Continued learning in this way is of particular prominence at this time, in light of the increase in presentations as a result of the pressures of the pandemic. It is important for the training needs of staff to be met, and for them feel safe and well-supported at this challenging time.

Quality Improvement and Patient Safety

1409

PREPARING PAEDIATRIC TRAINEES FOR THE TRANSITION FROM JUNIOR TO MIDDLE GRADE ROLES THROUGH FORMAL PEER-LED STUDY DAYS: A QUALITY IMPROVEMENT PROJECT

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Background The transition from junior to middle grade is widely considered one of the most challenging timepoints in speciality training. We recognised there was no formal education available for paediatric trainees in the North West to support them during this difficult period.

Objectives Our aim was to improve trainee confidence in stepping up to middle grade. To achieve this we developed a formalised programme of peer-led study days, occurring biannually prior to each rotation of doctors moving onto their first middle grade post.

Methods We identified five key domains pertinent to working as a middle grade; leading resuscitation, safeguarding, clinical prioritisation and time management, seeking senior support and awareness of options to subspecialise. To ascertain individual confidence in these areas we sent a survey to all paediatric junior grades in the North West. Confidence scores were determined using a five point Likert scale. We also provided an opportunity to give feedback on any additional concerns about the transition. We compiled a timetable for our first study day centering on areas of trepidation disclosed. The survey was then repeated to assess if confidence had improved across the domains. We also used open questions to collate feedback to shape future sessions. On organising our second study day we again surveyed trainees confidence scores before

Abstract 1409 Table 1

Key Domains	Confidence Scores	<i>First Study Day (August 2020)</i>		<i>Second Study Day (February 2021)</i>		
	<i>Before (n=12)</i>	<i>After (n=12)</i>	<i>Difference</i>	<i>Before (n=25)</i>	<i>After (n=24)</i>	<i>Difference</i>
Leading resuscitation	2.7	3.1	+0.4	2.6	3.5	+0.9
Safeguarding	2.3	3.1	+0.8	2.4	3.7	+1.3
Clinical prioritisation/ time management	3.8	3.9	+0.1	3.4	4.2	+0.8
Seeking support	2.3	3.1	+0.8	4.1	4.5	+0.4
Aware of options to subspecialise	2.3	3.1	+0.8	3.4	4.3	+0.9

and after the session to tailor ongoing content to individual trainee needs.

Results Following the first study day, confidence scores were increased in all key domains (table 1).

Feedback also highlighted the need for a 'resource' which middle grades could refer to. We created a 'Registrar Survival Guide' which can be accessed from any device via the North West Paediatric Trainee website. We also recorded all subsequent sessions, making them available to trainees on our online educational platform. By building on what we learnt from our initial study day and continuing to explore individual trainee needs we were successful in not only maintaining increased confidence scores after our second study day, but in fact a greater improvement was seen overall (table 1).

Conclusions We have demonstrated that through collaborative peer-led education, we can support and improve confidence in trainees as they transition to middle grade. By making recordings of our study days available for trainees to access at a later date, we hope to widen education to those who may be unable to attend due to work/personal commitments and not unfairly disadvantage trainees on a busy rotation. We anticipate the 'Registrar Survival Guide' will be a dynamic resource trainees can continue to update, encouraging engagement and a supportive culture amongst peers. By sharing our work, we hope to highlight how we can support each other during this difficult transition.

Quality Improvement and Patient Safety

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CHARTER FOR NEW INTERNATIONAL MEDICAL GRADUATES (IMGs) COMMENCING WORK AS LOCALLY EMPLOYED DOCTORS (LEDS)

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Background The journey of a new International medical graduate entering UK for the first time to commence work as a Locally employed doctor is both challenging and daunting. Statistically, international medical graduates make up one fifth of all licensed practitioners employed locally in respective NHS trusts and, contribute significantly in the provision of healthcare. Yet little support and guidance is offered to overcome this steep learning curve professionally, socially and culturally.

Objectives Our objective was to create a charter which would provide guidance, awareness of resources and equip new IMG's to make this transition seamless and once successfully established locally go on to be adopted regionally and later nationally by all trusts who employ international doctors

Methods To achieve this objective, a team of few experienced IMG's under the leadership of the Locally employed doctors led tutor looked into creating a document that would provide all the necessary information and resources for this transition. Data from various sources such as GMC, BMA, NACT (National Association of Clinical tutors), various Royal Colleges and feedback from experienced IMG's all contributed to the formulation of this Charter.

Results The Charter divides the transition period into 3 steps covering the timeline from acceptance of job offer to the weeks following entering the job role.

Step One, covers the period from accepting the job offer at the NHS Trust to entering UK. It includes understanding of the role, availability of rotas, completion of legal and immigration formalities, as well as support from human resources in finding accommodation, opening bank accounts and help in settling into UK.

Step Two, outlines the first 4 week into the job role. The importance of inductions, at Trust and departmental level, introductions to Clinical lead, supervisors and college tutors as mentors to the newly recruited doctor. The charter strongly recommends that all new IMG's join the GMC 'Welcome to UK Practice' workshop which would introduce them to Good medical practice. It emphasises on the importance of completing all statutory and mandatory training required for day to day practice.

Step Three, describes the following months where the IMG has commenced working independently and should start looking into creating e-portfolios, meet with designated clinical supervisor who could provide guidance on career progression and encourage these doctors to become members of their respective Royal College by successfully completing theoretical and clinical examinations.

Conclusions Through the publication and availability of this charter, we aim to create awareness of the responsibilities of every NHS trust to ensure that all newly recruited international medical graduates transition into their job roles with confidence, clarity and clear objectivity of their future within the NHS.

British Society of Paediatric Gastroenterology, Hepatology and Nutrition

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A PATIENT-LEVEL COST-ANALYSIS OF TUBE FEEDING IN PAEDIATRIC PATIENTS

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Background The use of gastrostomies in children is increasing and their need for ongoing management in the long term after discharge from acute healthcare providers presents a significant financial and resource challenge to local healthcare systems. However, the absolute costs associated with the care of a gastrostomy in the community are not well defined with wide variation in estimates in published studies.

Objectives The aim of this study was to determine, at the individual patient level, the financial, out-of-hospital costs of maintaining a gastrostomy in a child for a year.

Methods A retrospective, bottom-up cost-analysis was conducted in a cohort of 190 patients with gastrostomies aged 0–19 years. One in five patients in the cohort were randomly selected, stratified by age in four five-year brackets, for individual cost analysis. For each patient selected, the electronic health record was interrogated to determine costs directly related to the maintenance of the gastrostomy from the period of 1st March 2019 – 1st March 2020. Costs included in the