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

1410

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

1411

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

Abstract 1411 Table 1 Total costs of maintaining a gastrostomy per patient per year by age group

Age Group (n)	Mean Costs (£SD)
0–4 years (9)	£525.44 (330.33)
5–9 years (13)	£867.05 (341.71)
10–14 years (9)	£551.55 (388.33)
15–19 years (5)	£918.18 (533.64)

analysis were: staff time for telephone calls and home visits from the community nursing and nutrition teams and equipment costs related to maintaining or replacing the gastrostomy device in use.

Staff costs were determined using midpoints of pay scales in the NHS Service Handbook and unit costs of equipment using rates negotiated by the local Clinical Commissioning Group.

Results The mean cost of maintaining a paediatric gastrostomy across all ages was £709.87 (SD 403.18) per year. Costs varied by patient age (table 1).

Button devices had much higher equipment costs than PEG tube devices with a Mini button device using £573.38 of consumables each year compared to £279.34 for a PEG. This was due to a combination of increased staff costs to change and maintain the device and increased disposables used in maintaining the device.

Conclusions The community cost of maintaining a gastrostomy in a child averages just over £700 per patient per year. The cost varies over time with peaks in early primary school age children and around the time of transition into adulthood. Button devices are more costly to maintain in the community than PEG tubes.

Quality Improvement and Patient Safety

1412

INCORPORATING PARENTAL CONCERN AS AN INTEGRAL ESCALATION ENTITY ON A PAEDIATRIC EARLY WARNING SYSTEM

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Background It is recognised that parents and carers are often able to identify deterioration in their sick child before healthcare professionals. This is especially true in children with complex medical needs. The Birmingham Women's and Children's Hospital Paediatric Early Warning System (PEWS) has had a section for parental concern since 2014. A review identified gaps in how this information was assessed, recorded and escalated.

Objectives Our objective was to enhance parental escalation in the PEW System using ergonomic principles.

Methods A comprehensive review in 2017 analysed data from incident reports and feedback from key stakeholders using parent focus groups and staff questionnaires, to identify system gaps. An ergonomist conducted clinical observation of the system in use and a review of the PEWS chart. Results were analysed by an expert group, including doctors, nurses, an

ergonomist and a graphic designer. We used the data to adapt and refine the process in which we would engage parents/carers. We also made ergonomic design adaptations to the chart.

Teaching of the adapted system was delivered to the majority of nurses before piloting was started on a mix of four medical and surgical wards for four weeks. Daily sense checks to these clinical areas were carried out. Feedback was actively sought and analysed. Results demonstrated that only minor refinements were required. The process and charts were then signed off at relevant Trust committees. Over 80% of front-line clinical staff were then trained before roll out in December 2019. Post roll out evaluation was also completed.

Results Pre intervention parental focus groups revealed that 59% of parents were asked about their opinion of their child's health. This increased to 76% post pilot and 72% post roll out. The new parent question 'How is your child different since I last saw them?' made 100% of parents feel able to escalate concern. This enabled 50% of parents questioned post rollout to escalate a deterioration they had recognised in their child. Post roll out 78% of nurses felt that asking parents this question made it easier to identify a deterioration and 50% of the 325 nurse respondents felt that asking the question had led to earlier detection of deterioration. Allied health professionals liked the specific condition checklist on the PEWS chart designed to improve situational awareness. Although universally welcomed by doctors of all grades, there were some apprehensions around changes leading to increases in unnecessary escalation. The results of the pilot were helpful in addressing these as no such increases were reported.

Conclusions Parental opinion is a key safety feature of our paediatric clinical systems. Through engagement of stakeholders and use of an ergonomic approach we have been able to safely adapt and embed this within our escalation systems to influence work as done.

We would like to thank the West Midlands Academic Health Science Network for funding this review.

RCPCH Trainees Committee

1413

PILOTING A VIRTUAL 'SAFE SPACE' FOR FACILITATED PEER SUPPORT DISCUSSION

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10.1136/archdischild-2021-rcpch.629

Background The COVID-19 pandemic has placed unprecedented stress on the healthcare system and the professionals that work within it. It is increasingly recognised that peer support helps to strengthen resilience for professionals working within stressful systems, whether in healthcare or in other industries. Models such as Schwartz rounds and Balint groups focus on emotional responses to pre-determined themes or participant-suggested clinical cases in a facilitated, supportive group discussion setting away from the clinical area. Both methods have been shown to improve staff wellbeing whilst preventing the development of 'burnout' in participants. However, the need for social distancing during the pandemic increased the difficulty of organising safe face-to-face group