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 PEDIATRIC EARLY WARNING SYSTEM

Mary Salama, Karl Emms, Alice Hemesley, Oliver Amber, Higgs Jane V, Valler-Jones Traey, Heather Duncan, Birmingham Women’s and Children’s Hospital; West Midlands Academic Health Science Network; University of Birmingham

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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 frontline 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 roll out 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 parents this 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.

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RCPCH Trainees Committee

1413 PILOTING A VIRTUAL ‘SAFE SPACE’ FOR FACILITATED PEER SUPPORT DISCUSSION

Sean Monaghan, Elizabeth Bryson, Andrew Phillips, Paul Nash. Birmingham Women’s and Children’s NHS Foundation Trust

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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