more commonly older, and from ethnic minority groups. However, the age and ethnic profile of all-cause child mortality during lockdown appeared similar to deaths pre-lockdown and in 2019. We also found little evidence of over-representation of children with underlying health conditions among children who died with the virus. More specifically, we noted:

- 1550 child deaths were notified between 23 March and 28 June 2020; 437 of which were linked to SARS-CoV-2 virology records

25 (5.7%) had a positive Polymerase Chain Reaction (PCR) result. PCR positive children were less likely to be white (37.5% vs 69.4%) and were older (12.2 vs 0.7 years) compared to child deaths without evidence of the virus.

Conclusions For the period studied, it is reassuring to note that there is no evidence of excess mortality of children from SARS-CoV-2. Furthermore, the apparent higher frequency of SARS-CoV-2 positive tests among children from Black, Asian and minority ethnic groups is consistent with findings in adults. However, ongoing surveillance is essential as the pandemic continues.

Quality Improvement and Patient Safety

1669

THE EVOLUTION OF THE QUALITY IMPROVEMENT FORUM

Stacey Harris, Yvette Cloete. *NHS*

10.1136/archdischild-2021-rcpch.785

Background Competence in Quality Improvement (QI) is an important skill for healthcare staff. It is part of the postgraduate curriculum and developing knowledge and skills in quality improvement empowers staff to change the systems in which they work, improve patient care and develop leadership skills.

Methods The QI forum is junior doctor led and is supported by a paediatric consultant and the health board QI team.

After initially starting as a 'junior doctor forum' taking place in the doctors mess on a monthly basis. It has now evolved through quality improvement methodology over a period of 18 months.

The three main phases were;

1. September 2019 – March 2020, An inclusive all health-care staff health board wide face to face all QI forum. This was advertised by the education department newsletter, Twitter, Posters around the hospital as well as word of mouth. The format was 1.5 hours lunchtime sessions, pizza was available, a 30 minute teaching on QI followed by an informal brainstorming around participants QI projects. The 6 week topic cycles included; introduction to model for improvement, understanding your system, generating ideas for change, testing your change and data visualisation.

With the Coronavirus pandemic the forum was cancelled for a period of 6 months

2. September 2020 – December 2020. Virtual health board forum. This was run using the same format as the face-to-face forum, was accompanied with a teams channel which included a database of ongoing QI projects, QI resources as well as signposting to further QI training.

The sessions were recorded so that staff unable to attend the session could catch up at their convenience.

3. Jan 2021 – present. A Paediatric departmental virtual forum was set up. The format included presenting two in progress QI projects. The session included interactive participation using mentimeter and google jam board to facilitate discussion amongst the team around the QI projects.

Results A total of 110 staff participated in the 11 forums which were run. Staff were from a mixture of medical and surgical specialities and included medical students, physician assistants, advanced nurse practitioners, consultants and junior doctors. There were six health board wide face to face forums, 3 health board virtual forums and 2 virtual paediatrics quality improvement forums. The number of people attending ranged from 0 to 22. The average number of people attending each forum was 10.

Feedback from staff included; appreciating the help with getting started with QI projects, the time to brainstorm their projects and gain input from people from other and their own specialities, they were able to find out about ongoing projects which that they had not previously known about, they loved the opportunity to use the interactive forum as a way to get feedback and problem solve their QI projects.

Conclusions The departmental paediatrics model could be spread to other departments in the health board. It has the advantages of being interesting and relevant to the staff participating enabling a higher quality of input and problem solving. The QI of the QI forum is ongoing.

Paediatric Educators' Special Interest Group

1670

EARLY EVALUATION OF A RE-DESIGNED MB CHB PAEDIATRIC COURSE USING PRACTICE ASSESSMENTS

¹Gareth Homfray, ¹Felicity Beal, ¹Emma Samouelle, ¹Phoebe Anderson, ¹Lucy Scales, ²Kirstin Dykes, ²Manimaran Jayamurthy, ²Harriet Nicholas, ²Melanie Dean, ²Abhishek Oswal, ¹Alison Kelly. ¹Bristol Royal Hospital for Children; ²South Bristol Academy, University of Bristol

10.1136/archdischild-2021-rcpch.786

Background A redesigned MB ChB Medicine course at the University of Bristol had its first intake of students in 2017 and its first paediatric placement in 2020. An identical paediatric Practice Objective Structured Clinical Exam (pOSCE) was included in the 2020–2021 redesigned paediatric course as was previously in the 2019–2020 course. This provided us with an opportunity to assess any difference in outcome of the new Case Based Learning course.

Objectives We evaluated whether the new redesigned, shorter (6-week versus 9-week) Case Based Learning paediatric course altered student performance in this identical pOSCE.

Methods We evaluated the pOSCE marks of year 4 MB ChB students at the end of their paediatric courses, following initial successful pilot of the formative assessment. The two pOSCE stations (A and B) were identical in 2019–2020 and 2020–2021 and each student's performance was examined using the same University structured mark scheme. The teaching fellow examiners were different in 2020–2021 and were blinded to the 2019–2020 student marks. We compared student marks of 2020–2021 to 2019–2020.

Results One pOSCE took place in 2019–2020, due to Covid interruption, assessing 33 students. To date, 61 students have sat the pOSCE in the 2020–2021 cohort. After incomplete mark sheets were excluded, our evaluation compared 27

Abstract 1670 Table 1

Mean Scores	2019–20	2020–21
Station A	79.4%	73.5%
Station B	76.2%	79.0%
Total	77.8%	76.2%
Global Assessment	73.9%	72.0%

pOSCE mark sheets from 2019–2020 with 49 from 2020–2021. The mean scores are outlined in the table 1 below.

Conclusions Our evaluation provided evidence that students' paediatric clinical performance was similar from both courses. Whilst this is reassuring, perhaps one aim of a redesigned course would be increased clinical performance. Maintained performance despite the shortened course may have been due to the introduction of regular bedside teaching on the 2020 course. Limitations of our study included OSCE limitations and small sample size. Keeping practice assessments unchanged when introducing new courses can facilitate early course evaluation. Shorter courses may not reduce clinical performance when well designed.

British Association of Child and Adolescent Public Health

1672 SOCIAL, PSYCHOLOGICAL AND NEURODEVELOPMENTAL RISK FACTORS AND ROAD TRAFFIC ACCIDENT'S INVOLVING YOUNG PEOPLE

Christopher Evans, Zahra Sarwar. *King's College Hospital*

10.1136/archdischild-2021-rcpch.787

Objectives Young people aged 16–24 are at increased risk of serious injury from a road traffic accident (RTA). Studies often examine young people's 'risky' driving behaviours as risk factors for RTAs. However, few explore social, psychological and neurodevelopmental factors that may lead young people to engage in 'risky' behaviours.

This study sought to examine the relationship between RTA's, injuries sustained, and pre-existing social, psychological and neurodevelopmental risk factors. It was hoped a clearer understanding of risk factors can inform support practices, with a view to decreasing behaviours that can cause life-changing injuries.

Methods 16 people (88% male) admitted to hospital following an RTA took part in this study. Ages ranged from 15 – 22 ($M = 18.63$, $SD = 2.30$). A youth worker used a questionnaire to explore their social, psychological and health history. Each interaction was coded for number of pre-existing social, psychological and neurodevelopmental risk factors (identified by RCPCH (2020) and Gicquel et al. (2017)). Injuries and whether a helmet was worn at time of RTA were also recorded. Excel was used to examine data.

Results Table 1 shows that being 'expelled, suspended from, or did not finish school' was reported significantly more than any other risk factor. Number of risk factors for each person ranged from 0 – 6 ($M = 2.31$, $SD = 1.66$). Additionally, 50% of those riding motorbikes, bicycles or scooters were not wearing a helmet at time of accident.

Abstract 1672 Table 1 Reported pre-existing risk factors

Police involvement or anti-social behaviour	13%
Substance misuse	13%
Neurodevelopmental or learning difficulty	25%
Physical or emotional abuse	18%
MH or behavioural difficulties	31.30%
Expelled/suspended from or did not finish school	63%

A Pearson correlation revealed a moderate positive relationship between number of pre-existing risk factors and number of injuries sustained, however this was not significant with $r(14) = 0.35$, $p = 0.18$. Mean number of risk factors reported by those who were 'expelled, suspended from, or did not finish school' ($n = 10$, $M = 3.30$, $SD = 1.06$) was higher than for those who did not report this ($n = 6$, $M = 0.66$, $SD = 1.03$). The difference between means was significant, $t(14) = 4.86$, $p < 0.001$. The mean number of injuries sustained by those who were 'expelled, suspended from, or did not finish school' ($n = 10$, $M = 3.10$, $SD = 1.85$) was also higher than those sustained by patients who did not report this ($n = 6$, $M = 2$, $SD = 1.55$). However, this difference was not significant, $t(14) = 1.22$, $p = 0.12$.

Conclusions A high proportion of RTA's appear to involve young males and those expelled, suspended from, or not finishing school. The latter cohort seem to have a higher number of other pre-existing risk factors, whilst their RTA's may be more severe. This study demonstrates the necessity to recognise pre-existing risk factors that can increase risk of RTA's and calls for a holistic approach to managing the educational and behavioural needs of young people if we are to decrease risk of RTA's.

Paediatric Educators' Special Interest Group

1673 THE COVID-SAFE OSCE: INTRODUCING A NEW VIRTUAL OSCE INITIATIVE FOR PAEDIATRIC UNDERGRADUATES

¹Anna Burford, ²Anna Howells, ¹Kate Quinan, ³Sebastian Casalotti, ¹Camilla Sen, ¹Yasmin Baki. ¹University College London Hospitals; ²Whittington Hospital; ³University College London

10.1136/archdischild-2021-rcpch.788

Background The Objective Structured Clinical Examination (OSCE) is a widely used assessment tool used to evaluate the clinical and practical skills of UK medical students. It has been shown that participating in a mock OSCE can benefit students by reducing anxiety and increasing confidence in their summative assessment (Robinson et al, 2017). The current COVID-19 pandemic has made traditional face-to-face learning events, such as mock OSCEs, unviable and opens the door to online initiatives that effectively substitute in-person teaching.

Objectives We set out to design and run a novel, peer-led virtual OSCE experience for paediatric undergraduate students. Our aim was two-fold. First was to produce a viable and reproducible way of running an online mock OSCE which provided our students with a simulation comparable to an in-person session. Second, was to develop this session using feedback from students about the design and content with an aim