To improve these rates we devised change ideas:

- screening questions co-designed with parents,
- '123 fight inequality' leaflets of practical resources co-produced,
- presentations and workshops with local parents who had suffered hardship.

Despite these and regular communications to staff, poverty screening rates worsened during the pandemic. In October 2020 we re-launched Connected Communities (CC) and the provision of support workers within the hospital. Staff reported feeling empowered knowing that practical help would be given. A poverty screening guideline was drafted with case studies and recommended screening using framing like:

'Since the pandemic we know more parents are finding it difficult to pay bills/debts, afford food or find employment, - do you?' Or asking 'do you worry that your housing is affecting your child's health?' We delivered teaching together with CC support workers in February 2021.

In March 2021, 43% of doctors and nurses surveyed reported they had screened the last patient they saw; 79% were aware of resources and; 67% had signposted someone to help in the last 3 months. From zero introductions to Connected Communities in October 2020, a staggering 95 parents have been screened and recommended to contact our support workers. Only 23 have engaged so far and they have received help with housing, finances/benefits and citizenship. Ten do not speak English but will be supported to access advice.

Conclusions

Tackling health inequalities takes commitment By seeing, screening and intervening, we help reduce stigma and identify vulnerable families. Our close partnership with Connected Communities increased staff confidence and increased introductions. More work is needed to determine why only 23/95 parents take up the offer but language barrier, parental expectations or clerical factors may contribute.

British Association of General Paediatrics

1769

VIRTUAL ART THERAPY: MEETING THE PSYCHOSOCIAL NEEDS OF CHILDREN AND YOUNG PEOPLE WITH A LONG TERM HEALTH CONDITION DURING THE COVID-19 PANDEMIC

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Background Children and young people (CYP) with a long term condition (LTC) are known to have increased psychosocial needs. This is also true for siblings of CYP with a LTC.

The current COVID-19 pandemic has had an adverse impact on the psycho-social wellbeing of CYP, especially those with a LTC and their siblings. This has resulted in an increase in demand for psychosocial support which has presented a challenge as to how these needs might be met.

During the pandemic, a Children's Hospital, in partnership with Teapot Trust (a charity providing art therapy) offered a virtual art therapy intervention to CYP with chronic kidney

disease in order to support their psychosocial needs. The art therapy was delivered virtually via Zoom.

Objectives To explore the feasibility and effectiveness of delivering a virtual art therapy intervention and measure the impact of the intervention on Children and young people psychosocial wellbeing

Methods The hospital MDT identified and shared referrals with the Teapot Trust art therapist. CYP completed a Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) survey at the start and end of the intervention to assess impact on psychosocial wellbeing.

From August – December 2020: 8 CYP (aged 6–14 years) received virtual art therapy support. Sessions were either delivered 1:1 (N=4) or group (N=4). The art therapist delivered the therapy via Zoom. All CYP received an individual art resource pack. Youth workers participated in sessions where considered helpful. CYPs needs were identified at their initial session and a support plan put in place. Progress was reviewed after 8 weeks and sessions extended if needed. At the end of the intervention CYP also completed an enjoyment feedback form. Parent's feedback about their child's well-being and enjoyment was collected at the end of the intervention.

Results The CYP received a mean of 8 (range 6 – 18 weeks) sessions.

CYP:

N=8. 87.5% (N=7) completed the WEMWBS survey. Average WEMWBS score increased from 82.7 (high) at baseline to 91.3 (high) post intervention which is a positive change across the whole group.

All 100% (N=7) showed improved self-esteem, improved mood, increased energy and motivation, and increased relaxation.

Parent feedback:

62.5% (N=5) completed the feedback forms. 100% (N=5) responses were positive.

CYP said 'it helped me understand all those feelings that were hidden for such a long time.'

Parent feedback 'the difference in R's mental health from when she started the art therapy and finished was like night and day'..... 'being very proactive in her own self-care, seemed happierextremely pleased with the result'.

Conclusions

Delivery of a virtual art therapy intervention appears to support improvement of the psychosocial wellbeing of CYP. More research is needed to assess the effectiveness of virtual art therapy.

Paediatric Educators' Special Interest Group

1770

INCREASING CONFIDENCE IN USE OF ULTRASOUND GUIDED INTRAVENOUS ACCESS (US IVA): IMPLEMENTATION OF A PILOT PROGRAMME IN A TERTIARY CHILDREN'S HOSPITAL

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Background Establishing peripheral intravenous access (IVA) in children forms a significant constituent of clinical activity in

both the emergency department and inpatient setting. Advances in neonatal care and survival, the revision of neonatal guidelines on the management of extreme prematurity, and increasing prevalence of childhood obesity, mean that securing peripheral IV access in children is likely to become more common and challenging. Additionally, multiple failed cannulation attempts can cause pain and emotional trauma to both children and their parents, in addition to the significant time burden to clinicians.

Ultrasound guided intravenous access (US guided IVA) has the potential to improve patient care by enabling quicker and more reliable IV access. Improvements in US technology are making portable, user-friendly and affordable equipment readily available. Growing evidence suggests US guided IVA creates longer lasting, high quality IV access with fewer attempts, and is overall quicker.

Objectives Make US guided IVA a readily available option to all children in our institution, by designing a teaching programme to upskill paediatricians and allied healthcare professionals to obtain US guided IVA in children.

Methods This was a Quality Improvement project, following the established plan-do-study-act (PDSA) model. All stakeholders at our tertiary children's hospital were invited to conduct an anonymous online survey. Results outlined:

- Current practice of US guided cannulation
- Frequency in difficulty of obtaining IVA
- Identify the knowledge base regarding operating US, ability to recognise vessels, and insert an US guided peripheral venous cannula
- Ascertain demand to learn this procedure among stakeholders.

Results The initial survey was completed by doctors from a range of paediatric specialty and grades, paediatric specialist nurse practitioners and advanced nurse practitioners (n=57). 53% had had only one previous teaching session on US guided IVA and the rest had had more than one session. 74% were extremely interested in teaching to improve this skill. 75% reported being asked to do a 'difficult' cannula once a week or more. The average number of 4.5 times before escalating to an anaesthetist.

41 stakeholders attended one teaching session during the pilot programme. The post-session feedback for the pilot cycle was very positive with 51% rating the session 10/10. Stakeholders who attended sessions felt on average, more confident in use of US and inserted US guided IVA after the session [figure 1]. Points for improvement included increasing the quality of models, increased session time and repeat sessions. Additionally, the focus group had to adapt the programme to external factors due to the COVID-19 surge, this included rescheduling the sessions, rearranging groups into smaller sizes and gaining approval by the hospital education team.

Conclusions We have shown both a demand and a need to upskill paediatric healthcare staff in US guided IVA. Our pilot programme, having adapted to COVID-19 hospital pressures has successfully delivered teaching that has increased stakeholder confidence in this skill. The subsequent PDSA cycle will now aim to upsize the programme delivery to ensure all eligible hospital staff have the opportunity to attend as well as guide further focus group discussions on planning US-guided PICC training.

Quality Improvement and Patient Safety

1775

DEVELOPMENT OF A NATIONAL HUB FOR REVIEWING AND LEARNING FROM THE DEATHS OF CHILDREN AND YOUNG PEOPLE IN SCOTLAND

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Background Scotland has a higher mortality rate for under 18s than any other Western European country. Of the 300 children and young people who die annually, approximately a quarter could be prevented. There is currently no national system to support review or to share national learning, and not all deaths are reviewed. The quality of reviews varies across services and Scotland.

Healthcare Improvement Scotland and the Care Inspectorate co-host the National Hub for Reviewing and Learning from the Deaths of Children and Young People.

Objectives The National Hub aims to ensure that the death of every child in Scotland is subject to a quality review by:

- developing a methodology and documentation to ensure all deaths are reviewed through a high quality and consistent process
- improving the quality and consistency of existing reviews
- improving the experiences of and engagement with families and carers, and
- channelling learning from current review processes across Scotland that could direct action to help reduce preventable deaths.

This programme reflects the commitment to fostering a learning system that increases safety and quality improvement amongst services by:

- supporting individuals to learn through its culture and networks
- ensuring everyone is informed by evaluation and reflective practice
- enabling people to assess what is and is not working through the use of qualitative and quantitative data, stories and insights
- developing processes to aid decision-making and turn knowledge into action
- building systems to identify 'bright spots' and generalisable learning, and
- linking with rUK systems to allow a four nations approach to child death reviews.

Methods We have worked collaboratively with stakeholders to support implementation of a national child death review process, which will launch during 2021. This includes:

- establishing an Expert Advisory Group to provide an advisory role through expert (including clinical) input
- developing national guidance that sets out the process for NHS boards and local authorities to follow when responding to, and reviewing, the death of a child or young person
- developing a core review data set and online portal for collating data, and