murmur clinic appointment or after discharge from the murmur clinic.

Conclusions The provision of a registrar-led murmur clinic is a safe and effective screening tool for babies with a murmur. Following senior review all babies with murmur on the postnatal ward can therefore be safely discharged home in the first 24 hours after birth. In the absence of registrar availability, this screening clinic could be led by a general paediatrician or neonatologist. We have shown that this model can lead to a reduction in the number of babies requiring an echo by over two thirds. The introduction of echocardiography performed by the echo technician can further improve the waiting time for an echo.

We aim to improve neonatal trainee awareness of details of the pathway to ensure babies are discharged early from the postnatal ward with murmur clinic follow up, and that the echo technician appointments are utilised appropriately.

British Association of General Paediatrics

661 IDENTIFYING CHILDREN 'MISSING' DURING UK COVID-19 LOCKDOWN: A RETROSPECTIVE COHORT STUDY (2015–2020) OF OXFORDSHIRE ED ATTENDANCES AND INPATIENT DIAGNOSES

¹James EG Charlesworth, ²Rhian Bold, ²Rani Pal. ¹Paediatric Department, Horton General Hospital, Oxford University Hospitals NHS Foundation Trust; ²Oxford University Hospitals NHS Foundation Trust

10.1136/archdischild-2021-rcpch.127

Background On 23rd March 2020, the UK 'stay at home' order heralded the first national lockdown, lasting 7-weeks. Dramatic reductions of paediatric attendances/admissions were noted nationally and internationally, with concerns surrounding diagnosis which may be missing from secondary care.

We conducted a systematic review on 9th January 2021, searching PubMed for 'COVID', AND 'lockdown', AND 'paediatric' OR 'children', AND 'attendance' OR 'admission', in all languages using MESH terms. This identified n=41 primary articles exploring paediatric healthcare usage during a lockdown period. These covered Europe, Brazil, USA, Canada, Iran, and India. 44% examined ED settings only; 49% reported on admissions for a single disease or specialty; only 2 examined all inpatients.

No previous study has explored the changing patterns of diagnoses amongst all paediatric inpatients during a lockdown period, compared to historical years.

Objectives To establish the changing patterns of ED attendance and inpatient diagnoses across two Oxfordshire hospitals during the first COVID-19 lockdown in 2020, compared to five historical years (2015–2019).

Methods We retrospectively reviewed anonymised electronic records for all ED attendances and inpatients aged 0–15 years, across two Oxfordshire hospitals providing secondary and tertiary care services. Discharge ICD-10 coding were analysed to identify significant differences in lockdown inpatient diagnoses, compared to a matched 7-weeks in 2015–2019 (Mann-Whitney U test, admissions-per-week).

Results During the first 2020 lockdown period, 2,843 diagnoses were associated with 1,416 admissions (mean 4.81 diagnoses/patient), compared with 12,458 admissions and 19,946 diagnoses across matched dates 2015–2019 (2.97 diagnoses/

patient). Lockdown ED attendances (n=4030) and admissions (n=1416) were reduced by 56.8% and 59.4%, respectively, compared to 2015–2019 (mean n=7446.8 and n=2491.6, respectively). Proportions of admissions from ED and patients' subsequent length of stay were similar across all years. Reductions in hospital admissions were highest in 1–5-year-old (age <1 =48.4%, 1–5 =67.2%, 6–10 =53.3% and 11–15 years =48.9%).

We categorised diagnostic codes significantly reduced during lockdown ('missing') compared to 2015–2019: 80% were infectious diseases or their sequelae; non-specific pains/aches/malaise (11%) and accidental injury/poisonings (9%) accounted for the remaining 20%. Categories with increased diagnoses (24% of lockdown diagnoses) were 'related to pandemic screening', 'incidental finding/co-morbidity' and 'other diagnoses'. We also found significantly greater numbers of neoplasms (benign and malignant) diagnosed during lockdown (p=0.0123).

Conclusions Pandemic measures and messaging are altering paediatric disease presentation. Our study confirms large reductions in paediatric ED attendances and inpatient admissions during the first national lockdown, raising concerns of vulnerable children 'lost' to secondary care.

Our assessment of 'missing' paediatric diagnoses uses internationally comparable ICD-10 codes. We therefore postulate that the 80% of infection-related diagnoses 'missing' during the lockdown period are driven by a combination of stringent infection-control measures, parents/carers management of mild/self-limiting disease at home, and/or increased anxiety surrounding hospital attendance. As 20% were non-specific or accidental injuries, we remain concerned about significant disease with late presentations or patients with safeguarding concerns who may not be brought to hospital, amongst these patients.

Prospective studies are necessary to establish whether parents/carers are adequately supported, have adequate contact with health professionals and feel empowered to use referral pathways for hospital review.

British Association of Perinatal Medicine and Neonatal Society

665 DOES THE HOSPITAL OUTCOME OF BABIES (≥30 WEEKS) BETWEEN INBORN AND OUT BORN DIFFER? A SERVICE EVALUATION

¹Fiona Pittman, ¹Swathi Gunti, ²Prakash Loganathan, ²Prashant Mallya. ¹LET North East; ²South Tees Foundation Trust

10.1136/archdischild-2021-rcpch.128

Background There has been less research into neonatal outcomes of those ≥30 weeks gestation, who could be cared for in a Level-1 unit. Additionally, the Northern Neonatal Network is unique due to the fact it does not contain Level-2 units.

Objectives Describe the characteristics and outcomes of babies (≥30 weeks) born in Level-1 transferred out for intensive care (out-born) compared with babies born at similar gestation born in level-3 (inborn).

Methods This retrospective study was conducted in a regional level-3 unit, with nine Level-1 units in the region. Using the

neonatal database, babies (≥ 30 weeks) born in the year 2019 were identified. This included all inborn and out-born babies transferred to the Level-3 unit for ongoing intensive care. Eligible babies were categorised into two groups based on preset criteria: 'definitely needing intensive care' (e.g., HIE, PPHN) and with diagnosis of 'respiratory distress needing intensive care'. All the data were presented as percentages or median with inter-quartile range (IQR). We used Chi-square for categorical variables and Mann Whitney test for continuous variables (SPSS). The project was registered with local hospital authorities for service evaluation.

Results During the study period, there were 78 out-born babies from Level-1 units. After excluding 34 preterm <30 weeks and 15 classified as 'definitely needing intensive care', 29 babies transferred for 'respiratory distress needing intensive care' remained. There were 154 inborn babies after excluding 22 babies 'definitely needing intensive care', 132 inborn babies were admitted for respiratory distress. 29 out-born and 132 inborn babies with similar diagnoses were analysed (table 1).

Median time of transfer for out-born babies was 9hrs 12mins (IQR 5.5–22hrs).

Subgroup analysis of babies >30 –34 weeks gestation, except for difference in need for mechanical ventilation (18.5% vs 69%, $p<0.001$) and duration of mechanical ventilation (median 0 vs 1, $p<0.001$), there was no difference in other factors between the two groups.

Limitations included the heterogeneousness of the admission diagnosis.

Conclusions Out-born babies had higher odds of needing mechanical ventilation, developing pneumothorax, longer duration of hospital stay and longer time to reach full enteral feeds as compared to inborn babies in the Level-3 unit. The next steps are to compare the clinical characteristics of babies born in Level-1 units who were transferred out compared to those who remained in these units.

Abstract 665 Table 1

	Inborn N=132	Out-Born N=29	Statistics
Birth Gestation	35 (32.5–38)	36 (33–37)	0.15
Birth Weight	2540 (1770–3230)	2260 (1860–3210)	0.43
Male	81 (61%)	18 (62%)	0.94
Any Antenatal Steroids	64 (48.5%)	24 (83%)	0.001
C-section (Elective/Emergency)	103 (78%)	23 (82%)	0.81
Apgar Score at 5 min	9 (8–9)	9 (8–9)	0.47
Intubated at birth	5 (3.8%)	3 (10%)	0.16
CPAP duration	1 (1–2)	2 (0–3)	0.96
Pneumothorax	1 (0.8%)	6 (21%)	<0.001 Odds ratio: 34 (4–297)
Need for Mechanical Ventilation	15 (11.4%)	18 (62%)	<0.001 Odds ratio: 12.7 (5.1–32)
Duration of Mechanical Ventilation	0	1 (0–2)	<0.001
Day of Full Enteral Feeding	2 (1–4)	3 (2–6)	0.001
Duration of stay at Level 3 unit	8 (3–20)	6 (4–8)	0.24
Total Duration of Hospital Stay	8 (3–20)	10 (7–20)	0.01

Association of Paediatric Palliative Medicine

666

CARING ABOUT DEATH – PAEDIATRIC PALLIATIVE CARE SIMULATION COURSE

¹Ashish Patel, ²Annabel Copeman, ³Laura Roe, ²Stephanie Friedl, ²Sara Eacopo, ²Lucine Nahabedian, ²Ashley Holt. ¹Birmingham Women's and Children's NHS Trust; ²The Royal Wolverhampton NHS Trust; ³Royal Stoke University Hospital

10.1136/archdischild-2021-rcpch.129

Background Paediatric palliative care is a growing sub-speciality within paediatrics. Within England, 70% of child deaths are from complex chronic illnesses that are life limiting, and the number of children living with these diseases is increasing.

There is a significant lack of education on paediatric palliative care for trainees in the UK. Simulation-based education could help healthcare professionals practice communication skills and management of palliative patients in safe learning environment.

Objectives I designed a simulation-based course aimed at teaching our trainees about paediatric palliative care for our region. The course learning objectives were mapped to the Royal College of Paediatrics and Child Health palliative care curriculum, as well as taking the feedback from senior trainees following a survey monkey questionnaire.

The course focused particularly on symptom management, decision making with regards of care towards the end of life, managing sensitive and complex palliative care situations, bereavement care and practical palliative care skills like prescribing and advanced care planning.

Methods We have delivered a full day course at the high fidelity simulation centre at New Cross Hospital. Give the sensitive nature, the course was aimed at senior paediatric trainees (ST4–8). As palliative care is a multidisciplinary speciality, senior nurses were invited to attend also.

The course focuses and follows the journey of a child who died from a life limiting condition, using a patient story which has been filmed to provide a parent perspective.

The course was facilitated by simulation faculty as well as paediatricians and nurses expert in paediatric palliative care. The scenarios involved a trained actor playing a simulated patient or family member. Feedback was obtained from candidates using pre and post course questionnaires which included free text comments and Likert scale questionnaires to measure confidence.

Results So far, 21 (85% trainees, 15% nurses) candidates have attended our paediatric palliative care courses since January 2020, one happening face to face and the other virtually. 100% of candidates felt the course met their learning objectives. All candidates rated the patient story was useful to understand more about palliative care. There was an increase in confidence intervals across all domains, with the highest changes noted for how to set up a syringe driver and prescribing drugs at the end of life. Candidates commented on an 'excellent combination of scenarios, teaching and practical sessions', with the patient story 'putting a personal face, and providing a vital parent perspective'.

Conclusions Our paediatric palliative care course is new and novel way of educating our trainees and nurses about palliative care. The course has been adapted successful to a virtual platform with the current global pandemic, not losing any vital learning for our region. We aim to continue running our course three times a year. We also hope to work