Conclusions Wellbeing is multi-faceted and as such is difficult to measure. We have measured markers for engagement in our project rather than wellbeing per se.

There was a low response rate to our survey, though those who did respond were very positive. This is likely to be a confounding factor of the motivation of responders being those who are 'engaged'. From the survey results we have reduced the frequency of emails to weekly, and have acted on suggestions for content.

Overall our project has been well received and has raised the importance of staff wellbeing within our department.

Quality Improvement and Patient Safety

671 LEARNING FROM DEATHS – STILLBIRTHS, CHILDREN AND YOUNG PEOPLE

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Background Structured judgement reviews (SJR) are designed to help acute hospitals learn from retrospective mortality reviews. *'The process ensures a traditional, clinical-judgement review method but in a standardised format with a view to identify and make improvements in quality of care.'*¹

Trained reviewers score six phases of care from admission to end-of-life care. They also make explicit written comments about care for each phase. At the end of the review, a subjective 'avoidability of death judgement score' is made, the scoring system is as follows:

- Score 1 definitely avoidable
- Score 2 strong evidence of avoidability
- Score 3 probably avoidable (more than 50:50)
- Score 4 possibly avoidable but not very likely (less than 50:50)
- Score 5 slight evidence of avoidability
- Score 6 definitely not avoidable

*'The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.'*¹

The trusts 'Learning from Deaths Policy' mandates that all deaths amongst children, young people, 16–25 year olds and stillbirths undergo an SJR.

Aim To highlight learning from avoidable and unavoidable deaths amongst stillbirths, children and young people <25 years old, over an 18-month period across the trust.

Methods Review cases that underwent a SJR, over an 18 month period from July 2017 – December 2018. The trust SJR secure database was used to capture the data. In cases where the 'avoidability of death score' was 3 or less i.e.

suggesting the death may or was avoidable – the cases were reviewed in detail. In cases where the 'avoidability of death score' was 4 or above, the recommendations and key learning points were reviewed.

Results 3154 cases underwent a SJR. 171 deaths occurred in the sub-group we analysed. The structured judgement of avoidability of death in the cases are detailed below:

Conclusions The data seemed to mirror itself – problem areas identified in avoidable cases, scoring 1–3, conversely were highlighted as areas of good care in unavoidable deaths, scoring 4–6. These areas have been stratified into two key themes with learning points highlighted below

- Patient assessment and management:
 - Know and use local guidelines
 - Identify and respond to problems early
 - Involve seniors
 - Involve the multidisciplinary team
- Communication:
 - Adequate documentation
 - Clear communication
- Of results
- Overcoming 'language barriers'
- With patient and family regarding problems
 - Parental involvement, discussion and support
 - Future planning

REFERENCE

1. Royal College of Physicians. Using the structured judgement review method - A guide for reviewers. England: RCP, 2016.

Association of Paediatric Emergency Medicine

672 PAEDIATRIC CARDIAC ARRESTS – A DESCRIPTIVE AUDIT REPORTING CARDIAC ARRESTS PRESENTING TO A TERTIARY PAEDIATRIC EMERGENCY DEPARTMENT

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Background The 2018 Out-of-Hospital Cardiac Arrest Outcomes Registry saw 530 paediatric Out of Hospital Cardiac Arrests (OHCAs) in England, with a survival to discharge rate of 12.1%. It is widely reported that paediatric OHCAs have poor outcomes, with downtime being a strong prognostic determinant for survival to discharge. This audit will retrospectively describe local patients attending a tertiary paediatric emergency department (ED) presenting after undergoing a cardiac arrest between 2015–2020.

Objectives

SJR Score:	1	2	3	4	5	6	Total Number of Deaths
Avoidable:	Definitely avoidable	Strong evidence avoidable	Probably avoidable	Possibly avoidable	Slight evidence avoidable	Definitely not avoidable	
Stillbirths	-	1	4	3	8	49	65
Neonates	1	-	-	2	7	46	56
Paediatrics	-	-	-	1	2	29	32
16–25	-	-	1	-	1	16	18