

Abstract 246 Table 1 Describes change in key health measures. 40% of CYP and 43% of parents reported a deterioration in mental health but only 6 families accessed emotional support groups

	Better	Same	Worse	n/a
CYP Mental Health	13%	47%	40%	
Parent Mental Health	8%	49%	43%	
CYP Physical Health	19%	48%	33%	
Parent Physical Health	9%	59%	32%	
CYP exercise	8%	33%	56%	3%
CYP sleep	7%	50%	43%	
Finance	4%	55%	41%	
Housing	4%	83%	13%	
Employment	0%	63%	37%	

social and health needs of this population and shape our future service.

Methods A questionnaire was designed and piloted with two parents. The sample was non-random/convenience sampling taken from a contact list of CYP with SEND who were shielding or considered vulnerable. Participants were informed this was part of a service evaluation and consented to be interviewed. A total of 75 telephone interviews were conducted. The council completed 46 questionnaires and in October 2020 the medical team attempted contact with a further 94 families. 46 families answered the telephone and 29 agreed to complete the questionnaire. Ethics was not sought as it was a health service evaluation.

Results The participants children were between 0–19 years with the majority (40%) between 5–9 years. 89% of the sample was BAME. 55% of the school-age children were eligible for a school place during lockdown however only 21% of these opted to attend school. Parents cited reasons for not attending school as shielding, fear of COVID-19 and lack of equipment.

The most common services accessed were primary care, specialist services (eg child development centre) and food banks. Of the 27 families describing worse employment situation, only 1 accessed the jobcentre. Of the 31 families with worse financial situation 15 accessed the food bank and 1 accessed the Citizens' Advice Bureau.

Conclusions Further exploration is required with validated measures to understand the impact of the pandemic and of associated interventions (eg lockdown) on health and mental health in particular. Our survey shows that emotional and financial services were not widely used despite the difficulties many faced. Signposting families to these services is being prioritised in our clinical interactions and through development of a social prescribing model. More in-depth qualitative research is planned on this population exploring the interplay between social determinants and COVID in CYP with SEND and their families.

248

VALIDITY OF AN IVH AND PVL PREVENTION BUNDLE INTERVENTIONS IN A CENTRE WITH A VERY LOW INCIDENCE OF SEVERE IVH: A CASE-CONTROL STUDY

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Background Severe intraventricular haemorrhage (IVH, Papile's Grades 3 and 4) can cause significant neurodevelopmental impairment in 43% of affected infants.

Objectives The objectives of this study were to study the risk factors for severe IVH and evaluate the validity of an IVH prevention bundle in VLBW infants in a tertiary care centre with very low incidence of severe IVH.

Methods All VLBW infants born between January 2013 to December 2018 were included in the study. Data was collected from a prospectively maintained database and retrospective chart review. For each severe IVH infant (study group), 2 IVH-free infants were identified as control and were closely matched for birth weight (± 100 g) and gestational age (± 1 week). Eighteen risk factors studied under severe IVH review document and six risk factors explored under interventions were combined, edited for overlaps or repeats and compared between the two groups. Bundle of interventions to reduce severe IVH included 1) Neutral head position and developmental care (2012); 2) Optimising the time of administration of antenatal steroid to mothers at risk of preterm birth at ≤ 24 weeks gestation by administering the drug at least 48 hours before the delivery (2014); 3) Antenatal magnesium sulphate administration for neuroprotection to mothers in preterm labour with foetus of ≤ 32 weeks gestation (2015); 4) Protocol for prevention of hypothermia in newborn infants (2016); 5) Patent ductus arteriosus (PDA) management protocol featuring early selective treatment of high-risk infants (2016); and 6) Prophylactic indomethacin for IVH prevention guideline (2016, modified in 2017). Univariate and multivariate analysis were conducted.

The bundle was defined as valid, if there was a statistically significant difference in incidence of corresponding risk factors between the 2 groups and $\geq 50\%$ reduction in incidence of severe IVH in the post-intervention period. The stratified yearly incidences of IVH were captured.

Results 1261 VLBW infants were born during the study period and 48 (3.8%) infants developed severe IVH with 96 matched infants identified as controls. Baseline maternal and infant characteristics were comparable. The incidence of severe IVH was 6.2% and 1.9% in the 2012 and 2018 cohorts respectively. On univariate analysis, maternal tocolytic therapy, difficult resuscitation at birth, difficult procedures, hypercapnia, high-frequency oscillatory ventilation and, multiple inotropes for hypotension during the first week of life were found to be statistically significant. Multivariate analysis revealed tocolytic therapy (OR 0.26, 95% CI, 0.10 - 0.66) to be an independent protective factor whereas delivery room intubation (OR 8.77, 95% CI, 1.10 - 70.06) and multiple inotropes (OR 2.32, 95% CI, 1.44 - 3.76) were significant risk factors for severe IVH.

Conclusions The IVH prevention bundle interventions were found to be valid and the bundle model can be replicated to reduce the overall incidence of severe IVH in VLBW infants to less than 2%.

249

DOES THE 'CRIB II' SCORING SYSTEM SCORE WELL IN MORTALITY RISK PREDICTION IN INDIA?

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Background Introduction: