benefits and a comparison with alternatives such as non pharmaceutical interventions or extra adult vaccinations require assessment. The programme should be voluntary, cause least disruption to education and protect and honour public trust.

Valid consent would require a factual, culturally sensitive, age appropriate explanation of risks and benefits of vaccination/non-vaccination. Young people between 16 and 17 could give their own consent; parents would consent for younger children.

Results

Argument for vaccination: Children and young people have already suffered significant losses due to the pandemic in terms of interrupted education, social contact, safeguarding and mental health support. COVID has become a major driver in increasing health inequalities in this group. It is therefore in their interests to maintain school attendance.

Vaccination could reduce transmission of infection between students and education staff. This, coupled with other measures, could ensure that school/education settings remained open. Young people aged 16–17 may wish to express their autonomy to be vaccinated making altruistic choices to protect their families or wider community or to allay their own anxiety.

Argument against vaccination: In terms of national equity, the direct benefit of the vaccine to individual healthy children is minimal. As with all vaccination programmes, benefits, uncertainty and risks such as side effects would need factual, balanced information in order to allow informed decision making. Adverse experiences could impact vaccine confidence and trust in health professionals more generally.

Vaccinating younger children would require more specialised services than currently required for adults. This could adversely affect other routine child health and immunisation programmes, especially those based in schools.

In terms of global equity, the moral aspects of vaccine supply to countries most adversely affected by the pandemic require international political co-operation and are outside the scope of this paper.

Conclusions This decision is finely balanced. It depends on timing and dynamics of COVID infection in UK. It is important that alternatives to mass child vaccination are fully assessed before decisions are made.

Public attitude to personal risk and common good is, and always has been, vital to the success of the programme. The opinions of young people are especially relevant and should be actively sought.

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PREVALENCE AND SOURCES OF TENSION IN PAEDIATRIC INPATIENT CARE

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Background Rising numbers of children with medical complexity and the availability of life-sustaining treatments engender challenging decisions and opportunities for conflict. Conflict results in relationship breakdown, detrimental impacts on

family and staff wellbeing, and suboptimal patient care. The prevalence of conflict in paediatric inpatient settings remains poorly described.

Objectives To report the prevalence of conflict in a large UK children's hospital, as part of the wider term 'tension', which also encompasses the themes of ethical dilemmas, end-of-life issues and unresolved safeguarding concerns.

Methods Prospective twice weekly survey to medical and nursing teams in a 12-ward tertiary children's hospital, over a 4-week period, to identify presence and sources of tension in patients admitted for ≥ 5 days. Sources of tension were devised via a multidisciplinary focus group. Baseline clinical data were extracted from electronic patient records.

Results 153/1295 children (median age 5 years) had an admission of ≥ 5 days. Patients had a median of one co-morbidity (IQR 2, range 0–9) with tube feeding requirement, global developmental delay/learning disability and neurodisability most common.

Of the 153 patients, 65 (42%) had one or more sources of tension identified; 40 (26%) staff-staff conflict, 19 (12%) staff-family conflict, 28 (18%) unresolved safeguarding, 23 (15%) ethical and 8 (5%) end-of-life issues.

The most common reasons for staff-family conflict were 'unrealistic expectations/excessive healthcare demands' (20/40, 50%), 'communication breakdown' (19/40, 48%) and 'treatment disagreements' (12/40, 36%). 'Multiple team involvement with no clear plan' was the most common staff-staff conflict reason (9/19, 47%). Ethical matters centred on therapeutic misalliances, such as ceiling of care decisions (7/23, 30%) and parental refusal of recommended interventions (6/23, 26%); no cases were forwarded to our Clinical Ethics Advisory Group. Only 1/8 noted to have anticipated end-of-life issues by healthcare staff had active palliative care involvement.

31/65 (48%) had multiple sources present; commonest co-existing themes were staff-family conflict and staff-staff conflict.

Presence of any source of tension was associated with longer duration of admission (≤ 30 days: OR 6.04, 95% CI: 2.3 to 15.6, $p < 0.001$) and increased number of co-morbidities (≥ 4 co-morbidities: OR 2.34, 95% CI: 1.01 to 5.5, $p = 0.048$).

Conclusions This preliminary survey suggests sources of tension are highly prevalent in tertiary paediatric care, in particular conflict. Our data adds to the small existing literature and suggests targeting of resources to reduce tension.

Hospital-wide strategies are required for early identification and resolution, family and staff support and removing barriers to discharge home. A local framework to provide team and family support when tension is anticipated has been developed from our work, incorporating possible risk factors identified: existing medical complexity, multiple team involvement and prolonged admission. Measures within the framework include identification of a lead clinician to co-ordinate care, support by psychologists and social care professionals, upskilling staff in mediation and clear pathways for addressing safeguarding, ethical and palliative care themes.

Further studies are required in wider settings and with families to co-produce future solutions to address tension.