2. To determine whether or not there was any significant difference in the spectrum of patients attending our Paediatric Emergency Department in winter months during the COVID-19 pandemic compared to preceding years.
3. To reflect on how these findings should influence local, regional and national public health strategy moving forward.

Methods We reviewed all attendances for patients under 18 years of age at our Paediatric Emergency Department for the months November, December, January and February and years 2018–2021 inclusive.

We compared overall attendances for each year.

We also compared proportions of patients attending with respiratory presentations, mental health, safeguarding, minor injuries or 'other', using diagnostic coding.

Results

1. Paediatric ED attendances for December 2020, January 2021 and February 2021 were significantly lower than during preceding years.
2. The proportion of patients attending the Paediatric ED with respiratory complaints were significantly lower in the 2020–2021 Winter compared with the preceding two years.
3. The proportion of patients attending the Paediatric ED with mental health or safeguarding complaints were significantly higher in the 2020–2021 Winter compared with the preceding two years.

Conclusions At a local level, these changes have required rapid redeployment of staff and services to areas of greater need and, in particular, have driven improvement to better rapid Child & Adolescent Mental Health Services (CAMHS) input.

The significant reduction in respiratory illness should lead to careful consideration of some level of social distancing/infection control measures to remain in place in future years, with balanced consideration of the resulting impact on safeguarding and mental health.

Paediatric Clinical Leaders: Service Planning, Provision and Best Practice

1519

UNDERPAYMENT OF LESS THAN FULL TIME TRAINEES IN SOUTH LONDON DGHS DUE TO WEEKEND ALLOWANCE MISCALCULATION

Dominic Carr. *NHS*

10.1136/archdischild-2021-rcpch.695

Background With the introduction of the new Junior Doctor Contract (Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016), the way junior doctors are paid has changed dramatically. Pay is now made up of multiple elements, each with a unique and specific way of being calculated. These include a Basic Salary, Additional Rostered Hours, Weekend Allowance, Night Premium, Flexible Pay Premia and Less Than Full Time (LTFT) Allowance. For trainees who work LTFT each of these elements is calculated differently, adding a new layer of complexity.

Within the medical profession, this has led to widespread uncertainty about how pay should be calculated. While resources are available to explain it, most LTFT junior doctors are

unfamiliar with how they should be paid. This means they cannot check the accuracy of their own salary, relying on correct calculation and pay by hospital payroll departments. Anecdotally, it was recently noted that there were errors in the Weekend Allowance pay for a number of LTFT trainees in a South London DGH and therefore this study aims to categorise them further.

Objectives A retrospective study was conducted to identify the accuracy of Weekend Allowance supplements for trainees working LTFT in South London. The long-term objective is that identification of payroll errors will allow payroll departments to correct internal pay algorithms, ensuring accurate pay and increased satisfaction levels amongst LTFT trainees.

Methods LTFT trainees working in South London were asked to volunteer their personalised work schedules and pay slips for their current training post. Their expected Weekend Allowance was calculated manually, based on their personalised work schedule. This was then compared to the value stated on their work schedule and their actual take home Weekend Allowance pay. A copy of each trainees personalised work schedule was analysed to identify where (if present) the miscalculation error was made. At the same time, a survey was done to answer whether the trainee was aware of how their Weekend Allowance should be calculated.

Results Trainees from 5 DGHs in South London responded. Weekend Allowance pay was incorrect in 3 of the 5 hospitals. The nature of the error was different in each case and all errors led to trainee underpayment. Of the 11 trainees identified to have been affected, the mean underpayment was equivalent to £1600 gross per annum. The most significantly affected trainee was underpaid by £3531 gross per annum. Of all those surveyed, not a single trainee was aware of how their Weekend Allowance should be calculated or that an error had been made.

Conclusions The 2016 Junior Doctor Contract has led to increased complexity in salary, especially for those working LTFT. This survey has identified a clear need for personal responsibility in understanding how trainees are paid, along with improved education for payroll departments to ensure errors are not made. To date, around £3800 among five trainees has been recouped, with more pending. One hospital's payroll department has formally recognised the error and is taking steps to correct it.

British Association of General Paediatrics

1521

SCREEN TIME AND DELAYED DEVELOPMENT IN TODDLERS – IS THERE A LINK?

Adit Bassi. *UCL*

10.1136/archdischild-2021-rcpch.696

Background Children and young people are growing up in an environment where screens are abundant, and such devices are being used and improved at a rapid rate. The COVID-19 pandemic has exacerbated this problem with the widescale introduction and significantly increased use of initiatives such as online learning. Due to measures such as lockdown and people having to remain indoors and at home as much as possible, many new mothers have found it hard to engage and stimulate their young children without using devices with screens.

There is very limited information clearly available for those with young children and I aim to explore the relationship between screen time and delayed development in toddlers.

Objectives Determine the literature currently present regarding screen time and its impact on children and young people with a specific focus on sleep and how it affects circadian rhythms.

Locate relevant guidelines and information relating to screen time in the UK and analyse this along with the available literature.

Methods A comprehensive search of the literature was undertaken to assess relevant data and studies pertaining to the described objectives. This included search terms and MeSH such as 'sleep', 'child*', 'screen time' and 'development' with differing Boolean operators to narrow the search criteria.

After analysis of the literature and further research of applicable guidelines, two representative papers were described in detail on the poster with conclusions drawn and recommendations detailed.

Results Although a number of covariates were identified such as socioeconomic status, child's physical activity levels and parental media-habits, many studies concluded that there was an association between increased screen time and delayed development. In particular, higher levels of screen time in children aged 2 and 3 were associated with poor performance on the developmental milestones and that irrespective of other covariates, screen time usage was a factor associated with fewer hours of sleep and longer sleep latency.

A lack of focused guidelines in the UK was uncovered with the majority of evidence being low quality.

Conclusions The neuronal connections formed in the first 3 years of life are of utmost importance and it has been shown that increased screen time in early life has been associated with a negative impact on sleep and therefore neurodevelopmental outcomes. Adequate circadian rhythms are required to achieve optimal neurodevelopment and overexposure to the bright blue light emissions, particularly in the hours before sleeping, has been linked with suppression of endogenous melatonin.

It is imperative that more information be made available to expectant and new mothers regarding screen time and the effects that it can have on their infants. Furthermore, clear guidelines should be developed to allow clinicians to adequately advise families about what is right for their toddlers.

Quality Improvement and Patient Safety

1522

DEPLOYMENT TO THE FRONTLINE – IN SITU SIMULATION AS A TOOL TO MAXIMISE PREPAREDNESS FOR COVID-19

¹Rachel Kirk, ¹Elizabeth Powell, ²Nicholas Ward, ¹Jessica Brown, ¹Helen Bailie, ¹Hena Salam. ¹Addenbrooke's Hospital, Cambridge; ²Addenbrooke's Hospital

10.1136/archdischild-2021-rcpch.697

Background The COVID-19 pandemic required medical staff to quickly adapt to new policies and rota structures. In our large tertiary children's department, speciality paediatric consultants were redeployed to acute paediatrics. All clinical staff required training in new resuscitation protocols and personal protective equipment (PPE) guidance.

Objectives Simulation is an acknowledged educational tool. Our aim was to run in-situ simulations to prepare staff for undertaking resuscitation with appropriate PPE precautions during the evolving pandemic.

Methods In March 2020 we invited all clinical paediatric staff to participate in a 1-hour small group simulation. This focused on donning/doffing PPE and paediatric ABC assessment of the seriously unwell child. Feedback was undertaken using an online tool.

Results The main reason cited for participants to attend simulation was due to changing roles on a new rota, returning from other areas such as research and community paediatrics, and to take the opportunity to refresh skills particularly in the context of other courses being cancelled due to the pandemic.

41 participants provided feedback; 34.1% were non-acute paediatric consultants, 48.8% paediatric residents of all grades and 17.1% nurses. 39.2% of participants did not routinely cover an acute area where emergencies occur prior to the pandemic, and as such would not have taken the opportunity to refresh their knowledge if rota changes were not required.

92.3% felt better prepared for acute paediatric shifts during the pandemic. 70.7% reported reduced stress regarding rota reconfiguration. 97.3% found this a useful educational tool.

Anecdotally staff felt these sessions enhanced an overall sense of comradery, feeling more prepared for the 'worst case scenario'.

Conclusions

- In-situ simulation is a versatile tool which can help prepare medical staff following resuscitation policy changes (eg. during a pandemic)
- It has a positive impact on staff feeling prepared, improving staff morale and confidence during resuscitation.
- As access to and the landscape of educational opportunities change, small session in-situ simulations (while acknowledging physical distancing guidance) has an important role in being a key educational tool during pandemics.

Paediatric Critical Care Society

1523

PERSON BEHIND A PARENT

¹Rashmi Mehta, ²Amy Walker, ³Mildner Mildner. ¹West Midlands Deanery; ²University Hospitals Birmingham NHS Foundation Trust (Heartlands Hospital); ³Birmingham Women's and Children's NHS Foundation Trust

10.1136/archdischild-2021-rcpch.698

Background An article 'Please don't call me mum'¹ in BMJ highlighted the parents' perspective of how they would like to be addressed and empower them in decision making, towards the care of their child. How we as HCPs initially address parents or carers sets the tone for further communication and can have an influence on the quality of the relationship.

Objectives We aimed to explore how parents whose child was admitted to NICU or PICU wish to be addressed. Secondly, we aimed to explore how HCPs in PICU usually address parents.

Methods A questionnaire consisting of check-box choices with option of more than one selection and free text questions was designed to collect data from parents and HCPs.