In March 2021, 43% of doctors and nurses surveyed reported they had screened the last patient they saw; 79% were aware of resources and; 67% had signposted someone to help in the last 3 months. From zero introductions to Connected Communities in October 2020, a staggering 95 parents have been screened and recommended to contact our support workers. Only 23 have engaged so far and they have received help with housing, finances/benefits and citizenship. Ten do not speak English but will be supported to access advice.

Conclusions Tackling health inequalities takes commitment.

By seeing, screening and intervening, we help reduce stigma and identify vulnerable families. Our close partnership with Connected Communities increased staff confidence and increased introductions. More work is needed to determine why only 23/95 parents take up the offer but language barrier, parental expectations or clerical factors may contribute.

Association of Paediatric Emergency Medicine

1765

PAEDIATRIC EMERGENCY DEPARTMENT MULTIDISCIPLINARY IN-SITU SIMULATION PROGRAMME FOR THE COVID-19 PANDEMIC

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10.1136/archdischild-2021-rcpch.838

Background During the pandemic there were significant changes to our Emergency Department (ED). For example there was the creation of 'Red' (Patients requiring aerosol generating procedures or suspected COVID-19 patients) and 'Green' (low risk of COVID-19 patients) resuscitation and majors areas and complete relocation of the Paediatric ED to the Adult Clinical Decisions Unit. There were also significant changes to paediatric emergency protocols.

We established an on-going programme of simulation within the multidisciplinary teams managing children in the ED to enable the dissemination of these changes.

Objectives

Our aims were

1. to create a face to face Paediatric Emergency Medicine Simulation package that could be delivered during a pandemic
2. disseminate changes in protocols and geography within the Paediatric ED and wider ED
3. collect feedback from simulation participants
4. use this feedback to improve our programme

Methods In-situ simulations involving the acute on-call teams with real arrest calls were planned weekly. 6 participants could sign up to simulation teaching, but all other participants were 'unaware' of the simulation taking place.

Departmental leads were informed of training dates to minimise clinical disruption. Additional Personal Protective Equipment was sourced and debriefs were run in large spaces following social distancing rules. Advanced Life Support Group recommendations regarding the running of courses during a pandemic were followed.

We collected feedback from participants using electronic questionnaires.

Results 4 in-situ simulation mornings were held during July and August 2020. Participants included paediatricians, ED nurses and doctors, the trauma team, PICU and anaesthetics.

All participants found the simulation a positive learning experience with 81% of participants rating the sessions 'excellent' 36% rating the sessions 'very good' and 9% 'good'.

93% of respondents felt more prepared to manage children in ED during the COVID pandemic.

Conclusions We have shown that face-to-face simulation training is still possible during the pandemic, by ensuring social distancing rules are followed and sourcing PPE. Our simulation sessions allowed sharing of geographical & protocol changes and provides a model for shared learning within the paediatric ED. We have shown the majority of participants have found it a useful learning experience.

We have continued to run these simulations throughout the Pandemic from October 2020 into March 2021, focussing on new trainees rotating into our hospital and departments. We would hope in the future to ensure that this programme is sustainable and would like to include a larger teaching faculty, particularly including more nurses and resus officers.

British Association for Community Child Health

1768

THE POVERTY PANDEMIC: START SEEING, SCREENING AND INTERVENING

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10.1136/archdischild-2021-rcpch.839

Background Before the COVID-19 pandemic, 4 in 10 children local to North Middlesex Hospital lived in poverty. Recent job losses, rising debt, bereavement and deteriorated mental health, all inevitably increase hardship. Poverty increases the risk of chronic diseases, mental illnesses, accidents and trauma. Surprisingly, families living in the west of Enfield and Haringey live almost 15 years longer in good health than those in the east!

Objectives We challenged our paediatric staff to start seeing poverty as a chronic health problem and not just a moral issue. By screening for poverty, as we do other health risks, we can identify and intervene for vulnerable families and offer them essential help.

Methods In July 2019 we explored paediatric doctors' awareness of the social determinants of health. Using quality improvement methodology we built upon our pilot project in Kingston Hospital. Barriers to screening and possible questions were discussed. Education sessions, email communications, text reminders and leaflets were shared regularly with paediatric staff. Surveys were planned to monitor staff progress and record families being signposted.

Results Barriers to screening for poverty included a perceived lack of time, inexperience, being unaware of resources and inadequate privacy during clinical assessments. In October 2019, only 10% of staff surveyed routinely screened for poverty. 13% felt they had sufficient knowledge of where to signpost families in need and 22% recalled giving social help in the preceding 3 months.