and to find out about screen time use in our local paediatric population accessing neurodevelopmental clinics.

**Methods** Paper questionnaires were developed and distributed to our multidisciplinary community paediatric team to enquire about their practices around addressing screen time in clinic. Following this, paper questionnaires enquiring about children’s screen time use were developed and distributed to parents of children attending outpatient community paediatric clinic appointments over a two-week period in January 2022. Questionnaires were collected and analysed anonymously.

**Results** 20 questionnaires were completed by community paediatric doctors and therapists. None of the participants said they routinely asked or advised about screen time. 50% said they sometimes asked and 60% sometimes advised about screen time. All participants felt that screen time could have an effect on development.

27 questionnaires were completed by parents. Age of children ranged between 3 and 13 years. All parents reported that their child used screens. Age when children started using screens ranged from 6 months to 4 years. Type of screens used included television, phone, tablet and computer. 78% of children were reported to watch children’s television and 48% watched online videos. There were a range of times when children used screens (figure 1). Total daily screen time ranged from under 1 hour to 5 hours, with a mean of 2 hours (figure 2). 81% of parents had concerns about their child’s use of screen time. 29% were aware of current screen time recommendations. 41% said they would like more advice about screen time, with half saying they would like written advice and half requesting verbal advice.

**Conclusion** This project has provided an insight into current screen time use amongst community paediatric patients. The survey has highlighted that providing screen time advice is not routinely done in our practice at present. We were interested to find that only one third of parents were aware of current screen time recommendations. These findings prompt us to consider whether we should routinely ask and advise about screen time use during community paediatric consultations. The next step of our project will aim to provide useful information on screen time to our patients and their families.

2. Paediatrics Volume 140, s2, Nov 2017, Anderson et al.

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**Abstract 971**

**BARRIERS TO HEALTHCARE FOR UNACCOMPANIED ASYLUM SEEKERS**

Niall Durrant, Chloe Johnston, William Stephenson. Queen Mary’s Hospital for Children, Epsom and St Helier University Hospitals NHS Trust

**Aims** Initial Health Assessments (IHAs) for Looked After Children (LAC) account for a significant amount of statutory work. An increasing number of cases are UASC (unaccompanied asylum-seekers) We audited IHAs of UASC performed in 2018 against guidance from Coram BAAF and UASC Health, to investigate barriers to meeting standards.

Suspecting the COVID-19 pandemic exacerbated existing barriers to meeting standards, we re-audited in 2021 to investigate these, look at measures currently piloted, and plan future interventions.

**Methods** UASC seen for IHA in 2018 (n=50) and 2021 (n=26) were retrospectively identified from our database. We reviewed each IHA report, electronic records, and results of investigations.

**Areas reviewed were:** TB referral, optician and dental review, use of an interpreter, bloods including haemoglobinopathy and blood borne viral (BBV) screening, immunisations, and mental health concerns.

**Results** See table 1:

In 2021 A face-to-face interpreter was used in 65%, by phone in 31%, and in 4% no interpreter was available.

In 2021 only 35% had a dental review prior to IHA, 38% having an appointment booked. 8% were referred from IHA via a pilot pathway.

In 25% of cases across both years blood results weren’t communicated to all appropriate professionals.

In 2018 catch-up immunisations had been started in 12% and completed in 6%. In 2021 15% had begun immunisations started and 12% completed. 1 UASC refused immunisations.

**Conclusion** Our findings prompt us to consider whether we should routinely ask and advise about screen time use during community paediatric consultations.

**References**

2. Paediatrics Volume 140, s2, Nov 2017, Anderson et al.
Conclusion Barriers to treatment persist, with new covid related issues. Of note we saw a significant fall in patients seen by dentists. Carers report difficulty accessing NHS dentistry. Locally a pilot dental referral service for LAC has been initiated. Patients can be referred by their SW or the named doctor. Interestingly, access to opticians did not appear to be influenced by covid.

We found a fall in availability of interpreters face-to-face as well as in general. This appeared secondary to covid concerns and infections.

Direct (within Trust) TB referrals fell although this appeared due to local factors. 100% patients were referred via GP or directly.

We found good practice regarding mental health screening & catch-up immunisations. It is notable that in 2021 one UASC refused immunisations. Our IHA doctors report increasing frequency of reluctance regarding immunisations. It is possible this is secondary to covid vaccination misinformation on social media.

Routine blood and haemoglobinopathy screening markedly improved, however communication of results was consistently lower than expected. We noted in 2019 that results not communicated appeared to where bloods weren’t sent on the day and recommended all bloods be sent on day of assessment. However due to covid-19 the phlebotomy service is no longer walk-in, affecting our ability to achieve this.

There are insufficient CAMHS resources to see all UASC despite high incidences of PTSD and anxiety. A joint or contemporaneous assessment with mental or emotional health professionals might be a solution. The London Asylum seekers consortium is running a health and welfare check pilot project where bloods were not sent on the day.

Participation was voluntary and results were anonymised. 40% of respondents had received previous oral health training. Of those who had received training, 48% reported this was part of internal training, 17% as external training and 17% as part of a formal qualification. Other training included group sessions and lectures. 94% agreed or strongly agreed that good oral health is essential for general well-being with 86% of respondents having seen a child where they were concerned about their oral health.

33% of respondents reported that they did not discuss oral health with children and their families. The main barrier to oral health promotion was identified as lack of training followed by time, patient cooperation and lack of equipment. Table one demonstrates the barriers reported when providing oral health advice to children and their families in the community. 97% of respondents felt they would benefit from oral health training and free text comment themes included requests for regular refresher training and understanding how to provide oral health support for children with dysphagia and behavioural difficulties.

Table 1. Barriers faced when providing oral health advice to children and their families

<table>
<thead>
<tr>
<th>Barriers faced when providing oral health advice (multiple options)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Training</td>
<td>63%</td>
</tr>
<tr>
<td>Time</td>
<td>46%</td>
</tr>
<tr>
<td>Patient Co-operation</td>
<td>26%</td>
</tr>
<tr>
<td>Lack of Equipment</td>
<td>23%</td>
</tr>
<tr>
<td>Not a Priority</td>
<td>14%</td>
</tr>
<tr>
<td>Other</td>
<td>14%</td>
</tr>
<tr>
<td>None</td>
<td>11%</td>
</tr>
<tr>
<td>Don’t Want To</td>
<td>2%</td>
</tr>
</tbody>
</table>

Conclusion This training needs analysis outlines the need for further oral health promotion training to support those working with children in the community in providing the right advice to children and families. This has led to the creation of an e-learning package for non-dental professionals to support the promotion of good oral health, and to improve confidence in signposting children and their families within the community setting.

REFERENCE