guidance on identifying children at risk. Electronic Patient Records often have flags which highlight children who have had concerns raised. Separately, organisations such as the police maintain their own matrices for identifying those at risk. For example, our local Police Authority keep a list of children who score highly for proven risk factors for exploitation. This list is shared with the Trust Safeguarding Children team under an information sharing agreement, approved by our Caldicott guardian.

Objectives To retrospectively review whether children identified as high risk of exploitation by the local Police Authority are attending our Trust's Emergency Departments, and for what reason. Additionally, to determine whether these attendances resulted in appropriate safeguarding actions.

Methods All Emergency Department attendances between 1/12/19–10/09/20 were reviewed for the 44 children with the highest risk scores on the local Police authority Exploitation risk matrix. We assessed reason for attendance, whether the child had a safeguarding flag on EPR prior to their attendance, whether safeguarding concerns were raised, what actions were taken and whether these actions were appropriate.

Results 25 children attended the ED during the date range reviewed, 13 had a safeguarding flag, and 9 had multiple attendances. The most common reasons for attendance were self-harm (12), traumatic injury (9) and violence (7). Guidelines were followed appropriately and completely in two thirds of attendances (29/41). The patient was not referred to the safeguarding team when they should have been in nine attendances. Additionally, in three instances where referral to the safeguarding team was made, it is not clear that appropriate ongoing actions were taken. All attendances where there was a lack of, or incomplete, appropriate safeguarding action involved children aged 15 years or over.

Conclusions Children identified as high risk by our local Police's exploitation risk matrix attend ED frequently, and some are recurrent attenders. Most are older teenagers. Although detailed guidelines and a robust system of flagging exist, front line ED staff require further guidance on identifying those children at risk of exploitation as appropriate actions were not taken in all cases. One possible consideration is that older children presenting following violence are not being distinguished appropriately from adults on presentation as they are not seen by staff who primarily work with children.

This presentation will highlight some of the proposed guidance.

British Association for Paediatric Nephrology

788 RENAL GENETICS CLINICS: HOW ARE THEY PERCEIVED?

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Background NHS England recently initiated a reorganisation of genetic services across England to allow genetic testing to become more standardised and provide equality of access. This furthers incorporates genomics into all aspects of paediatrics.

Evaluation of family experiences of paediatric genetic services revealed common themes consistently reported by families as requiring improvement. These include a lack of information

pre-clinic about what to expect,¹⁻³ not being given written information to take home from clinic²⁻⁴⁻⁶ and desiring more follow-up once results were known than they received.²⁻⁴⁻⁷

Multidisciplinary genetics clinics have been established at Birmingham Children's Hospital (BCH) but their impact on family experiences was unknown.

Objectives A project was developed to determine the experiences of service users of the renal-genetics service at BCH and whether these are similar to the published literature.

Methods We wanted to understand how to help families feel adequately prepared for their appointment and ensure their concerns and questions were addressed in a time-limited clinic setting. Thus, we wanted to gather data on families' opinions on the overall service structure but also their experience of their genetic counselling.

Existing, validated questionnaires were evaluated but none covered all the necessary aspects individually. Therefore, two separate questionnaires were adapted and sent out to all the families that had used the renal genetics service so far. Anonymous results were collated.

Results Overall a 23% response rate was achieved. The majority of respondents had at least a basic idea why their family had been referred to the renal-genetics service and 45% had received written information about genetics clinics prior to their appointment.

Most families felt they had been listened to but two families felt they did not get to ask all the questions they wanted to. 81% of families reported they did not receive written information on genetics (testing) from clinic and 54% stated they would have liked to. Similarly, 64% did not receive information on relevant local voluntary or support groups and 57% of those would have found this beneficial.

The counselling results were varied across both understanding and the respondents' emotional response towards the genetic situation within their family.

Conclusions Whilst overall feedback was positive, more can be done to improve the experiences of families.

More can be done to help prepare families for attending their genetics appointments and there is a need for high-quality information for families to take home with them. If such resources do not exist, their creation could be hugely beneficial to families.

Families sought recommendations for local relevant support or voluntary groups. This might not be possible for rare diseases due to low patient numbers. Families may accept distant disease-specific groups or prefer local but more generalised groups and this is something that may have to be explored with individual families.

The counselling feedback suggests a flexible, tailored approach may better meet the differing needs of all service users. This may help ensure families feel they get everything they need from clinic but could pose challenges in structuring clinic appointments.

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British Association of Perinatal Medicine and Neonatal Society

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A STUDY OF TERM AND NEAR TERM INFANT ADMISSIONS TO A TERTIARY NEONATAL UNIT

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Background Analysis of care days provided by our tertiary neonatal unit has shown a higher than expected number of special care days. We focussed on this by studying term and near term admissions to the unit over a defined time.

Objectives Our aims were to identify the primary reasons for term and near term admissions and the level of care required. We sought to benchmark our admission rate with national data and measure separation days, as defined by low dependency care days where breathing support is not needed. We aimed to calculate the proportion of potentially avoidable admissions and to establish what changes in practice would be required to achieve this.

Methods This was a retrospective observational study performed from January 2020 to August 2020. Inclusion criteria were any infant born ≥ 35 completed gestational weeks (CGW) admitted to the neonatal unit. 'Term' was defined as ≥ 37 CGW, and 'near term' was ≥ 35 to < 37 CGW. Data were collected from BadgerNet and analysed using Microsoft excel.

Results A total of 214 infants were identified, 170 term (9.5% of term births) and 44 near term (42.6% of near term births). 139 (65%) infants were admitted for respiratory concern, which was the most common admission reason. Of these, 40 (29%) required less than 6 hours of respiratory support and 30 (21%) required less than 2 hours of respiratory support. The second most common admission reason was hypoglycaemia/feeding concerns, with 49 (23% of the 214 cohort) admitted for this. Of these, 32 (65%) required nasogastric feeding or feeding plan only, while 17(35%) required IV fluids. 18 infants (8.5%) were admitted for jaundice, neonatal abstinence syndrome, or observations. Our cohort of 214 required a total of 1261 care days, 903 (72%) being special care days. There were 898 care days in term infants, of which 621 (69%) were special care, and 363 care days in near term infants, of which 282 (78%) were special care. The average duration of stay was 5.3 and 8.3 days for a term and near term infant, respectively. Average separation days were 4.0 for a term infant and 6.9 for near term infant.

Conclusions Our study demonstrates a high admission rate of term and near term infants, above the national ATAIN programme recommendation of $< 6\%$ in this population. Our average separation days are above the NNAP unit comparison data of 2.9 for term and 5.8 for near term infants as published in the 2020 report. Our conclusions are to adopt the standards for transitional care as published in the BAPM 2017 framework and revise our guideline to manage infants at high risk of hypoglycaemia by introducing a new network guideline based on BAPM 2017 recommended thresholds for intervention. Our unit should subscribe to the ATAIN programme with a multidisciplinary weekly review of term and near term admissions. We calculate that 78 (36%) of our cohort could have avoided admission with these systems in place.

British Society of Paediatric Endocrinology and Diabetes

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CLINICAL IMPACT OF THE 2020 BSPED INTERIM GUIDELINE ON THE MANAGEMENT OF DIABETIC KETOACIDOSIS: A SNAPSHOT OF DATA FROM TWO LONDON CENTRES

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Background There is little consensus on optimal fluid replacement in DKA; and the 2020 British Society for Paediatric Endocrinology and Diabetes (BSPED) interim guideline on the management of children < 18 years with diabetic ketoacidosis (DKA) represents a significant shift away from the more restrictive approach to fluid replacement advocated in the 2015 guideline.

BSPED 2020 guideline recommends that all patients should receive an initial 10 mL/kg bolus and those in shock receive a 20 mL/kg bolus. Furthermore, the maintenance fluid requirement was liberalised to use the Holliday-Segar formula and given in the first 24 hours of admission, instead of the previously slower infusion rates over a 48 hour period.

Objectives This survey aimed to report any change in clinical outcomes with the switch to using the 2020 BSPED interim DKA guideline compared to the previous BSPED/NICE 2015 guideline.

Methods We collected data from all paediatric patients who presented with DKA to Croydon University Hospital and St George's Hospital, London. Data was collected from admissions during the 6 months pre and post-implementation in the respective trusts of the 2020 guideline (Sept 2019-Sept 2020). Patients were identified from local paediatric diabetes team databases and data was retrospectively extracted from electronic patient records.

Results A total of 30 patients were studied. 3 patient sub-cohorts were identified according to which guidelines were followed:

1. 2015 guideline (n=13)
2. 2020 guideline (n=13)
3. 2020 guideline on initial admission but subsequent change to the South Thames Retrieval Service (STRS) guideline (n=4)

All cohorts had similar demographics. Mean admission pH for each cohort was 7.17 (range 6.8–7.3) in the 2015 group;