CYP were followed up with non-clinic-based BP monitoring at home or by GP.

Results We identified 32 CYP seen within the first 6 weeks of the UK-wide Covid-19 lockdown who had BP above cut-off for prehypertension (44%) or hypertension (37%) (figure 1), all of whom previously had their BP in the normal range. Their medication types and doses had not changed. Their medical histories and anthropometric centiles were stable. By August 2020 when the lockdown had eased, their BP were back in the normal range without any further investigations or interventions.

Conclusions This audit highlights the point that clinical evaluation of changes in BP among CYP taking medications for ADHD should take the socio-ecological context into account and not automatically translate into making major clinical changes to treatment such as dose reduction or referral for cardiology review.

A conservative approach of non-clinic-based monitoring may be in the best interest of such young people, who, otherwise, may lose treatment efficacy following dose reduction. This conservative approach could also prevent the affected CYP being exposed to the inconvenience and risks associated with unnecessary medical investigations.

There could also be additional efficacy gains for the wider health economy.

George Still Forum: ADHD Disorders (ePoster presentations only)

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MELATONIN PRESCRIPTION PRACTICE FOR CHILDREN AND ADOLESCENTS WITH SLEEP DIFFICULTIES IN A COMMUNITY CHILD HEALTH OUTPATIENT CLINIC: SCOPE FOR COST-SAVINGS

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Background Sleep problems are common in children from preschool age to adolescence, especially among those who have recognisable neurodevelopmental disorders. Treatment options include parent psychoeducation, sleep hygiene with implementing modifiable daytime, bedtime, and night-time practices, behavioural strategies, and pharmacological treatment for selected cases. Melatonin is the most widely prescribed medication (mostly off-label) for paediatric insomnias. Melatonin acts mainly by its circadian phase-shifting effect, with a less established hypnotic and sleep-promoting effect. Although melatonin is generally considered to be safe, its long-term safety have not been extensively studied.

The annual spend in England and Wales on all melatonin preparations (ePACT2 Feb-Apr 19) was £30 million (74% accounting for paediatric prescriptions). The NICE guideline (2013) confirmed that the evidence to support the use of melatonin in children and young people with ADHD is very limited.

Objectives We aimed to audit the Melatonin prescribing practice among the clinicians within a local Community Child Health (CCH) unit in comparison with published evidence of best practice in the UK, and to identify potential scope for Quality improvement and cost savings.

Methods An audit of prescribing practices within the CCH department of the Bridgewater NHSFT (Halton) was conducted over a period of March to Aug 2020. A retrospective audit of all CYP under the attending the CCH clinics between March and August 2020 were identified on the electronic record system. A record of the clinical diagnosis and list of other professionals caring for the patients were identified. A convenience sample of 40 CYP randomly selected from the total cohort of patients was analyzed in detail.

Results A total of 195 CYP (76% males) with an average age of 11 years 7 months were issued 437 prescriptions issues (73/month and 2.2 prescriptions per patient) for different formulations of Melatonin over the period. The adolescents aged 9 to 14 years constituted 61% of the cohort (table 1).

68% of CYP on Melatonin had ADHD while 28% were diagnosed with Autism. 20% other children with had non-specific social communication concerns and some of them were on the waiting list for multidisciplinary Autism panel assessment.

There were an average of 2.7 other professionals other than the paediatricians and specialist nurses involved in the care of each patient, ranging from none to eight. Half of the patients on Melatonin had EHCP, 30% were under the Continence services and 20% under the OT.

94% of all the patients were prescribed Circadin, which was the cheapest available brand. Prescribed doses ranged from 2 mg (48%) to 10mg (5%), with an average dose of 4mg. The average duration of melatonin prescription was 23 months with 45% of the CYP having had it for between 2 and 3 years.

Conclusions This audit suggests that there are many potential areas for improvement and for cost savings. PrescQIPP (2020) has recommended not prescribing melatonin for sleep disorders associated with ADHD without a concomitant Autism diagnosis.

Other recommendations for improving evidence-based prescription practices include more effective involvement of the GP and regular trial of melatonin discontinuation especially at transition to adult-led services.

Paediatric Clinical Leaders: Service Planning, Provision and Best Practice

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INNOVATIVE USE OF VIDEOCONFERENCE TOOL FOR PARENTAL EDUCATION DURING COVID19

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Background The COVID19 pandemic brought a lot of questions and concerns from parents about the impact of the virus

on their children's health. The widespread presence of 'fake news' was adding to the confusion. Our Paediatric Integrated Care team based in a tertiary centre in London approached local parents and community centres to organise online child health workshops.

Objectives

- To support parents and carers in gaining knowledge and confidence to care for children and young people during the pandemic
- To reassure and reduce anxiety related to child health concerns
- To be responsive to our community and their health needs
- To make innovative use of video-conference technology and group teaching methods
- To make best use of professionals' time

Methods We worked closely with Community and Maternity Champions, who organise groups of local volunteers to promote health and wellbeing in North West London. Two Community Champions showed interest in having a webinar for parents on COVID19 and its impact on children in May 2020. We agreed dates and times for the 2 webinars. The Community hosts promoted the sessions and asked participants to submit any questions in advance so that the webinars could be tailored around the audience's needs. The session lead (paediatric senior registrar) and other paediatric junior doctors prepared a presentation and answers to the pre-submitted questions. The format for the webinars was flexible, co-designing the sessions with the champions. The first had a 15-minute presentation followed by Q&As, the second did not have a presentation to allow more conversation with the families who joined. After each webinar, we sent resources for the community hosts to share. After trialling two webinars in May, we were contacted by other community centres. We organised six more webinars from June to December 2020. We captured data during the webinars, such as teaching material used, duration, session breakdown, size and type of audience. We tested different approaches for feedback, sharing survey links at the event and following up with the hosts two weeks after the event.

Results From May to December 2020, we organised 8 webinars with 5 Community Centres, two youth groups and one secondary school, with a total of 72 attendees. Initially they were focused on COVID19, then we introduced other topics, including mental health, asthma and common childhood illnesses, depending on what the community hosts and local families requested. On average we ran the webinars for 1 hour. Formal and informal feedback confirmed that the webinars addressed concerns and that the attendees and community hosts found the session useful and reassuring. Peer to peer learning during the sessions was encouraged and this was key to improving audience's confidence in addressing health concerns.

Conclusions The COVID19 pandemic has opened up innovative ways to collaborate with community centres and have conversations on health-related topics sharing expertise. This project has also provided an important learning opportunity for paediatricians in training. The success of this programme is likely to lead to implementation of similar and related programmes, even after the end of the pandemic.

British Society for Paediatric Dermatology

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PAEDIATRIC STEVENS-JOHNSON SYNDROME AND TOXIC EPIDERMAL NECROLYSIS: A RETROSPECTIVE CASE SERIES & EVALUATION OF PRACTICE

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Background Stevens-Johnson syndrome and toxic epidermic necrolysis are rare but devastating skin reactions that carry a significant risk of mortality and serious morbidity in paediatric populations. The British Association of Dermatology (BAD) released new guidelines in 2018 for the management of Stevens-Johnson Syndrome (SJS) and toxic epidermal necrolysis (TEN) in children and young people, which included recommended audit points for evaluating patient care.

Objectives The aim of this study was to evaluate presentations of paediatric SJS/TEN to an English NHS trust over the last 10 years and retrospectively assess the management of these cases against the 8 audit points recommended in the BAD guidelines.

Methods Hospital electronic records were searched from January 2010 to January 2020 selecting for presentations attached with the ICD-10 codes for Stevens-Johnson Syndrome (L51.1) or Toxic Epidermal Necrolysis (L51.2). Inclusion criteria included a final diagnosis at discharge of SJS and/or TEN overlap and an age under 18 years at presentation. Where a patient had recurrent admissions, each admission was assessed separately against the guidelines.

Results After screening, 14 presentations from 12 patients met inclusion criteria. Of these presentations, 8 had confirmed infectious aetiologies (including *Mycoplasma* species (n=3), *Streptococcus pneumoniae* (n=3), herpes simplex virus (n=1) and parainfluenza (n=1)), 3 had presumed infectious aetiologies with no definitive positive testing, 1 had a presumed drug aetiology, and 2 had uncertain aetiologies. Initial causality assessments, review of oral and urogenital involvement, ophthalmology assessment and evidence of MDT involvement were present in all cases. While there were no mortalities, half of patients (6 of 12) went on to develop at least one long-term sequelae, of which psychiatric (n=3), urological (n=2) and respiratory (n=2) complications were most common. In 8 of the 14 cases there was no written documentation that patients, parents or GPs were counselled on the recurrence risk at discharge, and where this was documented, this was frequently in outpatient letters (n=5) rather than in discharge letters (n=1). In 12 out of 14 cases, there was no clear documentation that patients and parents had been counselled on the potential for long-term sequelae.

Conclusions This retrospective case series highlights a predominantly infectious aetiology in paediatric SJS/TEN with 78% confirmed or suspected infectious trigger. We have shown that the new BAD guidelines can be readily applied to assess the management of paediatric SJS/TEN. While most in-patient care met recommendations, there was limited documentation of parents and GPs being counselled on the risk of recurrence and long-term sequelae. The BAD guidelines include an