relationships, and empowering trafficked CYP through a strength-based approach is key for recovery.

(c) For TIC to be effective the whole system needs to be trauma-informed as currently the system causes a lot of re-traumatisation. A trauma-informed system would work collaboratively and training would need to be an integral part of that system.

(d) The foundations of TIC already exist in current care practice. It is a model of care that is CYP-centred, holistic, and compassionate. Creating TIC structures also helps decrease vicarious trauma for providers.

Conclusions This study has suggested a trauma-informed model of care for trafficked CYP that puts the provider-CYP relationship at its heart with a foundational basis of knowledge and understanding of trauma and its manifestations in CYP. It suggested a universal trauma-informed system with effective collaboration between professional groups to better address the complex needs of trafficked CYP. Finally, this study found that the foundations of TIC already exist in current practice and that, where TIC structures are in place, vicarious trauma can be reduced for providers. Further research is needed, particularly with CYP themselves, to further develop and adapt that model of care to best address trafficked CYP's needs.

Association of Paediatric Palliative Medicine

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DEVELOPMENT OF A PARTNERSHIP TO IMPROVE PALLIATIVE CARE SERVICES FOR CHILDREN IN THE GAMBIA

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Background Paediatric palliative care services in LMIC countries compete for resources with many other priorities. Their provision is desirable and includes advocacy, training health and community care workers, policy development and mentorship.

Objectives The THET J&J start-up grants provided an ideal opportunity to establish a partnership with the Ministry of Health (MoH). The long term aim being to develop children's palliative care services in The Gambia. A needs assessment was carried out in early 2020. We hope reporting the results raises awareness of the gaps and possible solution

Methods The study took the form of a cross-sectional design with a focus on estimating the need for CPC and gaps at the country level. A mixed methods approach utilising both quantitative and qualitative data was used. Both primary and secondary data sources were used. The estimation of the need for CPC was based on estimation techniques using the prevalence and mortality of the specific diseases known to require palliative care. The response to the need and existing gaps were analysed using interviews and focus groups with key persons as well as survey data from service providers.

Ethical approval for this study was given by the University of the Gambia, School of Medicine. Reference number R020 004

Results Five organisations completed a Capacity Self-Assessment Tool, 17 staff from 5 facilities were interviewed and 2 Focus Group Discussions conducted (8 staff). The leading cause of death in children was heart disease, then lower respiratory infections and neonatal disorders, with HIV/AIDS being 5th, Tuberculosis 7th and cancer 9th. Under 5 mortality is 47.8 per 1,000 live births. It was not possible to estimate prevalence. Facility capacity assessment to provide CPC ranged from 23%-74%. Themes identified were a need to improve diagnostic ability; a desire for training; improve access and utilisation of medicines; and provide support for families. Training in Palliative care is on the nursing and medical students syllabus. Senior staff were keen for more training. Topics that staff felt anxious about were breaking bad news, anticipating palliative needs and use of medication.

Conclusions The establishment of a training and mentoring service for staff in palliative care is required and desired. Paediatric diagnostic facilities need improved including equipment and access to specialist opinions eg an echocardiogram. in the main hospital in Banjul.

The use of online Palliative training through lectures and modules, supported by scheduled in person visits is thought to be a good solution particularly in the current Covid-19 situation. 1 online lecture session has already taken place for 30 participants, supported by the MoH. This had good media coverage and promoted CPC awareness within the country. M.Sowe is currently undertaking a Palliative Care Diploma in Uganda partly funded by this grant. The World Bank has recently provided funding for specialist paediatrician secondment to The Gambia to improve paediatric services and a memorandum of understanding for patient pathways has been signed with the much larger neighbouring country of Senegal.

British Association for Paediatric Nephrology

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PREVALENCE, RISK FACTORS AND OUTCOME OF ACUTE KIDNEY INJURY IN HOSPITALISED CHILDREN AT THE JOS UNIVERSITY TEACHING HOSPITAL JOS, PLATEAU STATE. NIGERIA

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Background Acute Kidney Injury (AKI) is a disease of global importance, contributing to high childhood morbidity and mortality. It is a preventable and treatable disease. Early identification of risk factors can prevent disease initiation and enhance prompt diagnosis and treatment.

There are limited data regarding the risk factors and outcome on the disease in Nigeria especially in Jos, Plateau state, and its neighbouring states.

Objectives The objectives of the study was as follows

(1) to determine the prevalence of AKI in hospitalised children at the Jos University Teaching Hospital (JUTH).

(2) To determine the risk factors among hospitalised children with AKI at JUTH.

(3) To determine the outcome of AKI in hospitalised children at JUTH

(4) To determine the association of the risk factors with the outcome of acute kidney injury in hospitalised children at JUTH

Methods This was a longitudinal hospital based study of 338 children aged 1 month to 18 years admitted to the Jos University Teaching Hospital, Plateau state via the Emergency Paediatric Unit (EPU), from August to November 2018. All children were screened for AKI using the 'Paediatric Risk, Injury, Failure, Loss, End stage renal disease' (pRIFLE) diagnosis criteria after obtaining the estimated Creatinine Clearance (eCCL) and urine output. The participants were assessed daily on admission until discharge or death. Normative values for eCCL reference were used for all children.

Data were stored on Microsoft excel spreadsheet then transported to Statistical Package for Social Sciences (SPSS) for analysis. Mean and frequencies were computed and association of risk factors for AKI occurrence and output were calculated using chi-square and odds ratio.

Significant risk factors were further subjected multiple logistic regressions. P-value of less than 0.5 was significant.

Results The prevalence of AKI from the study was 21.30%. The study diagnosed more participants (50%) in the least severe 'R' stage.

Independent risk factors for the development of AKI identified include, sepsis, (p-value <0.001, OR 5.56, CI 2.57–12.05), primary kidney disease (Nephrotic syndrome and Acute Glomerulonephritis) (p-value <0.001, OR 15.04, CI 5.37–42.13), heart failure (p-value <0.001, OR 8.14, CI 3.38–19.59), and chronic kidney disease (p-value 0.021, OR 14.38, CI 1.49–138.69).

The mortality rate from AKI was 20.83%. Among discharges, 82.46% of the discharged recovered fully from AKI while 17.54% had residual kidney injury.

Sepsis (p-value <0.001, OR 8.36, CI 2.38–29.46) and severe stage of AKI (p-value <0.001, OR 14.93, CI 3.64–76.92) were the most important risk factors for poor outcome in children with AKI.

Conclusions From this study therefore it can be said that AKI is a disease that is commonly associated with hospital admission (21.3%), though it is preventable and treatable when recognised early due to the high recovery rate with earlier stages of the disease. More worrisome is the high mortality rate 20.83% which contributed to 78.95% of total hospital mortality in the admitted children. Screening for risk factors early at the point of admission will prevent development of the disease and progression to severe stage.

Here we report our single-centre District General Hospital experience of managing HIE over an 8-year period with two year follow up data.

Objectives To examine the 2 year developmental outcomes for our cohort of patients with HIE, since cooling was introduced at our centre in 2009.

Methods A retrospective review of patients with a coded diagnosis of HIE managed at St. Helier Hospital was performed via electronic healthcare records. All patients treated between 1/10/2009 and 1/10/2017 were included for analysis. Non electronic records were then used to obtain detailed information about each patient at the time of HIE diagnosis and follow up at 2 years of age.

Results After manual exclusion of non-HIE cases (n=12), 55 patients with a coded diagnosis of HIE were identified and included in the analysis. The mean gestational age was 39.3 weeks (range 32–42), and most were born at our centre (76%). At the time of review, 47 (85%) were alive and 8 (16%) had died. 28 patients (51%) received cooling, 25 of which were cooled at our centre. In this latter group, 24 (96%) met both TOBY criteria A and B. The mean pH of cooled babies was 7.001 (range 6.53–7.38), and the median Apgar Score at 1 minute was 2 (range 0–9), at 5 minutes was 4 (range 0–10) and 10 minute was 6 (range 0–10). Of the 18 patients who were cooled in our trust with local follow-up data available, 8 (44%) had normal motor, speech and language development at 2 years, and 10 (55%) had abnormal development in one or both domains which reflects the original TOBY data (where survival without a neurologic abnormality was 44% at 18 months in the cooled group). Of patients who did not meet criteria, were not cooled and had local follow up (n=19), 6 (31%) had abnormal developmental outcomes at 2 years with 3 (15.7%) of children demonstrating both motor and speech delay.

Conclusions Looking back at our decade of experience since the introduction of cooling, our analysis shows that the outcomes from the original TOBY trial translate well to a DGH setting. Although we were compliant with TOBY criteria and had similar outcomes for our cooled babies, we found that over 8 years, 33% of patients who were appropriately not cooled had abnormal developmental outcomes at 2 years. Is there a case for cooling babies below the threshold set by the TOBY trial?

British Association of Perinatal Medicine and Neonatal Society

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A DGH EXPERIENCE OF COOLING IN HYPOXIC ISCHEMIC ENCEPHALOPATHY

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Background Hypoxic ischaemic encephalopathy (HIE) is a serious complication arising from impaired cerebral oxygenation in the perinatal period, which confers a high rate of mortality, morbidity and developmental delay. The Total Body Cooling (TOBY) Trial showed that moderate-induced hypothermia improves survival and neurological outcomes, and provides national criteria for patient cooling. We have been managing babies with therapeutic hypothermia in our unit since 2009.

Association of Paediatric Emergency Medicine

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UNDERSTANDING RESPONSES OF PAEDIATRIC EMERGENCY DEPARTMENTS TO THE FIRST WAVE OF THE COVID-19 PANDEMIC – A PAN-EUROPEAN PERSPECTIVE

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