urine culture performed. 91% (10/11) of children were prescribed antibiotics appropriately.

100% (7/7) had ultrasonography and DMSA in accordance with the schedule. There was one child who required an MCUG, and was prescribed prophylactic antibiotics.

Conclusions NICE CG54 comprehensively outlines the diagnosis and management of UTIs, but can be challenging to navigate. Results from our first audit cycle revealed a number of learning points. Firstly, there was a lack of clarity regarding the definition of upper and lower UTIs, and hence, antibiotic regimes and duration did not conform to NICE standards. Secondly, it was often not recognised that those under 3-months-old should have a urine culture performed. Lastly, there was poor compliance in undertaking imaging when warranted.

We addressed these areas for improvement through introducing teaching sessions and aide-memoires, and demonstrated improvement in compliance to NICE CG54 in our re-audit.

British Paediatric Respiratory Society

1011

SHARED CARE, SHARED RESPONSIBILITY BY NETWORK APPROACH: IMPROVING CARE FOR CHILDREN WITH SEVERE ASTHMA

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Background Children with severe asthma (SA) suffer from significant morbidity and healthcare utilisation (Bush: 2017). Children with SA benefit from early multidisciplinary assessment of disease severity, access to novel therapies and management of comorbidities in partnership with a specialist severe asthma service. However, the threshold for primary/secondary care referral to such services in the UK is high (Carroll:2019). Unlike for adult severe asthma, a paediatric service is yet to be commissioned by NHS England (NHSE) which may contribute to variation in practice and availability of resources for management of children with SA. In 2019, health professionals from 11 hospitals in a UK geographical region and the multidisciplinary severe asthma service at their tertiary Paediatric Severe Asthma Service set up a network to improve care in their region.

Objectives To describe the process of setting up a paediatric severe asthma network. To evaluate the experience of professionals participating within the network

Methods Referral pathways, proformas for home visits, an investigation pathway, and adherence assessments were designed by designated professional groups. Input from patients and NHSE representatives was sought. Regular meetings between shared care centres were planned to improve communication, provide feedback, share good practices and empower local services in managing comorbidities and asthma education closer to the child's home. A transition pathway is in place where young people with severe asthma and significant comorbidities, some of whom are on biological therapies, are discussed at the regional adult severe asthma multidisciplinary meeting, ensuring safe transition and care at an

appropriate adult asthma centre. Eighteen months after the network for children with SA was set up, a survey was conducted of the network members to investigate the impact of being part of the network.

Results 22 members of the network gave feedback including doctors (n=16), nurses (n=5) and a support worker (n=1). Members were asked to rate on a 10 point Likert scale whether they strongly disagreed (1) or strongly agreed (10) with several statements. Members rated the statements as follows:

Statement	Median (range) rating - 10-point Likert scale
Being part of the network has enabled me to share and/or receive best practice ideas	8 (4,10)
Participating in the network has made me more confident in the care and treatment of patients with severe asthma	7 (4,10)
There have been useful networking opportunities	9 (4,10)
Being part of the network WhatsApp group has made it easier for me to ask questions and raise queries	8 (4,10)
I have found the topics discussed relevant to my practice	8 (4,10)
I have gained new knowledge or skills participating in the network	7 (4,10)
The change to a remote meeting format has been positive	8 (6,10)

Conclusions Being part of the SA network was very positive for members' own professional development and improving the care they provided to children with SA. The network remained valuable despite restrictions enforced by the Covid-19 pandemic. This is a model of shared working and learning that can and should be replicated elsewhere.

British Association of General Paediatrics

1013

DELIBERATE SELF-HARM AMONG CHILDREN AND YOUNG PEOPLE AT A LARGE SECONDARY CARE CENTRE

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Background A recent global meta-analysis (2018) of children and adolescents showed that the lifetime aggregate and 12 months prevalence of deliberate self-harm was 13.7% and 14.2% respectively. Given the high prevalence of this problem and the frequent cases we see in our local population, it is useful to understand the demographics and associations with deliberate self-harm in our local population, identifying those at risk and identify any delays in care for those that need to be admitted to a psychiatric institution to facilitate appropriate care.

Objectives We designed a descriptive study to look at the self-harm associations in our population, to help identify the population at risk and to identify any delays in care to those

needing to be transferred to a mental health facility for specialised care.

Methods The acute paediatrics handover list (electronically stored on our Trust database) was searched for any patients fulfilling the criteria of deliberate self-harm – from April 2019 to November 2019. A total of 57 patients met the criteria for inclusion. The electronic patient database was then searched for each patient and the relevant information documented on a Microsoft excel sheet. The data was then analysed to determine the trends and patterns.

Results The most common method of deliberate self-harm was by overdose with paracetamol being the most common drug used. The most common trigger identified was family stressors (26%) followed by self-esteem issues/loneliness and low mood (25%). 39% of patients were assessed by the Emergency Department Psychiatry Team as needing one to one nursing. 88% of patients were discharged to their previous residence and 2% of patients required admission to a mental health facility. The rest were discharged to a place other than their previous residence – for example a relative's home. The patients requiring discharge to a mental health facility had the largest delays from the time point of the decision being made to the actual transfer – up to eleven days.

Conclusions There is a delay in transfer for patients who require admission to a mental health bed– this may have implications for patient care and use of resources.. One to one nursing was required in a high number of cases, although the majority of these had an inpatient stay of one day or less and discharged to the previous residence, – Previous studies have reported school stressors as a main trigger for deliberate self-harm, but our study indicated in this population, family stressors played more of a prominent role. This study can therefore form the basis for comparison of this pre-pandemic data with the patterns seen during and post the COVID – 19 pandemic as there would have been more time spent with family and less in school.

British Paediatric Neurology Association

1014

SAFETY OF BARBITURATES IN PAEDIATRIC STATUS EPILEPTICUS: A NARRATIVE REVIEW

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Background Status epilepticus (SE) is a life-threatening medical emergency in paediatric patients. Barbiturates such as phenobarbital and thiopental/pentobarbital are used as second- and third-line agents, respectively, in the management of SE after initial treatment with benzodiazepines. Whilst barbiturates are reported to be highly effective in treating SE, there is limited evidence to support their safety.

Objectives To review the evidence relating to the safety of barbiturate use in paediatric SE.

Methods A search of PubMed and Embase databases between January 2015 and January 2021 was performed. All original research papers and meta-analyses discussing the use of barbiturates in paediatric SE and safety-related outcomes were included. Studies conducted in adult populations and those reporting only efficacy outcomes were excluded.

Results Out of 418 studies screened, 18 relevant studies were identified (1 meta-analysis, 3 randomised controlled trials (RCTs), 2 retrospective cohort studies (RCSs), 8 retrospective chart reviews (RCRs), 2 case reports and 2 pre-clinical studies). No studies differentiated between different age groups within paediatric populations. Table 1 summarises the complications associated with barbiturate use in clinical and pre-clinical studies (excluding case reports).

Conclusions Barbiturate use in SE is associated with several respiratory and haemodynamic complications in clinical

Abstract 1014 Table 1 The type of study is in brackets

	Safety outcomes reported for each barbiturate			
	Phenobarbital	Thiopental	Pentobarbital	Barbiturates (undifferentiated)
Hypotension	In 37.5% and 45.2% of patients (2 RCRs)	In 75% of patients (1 RCR)		
Death due to thiopental-induced hypotension (3 RCRs)	In 91% of patients (1 RCS)	In 79% of patients (1 RCR)		
Sepsis	In 100% of patients (1 RCR)	Reported in 1 RCR	In 17% of patients (1 RCR)	
Pulmonary infection	In 38.5% of patients (1 RCR)	Reported in 1 RCR	In 59% of patients (1 RCR)	
Respiratory depression	6% increased risk compared with valproate (1 meta-analysis of 16 RCTs)			
Treatment course	43% reduced risk of admission to the intensive care unit compared with phenytoin treatment (1 RCT)			
Increased safety failures requiring discontinuation of treatment compared with levetiracetam (1 RCT)	Longer mechanical ventilation than in the propofol group (1 RCT)	Longer hospital stays than the benzodiazepine group (1 RCS)	64% of patients developed movement disorders and 55% got hypertension after pentobarbital discontinuation (1 RCS)	
Outcomes at discharge		Reduced return to baseline condition compared to the propofol group (1 RCT)	46–50% of patients had a decline in neurological outcome (2 RCRs)	
Increase in SE-like activity	Reported in 1 pre-clinical study			
Increase in seizure-associated neuronal injury	Reported in 1 pre-clinical study			