and vastly improving the engagement of the group we represent.

Conclusions Individual:

- Patience and persistence are vital to having a rewarding leadership experience.
- Continuity is key: development of a documented strategic plan allows a streamlined approach to long term ideas and minimises the stop-start nature seen with many junior doctor projects.
- A role shared is a role halved. Seek flexible working.

Organisational:

- Develop structures to support junior doctors in leadership roles outside of formal leadership pathways. Potentially pair roles with consultant leaders to provide mentorship.
- Develop a culture where leadership roles are valued and incorporated into training.
- Support virtual environments.

British Society of Paediatric Endocrinology and Diabetes

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ARE GREATER NUMBERS OF CHILDREN WITH NEWLY DIAGNOSED TYPE 2 DIABETES MELLITUS A FURTHER EXAMPLE OF COLLATERAL DAMAGE FROM THE COVID-19 PANDEMIC?

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Background The 2019 novel SARS-CoV-2 coronavirus infection (COVID-19) pandemic has led to a number of changes to the daily routine for school aged children. Specifically, remote learning due to school closure, increased screen time for virtual learning, greater sedentary exposure, less exercise and potential changes to diet. These risk factors pose a potential threat for significant increase in weight gain leading to further increase in obesity among children and young people (CYP). This might eventually translate to the increased incidence of complications due to obesity including type 2 diabetes mellitus (T2DM).

Objectives A case series to find the incidence of T2DM in children and young people in a large UK teaching hospital during the COVID-19 related lockdown period.

Methods We prospectively collected data on children aged <17 years admitted to a large UK teaching hospital with newly diagnosed T2DM. Data was collected between May 2020 and November 2020 during the COVID-19 pandemic. We examined demographic, clinical and biochemical data.

Results Six newly diagnosed children (five males, one female), four from minority ethnic backgrounds, mean (SD) age 14.4 (2.2) years, weight 84 (27) kg and BMI 32 (6) kg/m² (BMI Z score +1.92 (0.5)). 3 (50%) children had learning difficulties and all presented with classic features across the spectrum of severity from osmotic symptoms to one child with diabetic ketoacidosis (DKA). 50% had acanthosis nigricans at presentation and a mean (SD) blood glucose of 18.38 (4.5) mmol/L. Mean (SD) HbA1c was 89.5 (23.8)

mmol/mol. All six children had negative diabetes antibodies. All of them tested negative for COVID-19. Most parents reported that their children gained weight during lockdown. For comparison, in the preceding years, on average two children (age <17 years) per year are diagnosed with T2DM in the same centre.

Conclusions We are seeing an increased incidence of T2DM in children and young people (CYP) in a large UK teaching hospital during the ongoing UK 'lockdown'. This was reflected by a significant threefold increase in children with newly diagnosed T2DM. We draw attention to whether environmental and societal changes during lockdown have conferred an increased risk of obesity among CYP which have led to this significant increase in the incidence of T2DM. Alternatively this could be an indirect effect of the current pandemic. Both highlight the importance of adequate measures to be implemented to restore the physical and mental health of these CYP. In light of this we propose that parents, children and school authorities should work together to motivate CYP to participate in regular physical activities that are practically feasible during lockdown. Furthermore, there may be a delay in accessing healthcare services due to various psychosocial factors as seen in children with type 1 diabetes resulting in delayed diagnosis. All these highlight the importance of increased awareness among the public and healthcare professionals to diagnose these children early and initiate treatment.

Association of Paediatric Emergency Medicine

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COVID IS NOT ALL BAD. SERVICE IMPROVEMENT TO FRACTURE MANIPULATION IN THE CHILDREN'S EMERGENCY DEPARTMENT

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Background As part of a QI project looking at forearm fractures, a retrospective audit was performed looking at a 1-year period of wrist and forearm fractures up to March 2018. Over this period 98 patients had fractures that required intervention and 34% of these had a manipulation in CED. Reasons for not having a manipulation were cited a possibility child would not tolerate procedure under entonox and intranasal diamorphine and not having a sedation trained practitioner free to administer intravenous sedation instead. This resulted in the remainder requiring admission for manipulation under anaesthetic.

Given the concerns re noscomial COVID 19 transmission as well as lack of theatre capacity in the first wave of the pandemic, a change was made to our forearm fracture guideline in partnership with the Orthopaedic team with emphasis on attempt at manipulation in the emergency department with entonox and intranasal diamorphine prior to admission to actively avoid as many admissions as possible.

Given this change in practice we wanted to ascertain parent/patient satisfaction with this and see if this reduced hospital admission.

Objectives

- Ascertain if promoting manipulation of forearm fracture as first line treatment is effective at avoiding hospital admission

and subsequent further manipulation in theatre and reduces admission rates compared to previous audit data

- Ascertain if using entonox and intranasal diamorphine for the manipulation of forearm fractures was perceived by parents to be satisfactory pain relief for the procedure
- Ascertain if using entonox and intranasal diamorphine for the manipulation of forearm fractures provides a satisfactory patient experience

Methods A specially designed parental/patient experience survey was developed and given out to patients requiring a forearm manipulation in CED between June - October 2020.

Retrospective case notes review of all patients <16 years attending CED with a forearm fracture during the same period to identify management and outcome.

Results During the survey period 47 children attended CED with a forearm fracture requiring manipulation. Of these 21 parents completed the survey.

Overall 85% of all patients attending CED with a forearm fracture requiring manipulation had it done in CED compared to 34% in 2018.

100% of survey respondents felt their child's pain was well managed during the procedure.

Only 14% of patients with forearm fracture attending CED were admitted for manipulation in theatre during this period compared to 66% found in audit data previously.

Conclusions Use of Entonox and IN diamorphine is provides effective pain relief for manipulation of forearm fractures that is acceptable to parents. A change in practice to using this first line can reduce admission rates and subsequent theatre time for this common fracture significantly.

Child Protection Special Interest Group

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THE NEED FOR A STANDARDISED APPROACH FOR PAEDIATRICIANS TO MANAGE CHILDREN NOT BROUGHT (WNB) TO OUTPATIENT CLINICS

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Background Children not brought to outpatient clinics pose significant safeguarding and logistical challenges. Learning from serious case reviews indicate that whilst it may indicate carers struggling to provide adequate care for their child, it is also particularly relevant for vulnerable children already on CP plans. Failure to attend medical appointments is recognised as a child protection issue within statutory definitions of neglect. Implied, therein, is the adverse consequence on health. The logistical difficulties include wasted clinic slots and extension of stretched waiting lists.

Objectives Audit our management of non-attendance (DNA/WNB) in general paediatric clinics, to highlight this important issue, and improve consistency across professionals. We expect this will reduce both the safeguarding risk and logistical burden from missed appointments.

Methods

Sample Period: 01/11/19 – 10/11/19

Criteria: All paediatric outpatient appointments across both trust sites with outcome 'did not attend'.

Relevant Sample Size: 70

Data Collection: Retrospectively from electronic patient records accessing clinic notes and letters, we assessed for presence of safeguarding alert in referral letters and information shared back to referrer following non-attendance - verifying contact details, interim management advice, assessment of safeguarding context and copy of letters to HV, school nurse or key worker.

Data was analysed for upto 3 non-attendances.

Validation: Use of Pro-forma

Exclusion Criteria: Patients who had appointments cancelled by the Trust, or were admitted as in-patients.

Results

- There was slight male gender predominance at 57%.
- Preschoolers (1–5yrs) were the most common age group at 41%, followed by teenagers (11–16yrs old) at 31%, and then primary school children (6–10yrs) at 18%.
- 84% of the new referrals were discharged after the first appointment. Yet:
- Only 13% had safeguarding or social background documented in the referring letter.
- 85% of non-attending children had letters sent to the GP and parents informing them of the missed appointment.
- 11% of letters requested GP to confirm the patient's address or contact details, 14% for the first one.
- 24% of letters were copied to the key worker, health visitor or school nurse; 30% after the second non-attendance.
- 50% of the letters had management advice for the GP or the parent.
- 10% of letters had a safeguarding reminder to GP in view of Non-attendance, only about 12% for the 3rd non-attendance

Conclusions Significant variations in management of non-attendance are evident. Safeguarding, clinical management or logistic burden of missed appointments is NOT sufficiently mitigated.

We recommend:

- Request to complete safeguarding status for referral linked to local or national referral system.
- Bespoke guideline followed by paediatrics and specialty clinicians, with clear escalation pathways.
- A standardised template that highlights previous non-attendances, safeguarding context, contact details and is copied to relevant health professionals.
- Robust guidelines followed widely, and additional context of virtual clinics would be welcome.

British Association of General Paediatrics

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PARENT PREFERENCE: COMPARING TELEPHONE WITH FACE TO FACE CONSULTATIONS DURING THE COVID-19 PANDEMIC

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